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The King's Fund
Bold thinking for better health

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Strategic authorities and health inequalities: 10 actions for realistic progress

About CLES

Founded in 1986, the Centre for Local Economic Strategies is an independent economics think tank and charity. We work collaboratively across the UK and Ireland to develop solutions that ensure economies are rooted in the places people call home.

At CLES, we partner as equals with all levels of government, local institutions and communities — challenging outdated methods and tackling local issues with practical, long-term solutions.

About The Kings Fund

The King's Fund is an independent charity working to improve people's health. Our vision is a world where everyone can live a healthy life. Our mission is to inspire hope and build confidence for positive change. We achieve this through expert insights and original research, developing leaders and their organisations, convening, and strategic, collaborative partnerships.

About this essay

This is the final essay in a programme of work supported by The Health Foundation that answers key questions about the effectiveness of devolution in addressing health inequalities.

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Introduction and summary

Over the past two years, the Centre for Local Economic Strategies (CLES) and The King's Fund have gathered extensive insights into how strategic authorities (SAs) can influence the wider determinants of health and reduce persistent health inequalities across England. Through interviews, workshops and discussion with mayors, officers, NHS leaders and local government officials, we have seen a growing ambition among both established and emerging SAs to embed action on health inequalities into their governance, strategy and delivery. At the same time, we have seen the practical constraints and trade-offs that can undermine these ambitions if they are not carefully designed and delivered.

This essay is intended principally as a conversation starter for newly formed and soon-to-be-formed SAs, as well as for central government teams shaping future devolution settlements and support arrangements for SAs and their partners, including integrated care systems (ICSs) and integrated care boards (ICBs). It is also relevant to more mature SAs seeking to reappraise or strengthen their approach in the context of changing economic conditions, fiscal pressures and growing policy expectations around health and inclusive growth. Throughout, the essay is grounded in a pragmatic assessment of what SAs can realistically deliver with the powers, incentives and capacity they hold.

A core and durable way for SAs to narrow health inequalities is to focus on the things that most directly shape residents' living standards: raising disposable incomes, reducing unavoidable costs and improving access to good work, affordable housing and reliable transport. Income matters in its own right because it shapes access to almost every other condition that supports good health and helps explain why health follows such a strong social gradient. But employment, housing and transport also matter beyond their effect on income. Good work can provide security, purpose and progression; affordable, secure housing underpins stability and wellbeing; and accessible transport connects people to jobs, services and social networks. Together, these are among the most important foundations of health and the areas where SAs have the clearest ability to make a difference through their powers, influence and partnerships as they begin to take on their upcoming health duty.

What follows is not a comprehensive inventory of everything SAs could do, nor a claim that one specific intervention will always outperform another. The evidence is strongest on the importance of employment, housing and transport as drivers of health inequalities, and there is a growing body of practical experience from SAs and their partners in acting on these areas. While comparative evaluation of different SA-led interventions remains limited, the priorities set out here combine the available evidence with informed judgement about where SAs have meaningful influence, where action is most feasible within current devolution arrangements, and where visible progress is most plausible within the next 18 months.

The aim is to move the debate beyond broad ambition and towards a sharper agenda for delivery.

The essay proceeds in four parts. It begins by setting out why health inequalities matter for SAs and why employment, housing and transport are such important levers. It then examines the national policy context and fragmented incentives that currently limit progress. The third section sets out five priorities for a new SA's first 18 months, focused on what SAs can realistically do now. The final section turns to central government and the changes needed to enable more impactful local action. The aim throughout is not to offer an exhaustive blueprint, but to identify the most plausible route to practical progress.

1. Why this matters: health inequalities, income and the role of strategic authorities

Health inequalities are not simply the product of individual behaviour or unequal access to healthcare. They are produced and sustained by differences in the conditions in which people are born, grow, live and work.[1] These wider determinants of health include employment, housing, transport, education, social security and the local environment. Among these, income is especially important because it shapes access to almost everything else.

The evidence linking income to health is extensive and consistent.[2] In England, the social gradient in health closely mirrors the distribution of income: lower incomes are associated with poorer mental health, higher rates of long-term illness and shorter healthy life expectancy, even within a universal healthcare system. When people do not have enough money to meet daily essentials, they are less able to afford decent housing, healthy food, reliable transport, financial security and participation in social life. These disadvantages do not operate in isolation. They accumulate and reinforce one another over time, producing worse health outcomes and widening health inequalities.

This is why employment, housing and transport matter so much. Employment is the main route to income for most households, but job quality matters as much as labour market participation.[3] Insecure, low-paid and low-control work is consistently associated with worse physical and mental health, while secure, decently paid and well-designed work has protective effects. Housing affordability and housing quality are equally central.[4] High housing costs reduce disposable

[1] L Marshall. (2024). What builds good health? An introduction to the building blocks of health. Health Foundation. Read.
[2] See for example: JN Morris & C Deeming (2004). Minimum Incomes for Healthy Living (MIHL): next thrust in UK social policy?. Policy & Politics, 32(4). Read; JN Morris et al (2010)., Action towards healthy living—for all, *International Journal of Epidemiology*, 39 (1). Read. M Marmot et al (2010). Fair society, healthy lives : the Marmot Review: strategic review of health inequalities in England post-2010. Read; Public health England (2014). Local action on health inequalities: Health inequalities and the living wage. Read; ML Buzelli et al (2022). A framework for NHS action on social determinants of health. The Health Foundation. Read.
[3] Marmot et al (2010). Fair society, healthy lives : the Marmot Review : strategic review of health inequalities in England post-2010. Read.
[4] See for example: The Health Foundation. (2024). Inequalities in housing affordability. Read; and, The Health Foundation. (2024). Inequalities in households experiencing housing problems. Read.

income and increase financial stress, while poor-quality, overcrowded or insecure housing contributes directly to physical and mental ill health. Transport shapes whether people can reach jobs, education, healthcare and social networks.[5] When transport is unaffordable, unreliable or poorly connected, it can deepen isolation, restrict opportunity and compound financial strain.

These determinants matter not only because they shape health directly, but because they are increasingly within the orbit of SAs. Through devolved powers over skills, employment support, transport planning, bus services, strategic spatial frameworks, affordable housing investment and local growth planning, SAs now influence many of the systems that shape people's incomes and living costs. They also affect whether people can access the wider conditions that support a healthy life: secure and decent work, affordable and stable housing, reliable transport, access to essential services and the ability to participate in community life. These powers may appear technical, but together they have a major influence on whether residents can build healthy, secure and fulfilling lives.

This is what gives SAs their importance. They are large enough to shape labour markets, housing systems and transport networks, yet close enough to place to understand how these systems interact in people's everyday lives. Unlike individual local authorities, they can act across functional economic geographies, aligning investment, skills provision and infrastructure with patterns of work, travel and housing demand. Unlike central government, they can tailor interventions to local conditions rather than relying on one-size-fits-all policy.

Whether or not SAs choose to describe their work through a health lens, the decisions they make on economic development, transport, housing and employment will affect the health of their populations. The question is therefore not whether SAs influence health inequalities, but whether they do so intentionally, coherently and in ways that improve living standards for those most at risk of poor health.

2. What limits progress today: the national policy context and fragmented incentives

If SAs have meaningful levers, they do not operate in a frictionless environment. Their ability to act on the wider determinants of health is shaped, and often constrained, by national policy frameworks, institutional incentives and the uneven capacity of local systems.

The first constraint is the way economic success continues to be framed nationally. Central government guidance still tends to measure success primarily

[5] See for example: K Lucas at al. (2019). Inequalities in mobility and access in the UK transport system: Future of Mobility Evidence Review. Government Office for Science. Read; and, JS Mindell et al (2024). Transport, health and inequality: An overview of current evidence. *Journal of Transport & Health, 38*. Read.

in terms of aggregate growth.[6] This matters because it shapes which sectors, places and activities are prioritised locally. Growth measured only at the aggregate level, without attention to who benefits or whether living standards are improving for those with the poorest health, can rise without improving wages, job security or economic resilience.[7] It can also encourage strategies that worsen the very inequalities they claim to address. Approaches that focus heavily on attracting highly skilled workers, accelerating market-led development or prioritising commercially attractive transport routes may increase output, but can also raise costs, displace lower-income households and bypass the communities with the worst health outcomes.[8] Without a clearer test of distributional impact, actions taken in the name of growth may deepen inequality rather than reduce it.

The second constraint lies within the health system. ICSs are important partners for SAs, but their accountability frameworks and financial pressures remain heavily dominated by acute demand. Without changes to how success is measured and funded, the NHS is constrained in its ability to shift resources upstream, even where the case for prevention is strong. The risk is that partnership between SAs and ICSs remains rhetorical, rather than becoming a serious mechanism for acting on the economic and social conditions that drive ill health.[9]

Finally, devolved powers and resources vary significantly between places. Differences in the maturity of institutions, the strength of local partnerships, the availability of assets and expertise, and the degree of fiscal flexibility mean some SAs are better placed than others to act. This is not a trivial issue. Without mechanisms for shared learning and support, devolution can reproduce unevenness between places, with stronger systems pulling further ahead.[10]

Taken together, these constraints mean SAs hold meaningful but bounded levers. They have enough power to matter, but not enough to ignore context. This makes prioritisation, sequencing and strategic clarity especially important. The challenge is not to produce the perfect blueprint for all places, but to identify the few areas where SAs can act with real purpose and plausible impact.

3. Five priorities for the first 18 months

The first 12 to 18 months of a new SA will be critical in setting direction, building credibility and establishing whether the emerging health role of SAs becomes real or remains rhetorical. Early choices about governance, accountability, evidence,

[6] TL Goodwin et al (2026). Plans for growth and the building blocks of health. CLES, The King's Fund and The Health Foundation. (Forthcoming).
[7] TL Goodwin (2022). Labour can't just offer growth for growth's sake. The New Statesman. Read.
[8] A Bua, R Laurence and O Vardakoulias (2017). Understanding Devolution: A Critical Appraisal of the Greater Manchester Devolution Deal. The New Economics Foundation. Read.
[9] L Tiratelli, D Buck and TL Goodwin (2025). Integrated care systems and strategic authorities: Coming together to tackle health inequalities and the wider determinants of health. CLES and The King's Fund. Read.
[10] TL Goodwin et al (2024). Tackling health inequalities through English devolution. Towards a new framework. CLES and The King's Fund. Read.

delivery and partnership working will shape whether action on health inequalities becomes embedded in the mainstream of devolved economic governance.

The five priorities set out below are intended as a practical agenda for this early period. They are not meant to be interpreted as a rigid sequence. Different SAs will enter this agenda from different starting points depending on institutional maturity, local opportunity and the timing of policy cycles. What matters is coherence and intent.

Priority one: Make health equity a core test of strategy and governance

Health inequalities should be embedded explicitly within growth plans, transport strategies and spatial frameworks, not treated as an adjacent or secondary concern. This means shifting from a position where health is acknowledged in principle to one where it is used as a real test of policy design and investment.

At present, one of the biggest risks is that strategies continue to prioritise aggregate output without regard to distribution or health impact. Our work on local growth plans suggests that this is where some otherwise promising strategies fall short.[11] Plans often talk about inclusive growth or health, but fail to specify how investment will reach people with the lowest incomes or poorest health. The gap is often not ambition, but delivery.

If SAs are serious about narrowing health inequalities, major investment and policy proposals should be required to show who is expected to benefit, whether the proposal will improve disposable incomes, job quality or reduce essential costs, whether benefits will reach people and places experiencing the poorest health, and what delivery mechanisms will make this happen in practice. Where reducing health inequalities is not the purpose of an intervention, that should be stated clearly. The point is not to pretend that every intervention can do everything, but to make the intended balance of outcomes transparent.

In particular, SAs should move beyond assuming that growth will "trickle down". Proposed local growth plans should be assessed not only against expected gross value added (GVA) or jobs created, but also against whether they:

- strengthen sectors that employ large numbers of lower-income residents, especially the everyday economy;[12]
- include targeted recruitment, local labour clauses, skills pipelines or progression routes;
- use anchor institutions, procurement and commissioning to create demand for better-paid and more secure work; and
- improve affordability through housing and transport as well as through earnings.

[11] TL Goodwin et al (2026). Plans for growth and the building blocks of health. CLES, The King's Fund and The Health Foundation. (Forthcoming).
[12] This includes sectors such as retail, logistics, hospitality, education and health and social care.

Our previous work here argues that broader goals such as poverty reduction or health impact assessment should be reflected in local growth plans and the guidance that supports them.[13]

This also has implications for governance. Joint governance with ICBs is becoming increasingly important, especially as recent reforms mean mayors or their representatives will sit on ICBs.[14] This creates a new opportunity to align upstream economic levers with health system priorities. SAs should use that opportunity to ensure that health inequalities are not treated as a matter for public health teams alone, but as an organising concern across transport, planning, employment and growth.

Priority two: Build a minimum viable health equity operating system

Building analytical and delivery capacity is essential to delivering progress.[15] SAs should establish a shared intelligence and evaluation function drawing on expertise from the authority, constituent councils and the NHS. This could be a formal team or a more virtual model, most likely supported in the first instance by secondments, with some modest commissioning budget where specialist capability is not available in-house.

Its purpose should be practical. It should assess the distributional and health impacts of major investments. It should develop shared metrics that go beyond GVA, including measures such as disposable income after housing and transport costs. It should ensure consistent use of deprivation, population health and service-demand data across SA and ICS partners. And it should provide a common evidence base for the new health duty, so that decisions are made on something more solid than instinct or aspiration.

These are not glamorous institutional reforms. But they are important because duties only change behaviour when they are accompanied by the means to interpret, apply and evaluate them. Data-sharing arrangements, common analytical tools and joint evaluation frameworks are low-cost but high-impact enablers.[16] Without them, action on health inequalities risks becoming impressionistic and hard to sustain.

Priority three: Prioritise a small number of interventions that raise incomes and reduce essential costs

Given limited capacity, SAs should focus on interventions that can generate early progress while laying the foundations for longer-term change. Employment,

[13] TL Goodwin et al (2026). Plans for growth and the building blocks of health. CLES, The King's Fund and The Health Foundation. (Forthcoming).
[14] L Tiratelli, D Buck and TL Goodwin (2025). Integrated care systems and strategic authorities: Coming together to tackle health inequalities and the wider determinants of health. CLES and The King's Fund. Read.
[15] D Buck (2025). Crunching the numbers: why we need an analytical capability and workforce plan. The Kings Fund. Read.
[16] L Tiratelli, D Buck and TL Goodwin (2025). Integrated care systems and strategic authorities: Coming together to tackle health inequalities and the wider determinants of health. CLES and The King's Fund. Read.

housing and transport are prioritised here because they combine several strengths:

- there is strong evidence that they shape health inequalities;
- SAs already hold meaningful powers, influence or convening capacity in these areas;
- there are credible routes through which policy can improve outcomes, including raising incomes, reducing costs and improving access to opportunity; and,
- progress is realistic within current devolution arrangements, even where some gains take longer to emerge.

The discussion below therefore concentrates on these three areas. Further detail on the interventions highlighted can be found in our previous essays on employment,[17] infrastructure (housing and transport)[18] and local growth plans.[19] See also appendix one for a starter pack of evidence, tools and networks that SAs can draw on in developing their priorities.

Employment: connect people to secure, better-paid work

In employment, this means shifting away from "any job" approaches and towards integrated pathways that connect devolved skills funding, employment support and employer demand. Employment is one of the strongest determinants of health because it shapes income, security, stress and long-term opportunity. But not all work improves health. Jobs that are insecure, low paid or poor quality can leave people little better off and may reinforce inequality. SAs should therefore prioritise access to secure, better-paid work with genuine progression, particularly for people facing the poorest health outcomes.

The most promising interventions are those that link skills, employment support and employers into a single pathway. Rather than funding generic training, SAs should focus on integrated training-to-work pipelines in sectors with high local demand, including the everyday economy. This means using devolved adult skills budgets, employment support and employer partnerships to connect residents directly to real vacancies and progression routes.

Three priorities stand out.

- First, **develop employer-designed training and recruitment pathways in sectors where there are clear opportunities to improve pay and job quality**.
- Second, **create a "one front door" model of employment support** that joins up careers advice, training, health support and job brokerage for people facing the greatest barriers to work.

[17] TL Goodwin, D Buck and L Tiratelli (2025). Addressing health inequalities through employment. CLES and The King's Fund. Read.
[18] TL Goodwin, S Rahman, D Buck and L Tiratelli (2025). Affordable infrastructure: How strategic authorities can use housing and public transport to tackle health inequalities. CLES. Read.
[19] TL Goodwin et al (2026). Plans for growth and the building blocks of health. CLES, The King's Fund and The Health Foundation. (Forthcoming).

- Third, **work with anchor institutions and major employers to guarantee interviews, work placements or reserved jobs** for people completing pre-employment support.

There is evidence that these approaches can work. In the West Midlands, targeted recruitment and training programmes through the NHS have linked pre-employment support to reserved jobs for people farthest from the labour market.[20] In West Yorkshire, devolved adult education funding has been used to train bus drivers in areas of high unemployment, connecting skills investment directly to existing vacancies.[21] But these interventions only reduce health inequalities when they are explicitly targeted. Without that intent, the risk is that the benefits of growth and skills investment are captured disproportionately by those who are already better off.[22]

Housing: reduce housing stress and increase genuine affordability

In housing, early action should focus on locking in genuine affordability through tenure mix, planning conditions and publicly-led delivery models. Housing should be a priority because it affects both living conditions and household income. High housing costs reduce the money available for essentials, while overcrowded, insecure and poor-quality housing are associated with worse physical and mental health. Increasing the supply of genuinely affordable homes, particularly social rent and living rent products, is therefore one of the most direct ways to reduce health inequalities.

SAs have several forms of leverage here.

1. They can **use strategic planning and spatial frameworks to require higher proportions of genuinely affordable homes** in new developments and resist viability arguments that reduce provision.
2. They can **use public land, land commissions, joint asset boards and compulsory purchase powers** to unlock sites and support joint bids into national affordable housing programmes.
3. They can **support publicly-led and municipal housing models**, including council-owned housing companies and mayoral development corporations, so that more of the value created through development is retained locally and translated into lower rents, better quality and longer-term stewardship.

These priorities matter because the prevailing speculative development model has too often delivered housing numbers without delivering affordability. In high-demand places especially, this has contributed to rising land values, wealth extraction and a chronic undersupply of genuinely affordable homes.[23] Publicly led approaches will not be the whole answer, and private developers and housing

[20] CLES (2023). Case study: ICAN. Read.
[21] TL Goodwin et al (2026). Plans for growth and the building blocks of health. CLES, The King's Fund and The Health Foundation. (Forthcoming).
[22] A Bua, R Laurence and O Vardakoulias (2017). Understanding Devolution: A Critical Appraisal of the Greater Manchester Devolution Deal. The New Economics Foundation. Read.
[23] R Goulding,. A, Leaver, and J Silver (2025). Centripetal cities: A critique of supply-side urban development. Read.

associations will continue to matter. But SAs should use the powers they do have to shape housing systems around affordability, security and health rather than numbers alone.

Transport: improve affordability, reliability and access

In transport, affordability and reliability should be treated as flagship health inequality levers. Transport matters because it determines whether people can access work, education, healthcare, shops and social networks. Where transport is expensive, unreliable or poorly connected, it can reinforce social isolation and make it harder for people on lower incomes to enter or remain in employment. Transport disadvantage is concentrated in poorer and more isolated communities, and it contributes directly to wider health inequalities.

SAs therefore have an important role in ensuring that transport systems improve access rather than deepen exclusion.

1. They can **use Bus Service Improvement Plan funding, mayoral precepts and concessionary fare schemes** to keep public transport affordable, particularly for people on lower incomes and for groups such as young people, older people and jobseekers.
2. They can **prioritise reliability, frequency and coverage on routes serving deprived or less commercially attractive areas**, rather than focusing only on routes with the strongest market demand.
3. And they can **increase public influence over networks through franchising, enhanced partnerships and the establishment of municipal bus companies**, so that routes and fares are shaped by social need as well as commercial viability.

Greater public control matters because where transport is left entirely to the market, less profitable but socially vital routes are often the first to weaken or disappear.[24] The broader principle is simple: transport systems should be judged not only by passenger numbers or commercial return, but by whether they improve access for the people and places with the greatest need.

Priority four: Mobilise anchor institutions and community wealth building

Anchor institutions, especially the NHS, councils, colleges and large housing providers, are often the biggest employers, purchasers and asset owners in an area. When their workforce, procurement and estate strategies align with SA priorities, they create a multiplier effect that no single organisation could achieve alone.

This is where community wealth building can become especially useful, not as a parallel agenda but as a practical set of methods for turning strategic intent into delivery. In practice, this means using the spending, employment and

[24] A Donkin, M Childs and M Marmot (2024). Transport's role in creating a fairer, healthier country: a social determinants of health perspective. IPPR. Read.

commissioning power of large local institutions to support local businesses, create secure jobs, improve job quality and retain more wealth locally. For SAs, the value of this approach is that it connects growth ambitions to measurable improvements in wages, economic security and local institutional behaviour. Evidence from Preston suggests that place-based approaches of this kind can improve wellbeing and wages,[25] while broader CLES work has highlighted the role that anchor institutions can play in shaping local economies through their procurement and employment practices.[26] Community wealth building is a key organising principle of the York and North Yorkshire local growth plan and CLES is currently working with the SA to operationalise its guiding principles.

Drawing on our emerging work in this area, a regional anchor compact could focus on good work and targeted recruitment commitments, local and social value procurement, support for inclusive ownership and stewardship models, and joint SA–ICS delivery on prevention opportunities.[27] The importance of this approach is that it can improve the conditions that shape health: creating better jobs, widening access to employment, retaining more wealth locally, strengthening local supply chains and supporting the social infrastructure on which communities rely.

Priority five: Make political trade-offs explicit and govern them transparently

SAs will face unavoidable tensions between visible growth projects and distributional objectives. Rather than pretending these tensions do not exist, authorities should make them explicit. They should publish a clear statement of how trade-offs will be managed, including how decisions that may raise land values, rents or fares will be weighed against their effects on lower-income households.

This is important because duties influence behaviour only when they are accompanied by transparent intent, clear governance mechanisms and publicly visible tests for investment decisions.[28] SAs should therefore assess major growth and infrastructure proposals against explicit distributional tests. These might include income-focused tests, such as whether a proposal increases disposable income for households in the bottom quintile by a greater absolute and relative amount than the average, or more directly health-focused tests, such as whether a proposal makes a proportionately larger difference for those with the poorest health outcomes.

Shared accountability with ICSs is also critical here. Without it, health equity risks being displaced either by short-term growth pressures or by the acute-care

[25] See for example: TC Rose et al. (2023). The mental health and wellbeing impact of a Community Wealth Building programme in England: a difference-in-differences study. The Lancet Public Health 8 (6). Read.; TC Rose et al. (2025). Understanding the differential effects on employment of a community wealth building programme in England. Journal of Epidemiology and Community Health 79 (9). Read; TC Rose et al. (2025). Relationships between local public spending, employment and wages within local authorities in England – a longitudinal ecological analysis. NIHR Open Research. Read.
[26] TL Goodwin and H Power. Community wealth building: A history. CLES. Read.
[27] D Buck, L Tiratelli and TL Goodwin (2025). A new health duty for mayors and strategic authorities: getting it right. CLES and The King's Fund. Read.
[28] Ibid.

demands of the NHS. Stronger scrutiny, published distributional impact assessments and visible political leadership are all ways of reinforcing the discipline needed to stay aligned with long-term health goals.[29]

4. What government must do differently

SAs can only do so much within the rules, funding arrangements and incentives set by central government. If national policy remains misaligned, the ability of SAs to act upstream of the NHS will remain constrained. The government therefore has a decisive role in either enabling or undermining progress.

First, it should implement a strong and realistic health duty alongside a serious support system for SA–ICS engagement. Local systems need clarity that the government's health mission, English devolution agenda and 10-year health plan are genuinely aligned. The health duty should be tied to a clear theory of change for how SAs are expected to act through their own functions and through partnership.[30] This implies expectations that SAs cooperate formally with partners such as ICSs, develop a health inequalities strategy or equivalent process, maintain internal health capability, and agree co-owned outcomes frameworks that include their role in acting on the wider determinants of health.

Second, government should align national growth policy with health and distribution. Current guidance remains too heavily focused on aggregate output. Local growth plans should be required to consider explicitly who benefits, how income and affordability are affected, and what the likely implications are for health inequalities. Without this, national policy will continue to pull local systems away from the very objectives ministers increasingly claim to support.[31]

Third, government should provide stable, long-term funding for upstream determinants. Short-term and competitive funding pots are poorly suited to the kind of sustained investment needed in skills, affordable housing and public transport. More mature SAs should continue to move towards integrated settlements, but the principle of long-term certainty needs to extend more broadly across local government and relevant partners. Preventive action requires predictable and flexible funding, not episodic bidding rounds. As previous work in this programme has argued, underfunding in local government has a direct knock-on effect on the ability of SAs and their partners to support and scale activity on health inequalities.[32]

Fourth, government should enable stronger local control over housing and transport affordability. This means giving SAs clearer and more flexible tools to

[29] L Tiratelli, D Buck and TL Goodwin (2025). Integrated care systems and strategic authorities: Coming together to tackle health inequalities and the wider determinants of health. CLES and The King's Fund. Read.
[30] D Buck, L Tiratelli and TL Goodwin (2025). A new health duty for mayors and strategic authorities: getting it right. CLES and The King's Fund. Read.
[31] TL Goodwin et al (2026). Plans for growth and the building blocks of health. CLES, The King's Fund and The Health Foundation. (Forthcoming).
[32] TL Goodwin et al. (2024). Tackling health inequalities through English devolution. Towards a new framework. CLES and The King's Fund. Read.

lock in affordability, both within national housing programmes and in relation to transport. In housing, SAs should have stronger powers to require genuinely affordable homes through strategic planning and spatial frameworks, greater flexibility to use public land and compulsory purchase powers, and more freedom to support publicly-led development models, including council-owned housing companies and mayoral development corporations. Government should also reform national housing programmes and compulsory purchase rules so that land and empty homes can be acquired more easily and used to deliver social and living rent housing.

In transport, government should continue to support not only bus franchising but also the ability of SAs to establish municipal bus companies. Public and franchised transport models matter not only because they improve local control, but because they allow more of the revenue currently extracted as profit or shareholder dividends to be reinvested in cheaper fares, more reliable services and better coverage for lower-income communities.[33] Greater local control should therefore be understood not simply as a governance issue, but as a practical route to making essential infrastructure more affordable.

Fifth, NHS incentives must be reformed to support prevention and place-based action. As long as NHS accountability is dominated by acute demand and activity targets, ICSs will struggle to invest upstream. National policy should ensure that prevention, population health and partnership with SAs are properly resourced and rewarded. That includes a substantial real-terms increase in the public health grant, outcomes frameworks that include the wider determinants of health, and payment mechanisms that reward progress on prevention and health inequalities rather than only activity levels.

All of this should sit within a wider cross-government health inequalities strategy that gives real operational meaning to the ambition to narrow the healthy life expectancy gap. Without that wider strategy, too much will continue to depend on local improvisation.

Conclusion

SAs are not starting from scratch. Across England, there is already a growing body of practice showing how devolved economic powers can be used to improve the building blocks of health. But for many newly established and soon-to-be-established SAs, the challenge is less how to design a perfect strategy than where to begin. The first 12 to 18 months will be critical in setting direction, establishing relationships and deciding whether health inequalities become a real organising concern or remain a rhetorical aspiration.

[33] TL Goodwin et al. (2025). Affordable infrastructure: How strategic authorities can use housing and public transport to tackle health inequalities. CLES and The King's Fund. Read.

This essay has argued that a practical and high-impact route for SAs to narrow health inequalities is to focus on raising disposable incomes and reducing unavoidable costs, particularly through employment, housing and transport. These priorities are not presented because they are the only determinants that matter, nor because there is definitive evidence that one intervention will always outperform another. Rather, they are the areas where the evidence of need, the reality of SA influence and the prospect of practical delivery overlap most clearly.

For new SAs, this implies a practical starting point rather than an exhaustive blueprint: embedding health equity into mainstream strategy; building shared analytical capacity; prioritising a small number of high-impact interventions; mobilising anchor institutions and community wealth building; and being transparent about trade-offs. Different places will approach these priorities differently depending on their powers, institutional maturity and local context. The point is not that every SA should do exactly the same thing, but that all should begin with a clearer and more deliberate focus on the conditions that most shape health inequalities.

But SAs cannot do this alone. Without changes to national growth policy, longer-term funding, stronger local powers and NHS incentives that support prevention, local ambition will continue to run up against national constraints.

The broader implication is clear. Economic growth should not be treated as an end in itself. Its value depends on whether it improves living standards and expands the conditions for a healthy life. If devolution is to matter for health inequalities, it must be judged less by the volume of investment it attracts and more by whether it changes the everyday conditions in which poorer communities live.

The task for the next phase of devolution is therefore not simply to devolve more powers, but to use those powers more deliberately in the service of healthier and fairer local economies.

Appendix one: Toolkits and evidence to support SAs to deliver on the five priority actions

Toolkits and evidence

- The West Midlands Combined Authority Health in All Policies toolkit – a set of resources developed specifically for strategic authorities to help them use their powers and levers to improve health and reduce inequalities.
- The King's Fund "ready reckoner" – originally developed for local authorities, this tool helps assess which policy areas are likely to have the greatest impact on health inequalities, based on factors such as strength of evidence, time to impact, equity and cost-effectiveness.
- The Health Foundation health inequalities evidence hub – a collection of evidence on the wider determinants of health, designed to support better local decision-making.

Networks

- The Health Foundation Mayoral Regions Programme learning network – supports strategic authorities, local government and health partners to share practice and develop work on health inequalities.
- The Institute of Health Equity Health Equity Network – a UK-wide network of around 7,000 members focused on the social determinants of health, alongside wider resources including learning from "Marmot Places".
- The Growth and Reform Network – supports mayors and strategic authorities to pursue forms of growth that are equitable and improve wider social outcomes, including health.
- The Health Anchors Learning Network – helps organisations learn how to use their spending, employment, estates and influence to improve the social determinants of health. It is particularly valuable for health and care institutions, which are often among the largest anchor organisations within strategic authorities.

Other useful resources include tools for health impact assessment, health economics, and the measurement and evaluation of prevention and health inequality interventions.[34]

[34] For example, CIPFA's recent work on understanding how to measure and account for preventive spending in local government. This approach could be very useful for strategic authorities to understand the preventive 'density' of their own spending and through their partnerships.

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