Growth and Reform Network

Metro Dynamics

Future Governance Forum

Improving Health Through Economic Development

A Structured Evidence Review

August 2025

This report has been supported by The Health Foundation

The Health Foundation

Contents

Acknowledgements

Written and researched by Tanya Singh.

The author would like to thank several people for their helpful thoughts and feedback over the course of this project including: Professor Vittal Katikireddi and Dr Jonathan Stokes from the University of Glasgow, David Buck from The King's Fund, Dr Luke Munford from the University of Manchester, Professor Anne Green from the University of Birmingham, Thomas Pope from the Institute for Government and Rosie Fogden from the Growth and Reform Network.

Full responsibility for the report and its content remains with the author.

1. Summary

> "This structured evidence review identifies six critical features of socioeconomic policies that improve health: multi-component design, sustained intensity and duration, context-sensitive delivery, workforce capacity and implementation quality, delivery infrastructure and financial sustainability, and embedded learning and political coherence."

This structured evidence review provides a comprehensive synthesis of the evidence on how socioeconomic policies shape health outcomes, with a focus on informing UK local and regional economic strategies and devolution policy. Drawing on 144 studies from high-income countries, it establishes that population health is profoundly influenced not only by healthcare or individual behaviour, but also by the structural conditions created by economic policy.

These studies include a mix of national, regional, and local policy interventions. Within the context of an evolving devolution agenda in both England and the devolved nations, approaches to improving health though economic development should be considered as part of efforts to improve partnership and coherence across tiers of the state. This is explored in more detail in policy report based on this review.

The review employs a robust search methodology, combining structured searches across academic and grey literature with multi-stage screening, quality appraisal, risk-of-bias assessment, and a novel UK-specific transferability framework. Studies were assessed for methodological rigour, relevance to policy, and external validity, ensuring that only evidence of sufficient credibility and applicability informed the final synthesis. Equity impacts, implementation features, and causal mechanisms were systematically coded across policy domains, allowing for nuanced, policy-relevant insights grounded in strong empirical foundations.

This structured evidence review identifies six critical features of socioeconomic policies that improve health: multi-component design, sustained intensity and duration, context-sensitive delivery, workforce capacity and implementation quality, delivery infrastructure and financial sustainability, and embedded learning and political coherence. Interventions that combine complementary services—such as housing, employment, and education—consistently outperform fragmented or single-focus efforts. This reflects the importance of multi-component design, where different elements interact to address structural disadvantages holistically. These programmes are most effective when delivered with sustained intensity and duration, often requiring a minimum engagement period (e.g. 6–36 months) to generate measurable health improvements. Success also depends on models that support context-sensitive delivery, balancing fidelity to core principles with flexibility to meet the needs of specific places and populations. When interventions are delivered by qualified staff—such as nurses, teachers, or social workers—with proper support and supervision, they benefit from strong workforce capacity and implementation quality. Integration into existing systems and services further enhances outcomes, particularly when backed by delivery infrastructure and financial sustainability, including secure, multi-year funding.

However, even well-intentioned programmes can produce limited or negative effects if these core features are absent. Weak implementation, underinvestment in workforce training, or misalignment with local context can undermine effectiveness or exacerbate inequalities. Programmes that are not tailored to local governance structures, economic conditions, or population characteristics may fail to engage those most in need. This highlights the importance of context-sensitive delivery and the risks of one-size-fits-all approaches. To remain effective over

time, interventions must incorporate embedded learning and political coherence—that is, systems for real-time monitoring, evaluation, and adaptation, supported by sustained political will and coordination across policy areas and levels of government. These six features, when embedded together, help ensure that socioeconomic interventions not only deliver better health outcomes but also maximise public value and reduce long-standing health inequalities.

Despite the review's wide scope, significant evidence gaps persist. Migrants, disabled persons, and many minority-ethnic communities remain conspicuously underrepresented, and context-blind interventions risk entrenching—or even amplifying—existing inequities. Long-term data on health and economic outcomes are sparse, and formal cost-effectiveness analyses are rare, weakening the fiscal case for preventive investment. Key policy domains central to tackling contemporary challenges—industrial strategy, low-carbon transitions, and spatial planning—have yet to be systematically appraised for their health implications. Most critically, the political and institutional conditions that enable adoption, scaling, and sustainability are under-theorised and empirically thin.

> "…the review highlights clear opportunities for subnational leaders—particularly within England's evolving devolution settlement—to embed health considerations into economic strategy."

Notwithstanding these gaps, the review highlights clear opportunities for subnational leaders—particularly within England's evolving devolution settlement—to embed health considerations into economic strategy. It offers three principal contributions: first, a cross-cutting synthesis of international and UK evidence; second, an articulation of the conditions under which socioeconomic interventions deliver the greatest health dividends; and third, an empirical foundation for developing an actionable framework for integrating health into economic policymaking at local and regional government levels. As mayoral strategic authorities assume broader economic powers with the deepening and widening of devolution, these findings provide a timely, evidence-based foundation for designing inclusive growth strategies that actively improve population health.

1.1. Structure of the Paper

This review is structured into eight main sections, each serving a distinct purpose in addressing the research question.

- **Section 2: Introduction** outlines the rationale for the review and situates the research question within the wider policy and academic context.
- **Section 3: Methodology** describes the structured approach employed to identify, appraise, and synthesise the evidence.
- **Section 4: Findings** presents the results of the review. It begins with a descriptive overview of included studies, summarising their methodological characteristics, assessed quality, and relevance to the UK context. Detailed analysis is subsequently provided for each thematic policy domain.
- **Section 5: Discussion** synthesises the cross-cutting findings from the evidence base, identifying common features of effective interventions for improving health. This section also includes a dedicated analysis of equity impacts and the distributional consequences of different policy approaches.

- **Section 6: Leveraging the UK Evidence Base** draws on the subset of UK-based studies to explore their policy relevance in light of current institutional and political developments, including devolution and public service reform.
- **Section 7: Strengths and Limitations** critically assesses the strengths and limitations of both the included evidence and the review process itself, reflecting on implications for interpretation, generalisability, and future research.
- **Section 8: Conclusion** synthesises the overarching insights from the review and highlights its contributions to understanding the relationship between socioeconomic policy and health

---

2. Introduction

2.1. Context and Policy Rationale

"This disconnect between evidence and practice represents both a critical knowledge gap and an opportunity for more intentional, integrated policymaking that recognises health…"

Rising levels of long-term sickness have become the leading cause of economic inactivity in the UK, representing not merely a public health challenge but a fundamental constraint on growth, productivity, and fiscal sustainability (Office for National Statistics, 2023). The Office for Budget Responsibility has identified poor health as one of the largest long-term fiscal risks, estimating that improving health outcomes could substantially reduce the national debt burden, which is projected to rise to 270% of gross domestic product (GDP) by the mid-2070s based on current policy and the latest demographic projections (Office for Budget Responsibility, 2024a; Office for Budget Responsibility, 2024b). This marks a paradigm shift: population health is increasingly understood as a core driver of economic prosperity, not just a social good.

Social determinants of health—the conditions in which people are born, grow, live, work, and age—shape health outcomes more powerfully than healthcare services alone (Wilkinson and Marmot, 2003). Economic policies influence health through multiple pathways by shaping the distribution of resources, opportunities, and living conditions. Local and regional policy levers, from employment programmes to infrastructure investments, create conditions that either support or undermine population health, with differential impacts across social groups.

Yet despite this evidence that socioeconomic factors are primary drivers of population health, our knowledge of how socioeconomic policy design and implementation can incorporate health considerations or trace the causal pathways from interventions to health outcomes and inequalities remains limited. This disconnect between evidence and practice represents both a critical knowledge gap and an opportunity for more intentional, integrated policymaking that recognises health as both an input to and an outcome of economic prosperity.

The UK's evolving governance landscape presents unique opportunities and challenges for integrating health and economic policy. Since 2014, devolution has granted strategic authorities and metro mayors increasing control over skills, transport, housing, and economic development. The 2024 English Devolution White Paper signalled a step-change in ambition, with the government committing to universal coverage of strategic authorities across England, preferably led by elected mayors (Ministry of Housing, Communities and Local Government, 2024). This expansion of devolved powers creates new opportunities for place-based approaches that can align economic strategy with health outcomes at scale.

As devolution expands local control over economic levers, understanding how to harness these powers for health improvement is crucial. We need stronger evidence on which economic development interventions most effectively prevent health problems, through what mechanisms, and under what conditions. This evidence review addresses these gaps by synthesising existing literature to provide the comprehensive evidence base necessary for designing policies and interventions that achieve their primary objectives while also reducing health inequalities and/or maximising health benefits.

2.2. Objectives and Research Questions

This structured evidence review aims to provide a grounding for understanding the benefits of taking action to improve health through economic development policies and the conditions under which such policies are most effective. The policy implications of this research will be explored in a subsequent report.

The primary research question relates to how local and regional economic interventions affect health outcomes. Due to the limited international evidence available on local economic development specifically and the significance of broader economic factors in determining health outcomes, our review takes a wider perspective in considering socioeconomic policies more broadly. We then consider a set of interlinked secondary questions designed to generate actionable insights for improving health and reducing health inequalities through socioeconomic policy.

We consider housing, labour market, community infrastructure and regeneration and transport policies as being closely relevant to economic development and include domains such as early years support, welfare and fiscal policy as broader socioeconomic policies that influence health through multiple pathways. Population health outcomes include mortality, morbidity, mental wellbeing, health behaviours, and their distribution across social groups.

Primary question:
How do economic development interventions and broader socioeconomic policies influence population health outcomes?

Secondary questions:

Policy effectiveness:
Which types of economic policies are most consistently linked to better health outcomes? This assesses the strength and consistency of associations across policy domains and their comparative effectiveness.

Causal mechanisms:
Through which pathways do policies affect physical and mental health, behaviours, and health equity? We consider material (e.g. income, housing), psychosocial (e.g. stress, control), environmental, behavioural, and service access pathways.

Contextual conditions:
Under what geographic, demographic, institutional, and cultural conditions are these policies most effective? This includes spatial inequalities, population characteristics, governance, welfare regimes, social capital, and labour market conditions. Where are examples of good practice in the UK?

Implementation factors:
What features shape policy success or failure? We examine targeting, delivery, fidelity, resources, partnerships, and alignment with existing systems.

Equity impacts:
How do effects vary across population groups? We explore differential outcomes by socioeconomic status, ethnicity, gender, age, disability, and geography—comparing universal and targeted approaches and identifying equity-promoting features.

Evidence gaps:
What are the strengths and limitations of the existing evidence on economic development and health in the UK?

3. Methodology

3.1. Core Definitions

To address our primary research question—How do economic development and broader socioeconomic policies influence population health outcomes?—we adopt comprehensive operational definitions that capture the breadth of policy levers and health impacts relevant to local, regional, and national decision-makers. The policies considered generate health consequences through multiple pathways although they may not be defined with health in mind.

Economic development policy is defined as strategic public action to enhance a region's economic capacity through investment, innovation, infrastructure, and skills, with the aim of improving productivity, employment, and long-term wellbeing. For the purposes of this paper we consider housing, regeneration, community infrastructure, and labour market programmes to be economic development interventions.

Socioeconomic policy is defined as governmental interventions designed to influence economic conditions. While socioeconomic policies will include economic development policies, for the purpose of this paper, we consider welfare, early years and family support, and fiscal measures to be relevant socioeconomic measures for population health improvement not ordinarily captured by 'economic development'. For detailed classification of policy domains and sub-domains and example interventions, see Figure 1: Policy Domain Taxonomy.

Policy type	Primary Domain	Sub-domains	Example Interventions
Economic Development	Housing	Housing Quality & Crisis Response; Housing Mobility; Social Housing; Energy Efficiency; Supported Housing	Home insulation retrofits; Housing voucher programs; Supportive housing with case management; Social housing provision; Fuel poverty interventions; Mixed-income housing developments
	Regeneration and Built Environment	Urban Renewal; Transportation Infrastructure; Traffic Safety; Active Transport; Green Spaces; Neighbourhood Design	Public transport development; Walking and cycling infrastructure; Traffic calming measures; Street design improvements; Parks and green space creation; Public realm enhancements
	Community infrastructure	Community Development; Social Capital; Arts & Culture; Volunteer Programs; Neighbourhood Safety; Social Cohesion	Community arts initiatives; Volunteer engagement programs; Neighbourhood partnerships; Community centre development; Local safety interventions; Social integration programs
	Labour market interventions	Active Labour Market Programs; Wage Policy; Workplace Health & Safety; Working Time Regulations; Vocational Training; Disability Employment	Minimum wage increase; Tax credit programs; Job training programs; Workplace health interventions; Working time reductions; Supported employment; Skills development
Broader socio-economic policy	Welfare	Social Security Benefits; Unemployment Insurance; Conditional Cash Transfers; Welfare-to-Work; Benefits Advice	Unemployment insurance reforms; Income support programs; Conditional cash transfer schemes; Welfare advice services; Social protection systems
	Early childhood and family	Parental Leave; Early Childhood Education; Childcare; Child Welfare; Parent Support; Family Benefits	Paid parental leave policies; Universal pre-kindergarten; Early childhood programs; Home visiting programs; Marriage and parenting education; Child support systems; Teen pregnancy prevention
	Fiscal Policy	Food & Beverage Taxation; Alcohol Taxation; Tobacco Taxation; School Food Subsidies	Sugar-sweetened beverage taxes; Alcohol excise taxes; Tobacco taxes; Unhealthy food taxes; School meal subsidies; Food access programs

Figure 1. *Policy Domain Taxonomy*

Health outcomes are conceptualised across six interconnected dimensions, reflecting both direct health indicators and the broader determinants through which policy interventions exert influence. *Physical health* refers to objectively measurable health states, including all-cause and cause-specific mortality, morbidity (such as disease incidence, prevalence, and multi-morbidity), clinical biomarkers (e.g. blood pressure, cholesterol, body mass index, inflammatory markers), and functional status (such as disability prevalence, work capacity, and ability to perform activities of daily living). *Mental health and wellbeing* encompasses both clinical and subclinical outcomes, including diagnosed mental health conditions (e.g. depression, anxiety disorders), psychological wellbeing (life satisfaction, flourishing, positive affect), stress-related outcomes (perceived stress, burnout, dysregulated cortisol), and cognitive function across the life course. *Health behaviours* serve as both outcomes and mediators in the relationship between policy and health. These include substance use (tobacco, alcohol, illicit drugs), physical activity (levels of activity, sedentary behaviour, active travel), and dietary behaviours (nutritional quality, consumption of processed or high-fat foods, and food insecurity). *Health equity* addresses the distribution of health outcomes and access to health-promoting resources across population groups. This includes disparities by socioeconomic status, geography, ethnicity, gender, and other structural and demographic characteristics. *Child health* is treated as a distinct dimension, capturing indicators of physical and mental health, early developmental outcomes, and cognitive function in infancy, childhood, and adolescence. This may include birth weight, early life morbidity, emotional and behavioural difficulties, and school readiness or attainment as proxy indicators of developmental health. *Mortality* is defined as death from any cause (all-cause mortality) or from specific causes (cause-specific mortality), serving as an ultimate health outcome and an integrative indicator of population health over time.

3.2. **Screening to Synthesis Framework**

Our structured evidence review employs a five-stage screening process with progressive assessment criteria and defined stopping points (Figure 2). Following initial screening for basic eligibility (Stage 1), studies undergo full text assessment against detailed inclusion criteria (Stage 2). Those meeting inclusion criteria are evaluated using the quality framework across three dimensions—credibility, methodology, and relevance—with minimum scores of 3.0 required for progression (Stage 3). External validity assessment examines UK transferability across four factors, requiring scores above 3.0 (Stage 4). Studies meeting all thresholds proceed to comprehensive data extraction and synthesis (Stage 5). For the number of records identified, included and excluded, and the reasons for exclusions see the PRISMA 2020 flow diagram included in the appendix to this report.

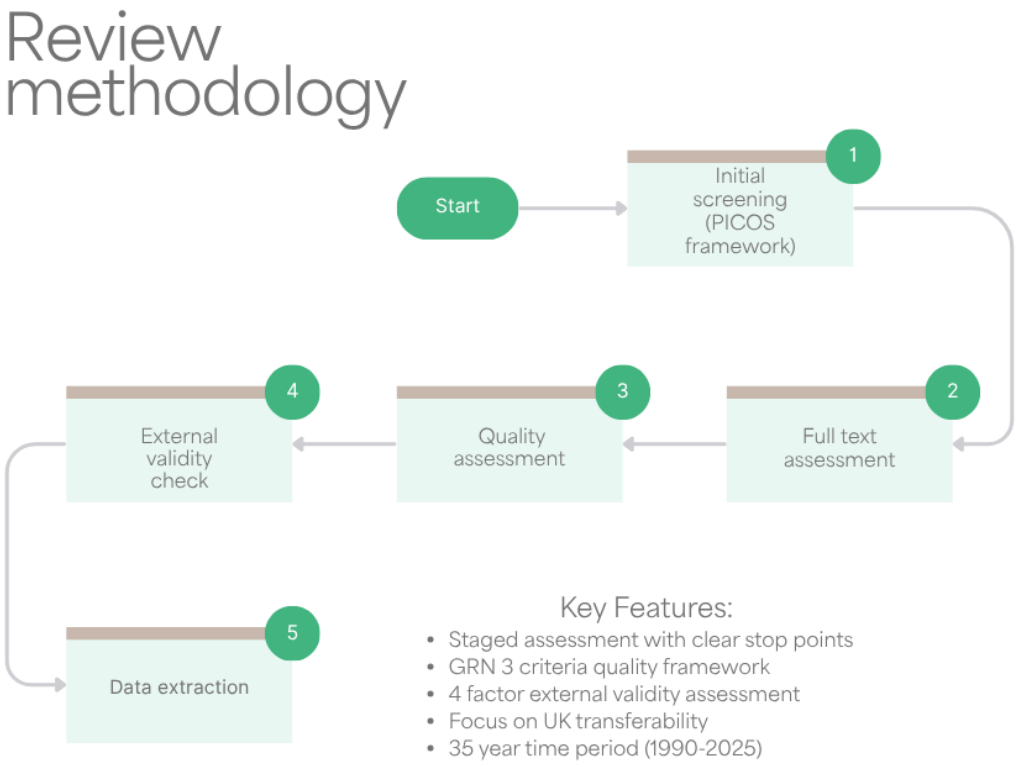

Figure 2. *Structured Review Methodology—Screening to Synthesis Framework*

3.3. Search Strategy and Selection

We searched three academic databases (PubMed, EBSCO Academic Search Complete, Google Scholar) and grey literature sources—information published outside traditional channels—to capture both peer-reviewed evidence and policy evaluations. Search terms were developed through concept mapping and pilot testing; also, see the search strategy development process in Appendix: Search Strategy), employing four concept blocks connected by 'AND' operators: 1) economic/fiscal/public policy terms; 2) health outcomes across physical, mental, behavioural, mortalityand equity dimensions; 3) specific policy domains; and 4) evaluation terms. Within blocks, 'OR' operators and truncation captured term variations (full search string in Appendix: Search Strategy). Searches covered January 1990 to May 2025 with English-language restrictions. Following initial searches, we refined strategies based on relevance and conducted snowballing through reference lists and forward citations.

Study selection followed predefined eligibility criteria (Figure 3: Inclusion/Exclusion Criteria). Key exclusions at this stage comprised studies without any explicit interventions, studies measuring only economic outcomes, and non-empirical publications.

Element	Inclusion	Exclusion
Population	• General population	• Clinical populations only • Non-human studies • Highly specialised groups
Intervention	• Economic/ socioeconomic policies • Welfare policies • Infrastructure investments • employment programmes	• Purely clinical interventions • Individual level bhaviour change only • medical treatments • Pharmaceutical interventions
Comparison	• With/without • Pre-post implementation • Different intervention types • Dese-response comparisons • Geographic comparisons	• Nocomparison possible • Purely descriptive
Outcomes	• Physical health measures • Mental health • Health behaviours • Health equity • Wellbeing measures	• Economic outcomes only • No health measurement • Process measures only
Study Design	• Evidence synthesis • Random experiments • Quasi-experimental • Mixed methods • Descriptive studies • Policy evalusations	• Commentaries • Protocols only • Theory papers without data • Single case reports
Geography	• UK • OCED • EU • Comparable contexts	• Low/middle income countries (unless highly transferrable) • Very difference health systems
Time period	• Published 1990-2025	• Published before 1990 • Outdated policy contexts

Figure 3. *Inclusion/Exclusion Criteria*

3.4. Quality, Transferability, and Risk-of-bias Assessment

Quality assessment was carried out by researchers and employed a three-dimensional framework (Figure 4: Quality Assessment) scoring credibility, methodology, and relevance from 1–5. Credibility captured source quality and transparency, and methodology assessed design appropriateness and analytical rigour, while relevance evaluated the policy–health linkage and UK applicability. Studies required scores ≥3 across all dimensions to progress.

Risk of bias was assessed across all included studies using standardised criteria evaluating key bias domains: selection bias, confounding, measurement bias, attrition bias, and reporting bias. Studies were categorised as low risk (appropriate controls for confounding, transparent methodology, minimal attrition), moderate risk (some methodological limitations but acceptable overall), high risk (serious flaws that substantially limit validity), or unclear risk (insufficient information to assess bias).

Dimension	High	Moderate	Low
Credibility	• Peer reviewed journal • High impact factor • Expert authors • Transparent funding • Reputable institution	• Peer reviewed OR high quality grey literature • Established authors • Clear methods • Some limitations acknowledged	• Non peer reviewed • Unknown authors • Unclear methods • Potential conflicts • Limited transparency
Methodological rigour	• Appropriate design • Adequate sample size • Validated measures • Controlled confounding • Robust analysis • Missing data handled	• Generally appropriate • Some limitations • Reasonable sample • Standard measures • basic confounding controlled	• Significant Flaws • Small sample • Poor measures • Uncontrolled confounding • Weak analysis
Relevance	• Direct policy-health link • Clear intervention • Health primary outcomes • Strong theory • Policy actionable	• Indirect but clear link • Intervention described • Health outcomes included • Some theoretical basis • Some policy relevance	• Tangential link • Vague intervention • Health secondary • Weak theory • Limited policy relevance

Average score	Quality catagory	Implication for review
Greater than 4.0	High	Primary evidence, full weight in synthesis
3.0 to 3.9	Medium	Include with caveats, note limitations
Less than 3.0	Low	Supporting evidence only, interpret cautiously

Figure 4. *Quality Assessment*

External validity assessment examined four transferability factors: geographic context, demographic representativeness, policy environment fit, and cultural sensitivity. Each factor was scored 1–5, with studies averaging a score of less than 3.0 excluded from the main synthesis but a few retained for supplementary insights. (See Figure 5: Transferability Assessment for more detail.)

Factor	Assesment Focus	Scoring Guidance
Geographic match	• Urban/rural balance • Regional characteristics • Governance structures • Economic conditions • Population density	5 = Very similar to UK context 4 = Similar with minor differences 3 = Moderately similar 2 = Some major differences 1 = Very different context
Demographic Similarity	• Age distribution • Socioeconomic profile • Ethnic diversity • Education levels • Employment patterns	5= Highly comparable population 4 = Mostly similar demographics 3 = Some key similarities 2 = Notable differences 1 = Very different population
Policy environment	• Local government powers • Health system structure • Welfare System • Regulatory Framework • Funding System	5 = similar systems and powers 4= compatible with adaptation 3 = Some system alignment 2 = Major system differences 1 = incompatible systems
Cultural factors	• Social norms • Community structures • Behavioural patterns • Public attitudes • Trust in institutions	5 = Very similar culture 4 = Minor cultural differences 3 = Some cultural adaptation needed 2 = Significant differences 1 = Very different culture

Overall Transferability Score:	
Average score >4.0	High
Average score 3.0-4.0	Moderate
Average score <3.0	Low

Figure 5. *Transferability assessment*

3.5. Data Extraction and Synthesis Methods

Data extraction used a standardised template, capturing study characteristics, intervention details, outcomes, and implementation factors. Coding followed a two-cycle approach combining deductive application of pre-specified categories (seven policy domains, health outcome types, mechanism categories, implementation features) with inductive identification of emergent themes. This captured both anticipated patterns and unexpected findings including cross-domain interactions, novel implementation strategies, and unintended consequences.

Our narrative synthesis employed standardised language to communicate evidence strength across policy domains (Figure 6: Evidence Strength Assessment). We used a four-tier grading system—Strong, Moderate, Limited, and Insufficient—to guide how we reported findings and framed conclusions.

Grade	Criteria	Reporting language
Strong	• High quality studies with robust methods • Consistent findings across studies • Clear causal mechanisms identified • Clinically meaningful effect sizes • Minimal unexplained variation	• "Evidence strongly indicates..." • "There is robust evidence..." • "Studies consistently demonstrate..."
Moderate	• Good quality studies available • Generally consistent findings • Plausible mechanisms proposed • Moderate effect sizes observed • Some variation explained	• "Evidence suggests..." • "Studies indicate.." • "There is moderate evidence..."
Limited	• Few high-quality studies available • Mixed or conflicting findings • Mechanisms remain unclear • Small effect sizes detected • Substantial unexplained variation	• "Limited evidence indicates..." • "Some studies suggest..." • Evidence is emerging..."
Insufficient	• Lack of quality studies • Inconsistent or contradictory findings • No clear patterns emerge	• "Evidence is insufficient to determine..." • "More research needed..."

Figure 6. *Evidence Strength Assessment*

4. Findings

4.1. Overview of Findings

Study Characteristics

This structured evidence review included 144 studies examining the health impacts of economic policies. The evidence base reflected substantial methodological diversity. Evidence synthesis studies—including systematic reviews and meta-analyses—formed the largest category (53 studies, 36.8%), highlighting the accumulation of aggregated knowledge in this field. Quasi-experimental designs accounted for 40 studies (27.7%) followed by randomised experiments (23 studies, 15.9%) and observational or analytical studies (12 studies, 8%). Additional study types included mixed methods (6 studies, 4%), descriptive studies (2 studies, 1%), and economic or policy evaluations (8 studies, 5.5%). Together, experimental and quasi-experimental designs comprised 44% of the evidence base, providing strong foundations for causal inference. Meanwhile, the prevalence of synthesis studies ensures that findings are informed by wide-ranging primary research.

The temporal distribution of studies spans over three decades (1990–2025), with the majority published from 2006 onwards. The largest share came from 2011–2015 (43 studies, 29.9%), followed by 2006–2010 (34 studies, 23.6%) and 2016–2020 (29 studies, 20.1%). Earlier periods were less represented, with 2001–2005 accounting for 21 studies (14.6%) and 1990–2000 for just 2 studies (1.4%). The most recent period, 2021–2025, contributed 15 studies (10.4%), reflecting a slight decline in recent publications relative to the preceding decade.

Geographic Coverage and Transferability

The evidence base remained concentrated in high-income countries. Of the 144 included studies, 99 (68.8%) were single-country analyses, while the remaining 45 (31.3%) were multi-country studies. The United States was the most frequently studied country, with 49 single-country studies, followed by the United Kingdom, with 29 single-country studies and 66 studies overall including UK data. Other countries featured in single-country studies included Spain (5), Denmark (3), Italy (2), Norway (2), Germany (2), and one study each from Mexico, Australia, New Zealand, Brazil, Netherlands, Finland, and Canada. The UK featured in 66 studies (45.8%) in total.

Transferability, assessed across four external validity dimensions, averaged 3.78 overall. Scores were relatively consistent across dimensions: policy environment fit (3.73), geographic relevance (3.78), cultural sensitivity (3.79), and demographic fit (3.80).

Quality and Risk of Bias

Studies demonstrated strong credibility (mean score 4.73), methodological rigour (4.1), and relevance to economic policy and health outcomes (4.46), resulting in an overall quality rating of 4.435.

A streamlined risk of bias assessment revealed that 89 studies (61.8%) were rated as moderate risk, 52 (36.1%) as low risk, and only 3 (2.1%) as high risk.. Low-risk studies typically employed randomised controlled trials or natural experiments with robust statistical techniques, representative samples, and strong controls for bias. Moderate-risk studies, although generally rigorous, faced common limitations such as reliance on quasi-experimental designs, attrition, and confounding in complex policy settings. However, most used mitigation strategies such as propensity score matching and fixed effects models. High-risk studies were retained only when offering unique insights into under-researched topics, and their findings were interpreted with appropriate caution.

Policy Domain Coverage

The 144 studies addressed eight major policy domains. Reporting by primary domain, early childhood and family policy was the most commonly studied (32 studies, 22.2%), followed by regeneration and the built environment (31 studies, 21.5%) and housing (15 studies, 10.4%). Welfare policy was examined in 15 studies (10.4%), and fiscal policy in 20 studies (13.9%). Both community infrastructure and labour market interventions were represented in 13 studies each (9.0%). The remaining 5 studies (3.5%) fell into an 'Other' category, including research on immigration and multiple domains.

Policy Domain	Policy Intervention	Physical Health	Mental Health and Wellbeing	Child Health	Health Equity	Health-related Behaviour	Mortality
Housing	Housing Mobility Programmes						
	Housing Quality & Energy Efficiency						
	Housing-Led Urban Regeneration						
	Supported & Crisis Housing						
Regeneration and Built Environment	Active Travel Infrastructure						
	Area-Based Regeneration						
	Neighbourhood Design & Walkability						
	Neighbourhood Renewal Policies						
	Road Infrastructure & Safety						
	Urban Green & Blue Space Regeneration						
	Urban Planning & Public Infrastructure						
Community Infrastructure	Arts & Cultural Programmes						
	Community Engagement for Health						
	Intergenerational Programmes						
	Social Identification & Group Interventions						
	Social Prescribing & Volunteer Health Promotion						
Labour Market Interventions	Active Labour Market Programmes (ALMPs)						
	Supported Employment & Transitions						
	Wage Policy						
	Working Time Reduction						
	Workplace Health Promotion						
	Workplace Participation & Organisation						
Welfare	Conditional Cash Transfers						
	Disability & Unemployment Benefits						
	Income Maintenance & Supplements						
	Tax Credits & Income Support						
	Universal Credit & Conditionality						
	Welfare Benefits Advice						
Early Childhood and Family	Child Maltreatment & Support Systems						
	Childcare Affordability						
	Community-Based Child Protection						
	Early Childhood Education (ECE)						
	Family & Relationship Education						
	Parental Leave Policies						
	Parenting Programmes						
	School Nutrition & Food Access						
Fiscal Policy	Alcohol & Tobacco Taxation						
	Combined Food Fiscal Strategies						
	Food & Beverage Taxation						

Figure 7. *Heatmap of health outcomes by intervention type*

Note: *Positive Evidence: Assigned when there are 1–2 studies showing positive outcomes for the domain in question.*
Strong Positive Evidence: Assigned when there are more than 2 positive studies.
Negative Evidence: Assigned when there are 1–2 studies showing negative outcomes.
Strong Negative Evidence: Assigned when there are more than 2 negative studies.
Mixed Evidence: Classified as mixed when positive and negative findings are nearly balanced (e.g. 1:1 or 2:1 in either direction), but shifts to Positive or Negative when three or more studies clearly outweigh one opposing study, with a net score calculated as the difference (e.g. 3–1 = 2).

	Positive Evidence
	Strong Positive Evidence
	No Evidence
	Negative Evidence
	Strong Negative Evidence
	Mixed Evidence

For more detail on equity-specific outcomes, see the Equity Map (Fig. 8). As there are five dimensions of equity considered, the evidence on health equity in this map follows the same logic—if findings are mixed across studies or dimensions, the result is classified as Mixed; otherwise, classifications reflect the prevailing direction and strength of evidence.

4.2. Findings by Policy Domain

This section presents the findings thematically, organised by policy domain. The sequence reflects a practical distinction between two broad types of intervention. The first domains—housing, regeneration, community infrastructure, and labour market programmes—are more closely associated with **economic development policy**, focusing on the physical, social, and economic conditions of specific places. These interventions often involve spatially targeted investment, institutional coordination, and local delivery mechanisms aimed at creating opportunity and improving neighbourhood environments. Subsequent sections turn to broader **socioeconomic policy**, including welfare, early years and family support, and fiscal measures. These operate primarily at a system or population level, shaping health outcomes through mechanisms such as income protection, service entitlements, and life course support, often irrespective of geography, although local and regional governments are often closely involved in delivering related services. This ordering reflects the structure of the evidence base and the different scales, levers, and pathways through which these policy domains influence health and health inequalities. The chapter considers whether there is evidence for positive or negative health impacts within each policy domain. The size of the health effect in question is outside the scope of this discussion.

Housing

Housing is one of the most well-established levers for improving public health, acting through both direct and indirect pathways. While it can be considered within the context regeneration policy, we judge that the large body of evidence on housing specifically warrants the more defined focus in this section. Physically, good quality housing can reduce exposure to hazards such as cold, damp, injury, and poor air quality. Socially and psychologically, it can influence stress, mental wellbeing, social connection, and perceptions of safety. These pathways are particularly important for low-income and vulnerable groups, where improvements in housing quality, affordability, and neighbourhood environments can have measurable health impacts.

Upgrading housing conditions—through insulation, heating improvements, and hazard reduction—has repeatedly shown health benefits, largely through reduced respiratory illness, improved thermal comfort, and enhanced safety. For example, a randomised trial in New Zealand found that retrofitting insulation improved respiratory health, reduced school and work absences, and decreased healthcare demand, making it highly cost-effective (Howden-Chapman et al., 2007). Systematic reviews confirm links between physical upgrades and better respiratory outcomes, lower injury rates, and improved quality of life (Thomson et al., 2001; Chang et al., 2004). Energy efficiency retrofits can also support health via reduced fuel poverty, although evidence from Barcelona shows that impacts may vary across groups—benefitting some, such as older women, while potentially disadvantaging others, such as older men (Camprubí et al., 2017).

Interventions that integrate housing improvements with wider social or health support often have amplified effects. Programmes such as Caritas Barcelona, which combined relocation from substandard housing with welfare support, improved affordability, living conditions, and mental health (Novoa et al., 2017). Housing First models, as tested in the US with chronically ill homeless adults, reduced emergency visits and hospitalisations by addressing both housing stability and case management needs (Sadowski et al., 2009). These findings suggest a pathway in which housing acts as a platform, enabling access to care, stabilising daily life, and reducing acute health crises.

Housing mobility policies—enabling moves from high-poverty to lower-poverty areas—illustrate another pathway, where the health gains derive less from the physical home itself and more from improved neighbourhood safety, amenities, and reduced environmental stressors. Evidence from the US Moving to Opportunity programme and other evaluations shows mental health improvements, especially among women and girls, and in some cases

reductions in obesity and substance use (Leventhal & Brooks-Gunn, 2003; Kling et al., 2007; Acevedo-Garcia et al., 2004). Voucher-based schemes - those that distribute funds or support through vouchers for goods or services - for specific groups, such as veterans or people with HIV/AIDS, have also improved mental health, housing stability, and reduced hospitalisations (Rosenheck, 2003; Wolitski et al., 2010). However, gains are not universal—some adolescent boys in mobility programmes reported riskier behaviours, and healthcare access did not always improve post-relocation, underscoring the importance of pairing mobility schemes with health and social care integration (Acevedo-Garcia et al., 2004).

Regeneration initiatives that involve relocation can deliver mixed results. In Glasgow's GoWell programme, many residents reported improved housing quality and pride, but others—particularly those with chronic illness or strong community ties—experienced disruption, loss of social networks, and isolation (Egan et al., 2015). This highlights a critical pathway consideration: without safeguarding community cohesion and resident agency, the potential mental health gains from physical improvements may be undermined.

Equity is a recurring concern. Some energy efficiency schemes have failed to reach older adults, private renters, or those in shared housing, due to landlord disincentives and limited community engagement, risking reinforcement of existing inequalities (Camprubí et al., 2016). Similarly, systematic review evidence suggests that tenant-based rental assistance programmes can reduce exposure to violent crime and disorder, but without integrated support, they may not sustain broader health benefits and can even reduce access to preventive care in some contexts (Anderson et al., 2003).

Regeneration and the Built Environment

> "Strong governance and community engagement underpin successful regeneration. When residents are empowered to shape local decisions and have a meaningful say in how projects are delivered, outcomes tend to be better and more enduring."

Well-designed regeneration and built environment interventions can improve health and wellbeing by reshaping the physical and social fabric of neighbourhoods to make them safer, more connected, and more supportive. Improvements in housing, transport, green space, and urban design can influence health both directly—by reducing injury risks, improving air quality, and enabling physical activity—and indirectly, by fostering social cohesion, reducing stress, and enhancing perceptions of safety.

Housing-led regeneration, particularly when incremental and sensitive to community ties, has been linked to better mental wellbeing through improved living conditions and stable social networks (Kearns et al., 2020). Multi-sector programmes that combine housing, environmental, and social investment, such as Communities First in Wales, have improved mental health via better neighbourhood conditions (Greene et al., 2020), while large-scale, coordinated housing and community infrastructure investment in Andalusia in Spain has been associated with reductions in preventable mortality (Zapata Moya & Navarro Yáñez, 2017). These effects appear strongest when interventions address multiple determinants simultaneously, rather than focusing on a single environmental feature.

Neighbourhood design and urban form affect opportunities for mobility, access to services, and social connection. Walkable, well-connected environments with good transport access have been linked to lower antidepressant use (Melis et al., 2015a), improved self-rated health, and stronger social cohesion (Mehdipanah et al., 2014), particularly in disadvantaged areas. Systematic reviews confirm that walkability, when combined with accessible amenities, is

associated with lower chronic disease rates and better mental health (Ige-Elegbede et al., 2022). However, the health benefits of accessibility rely on actual uptake; proximity alone does not guarantee use (Pollack et al., 2024). Barriers such as affordability, safety, and inclusivity must be addressed to avoid reinforcing inequalities.

Green and blue infrastructure projects—parks, woodlands, waterfronts—can improve physical activity levels, reduce stress, and enhance environmental quality (Brückner et al., 2022). Integrated designs that combine infrastructure improvements with community engagement, such as Belfast's Connswater Community Greenway, have demonstrated added benefits for perceptions of safety and local pride (Wang et al., 2023). Yet without targeted measures—such as safe routes, inclusive programming, and maintenance funding—these benefits often accrue disproportionately to more affluent groups (Gelormino et al., 2015b).

Transport and active travel infrastructure are another pathway to health improvement. Traffic-calming schemes can reduce injuries by around 11% (Bunn et al., 2003), while speed cameras are associated with substantial reductions in collisions, injuries, and fatalities, albeit from a largely observational evidence base (Pilkington & Kinra, 2005). Investments in walking and cycling routes—particularly when combined with behaviour-change support—have increased physical activity (Kramer et al., 2017; Aldred, 2019). However, infrastructure-only approaches have shown mixed effects, with sustained uptake more likely where environmental improvements are paired with targeted engagement, especially in low-walkability areas (Robertson et al., 2012; Ogilvie et al., 2004; Macmillan et al., 2018).

Evidence on mental health impacts of built environment change is weaker and often inconsistent, with UK-specific evaluations showing variable results (Moore et al., 2018; McGowan et al., 2021). Some regeneration initiatives, like Northern Ireland's Neighbourhood Renewal, delivered modest subgroup benefits and may have prevented widening disparities, but failed to show population-level health gains—likely due to insufficient health prioritisation, limited investment, and uneven implementation (Mohan et al., 2017). This underlines the need for adequate "dosage" and for health goals to be embedded explicitly from the outset (Thomson et al., 2006).

The built environment also shapes diet through the neighbourhood food environment. High concentrations of fast food outlets in deprived areas contribute to dietary inequalities (Lake, 2018). Planning powers, such as restricting takeaways near schools, offer a tool for reshaping local foodscapes, but their impact depends on consistent application and integration with broader urban health strategies.

Across interventions, success depends on governance, equity, and sustained delivery. Strong governance and community engagement underpin successful regeneration. When residents are empowered to shape local decisions and have a meaningful say in how projects are delivered, outcomes tend to be better and more enduring (Kearns & Whitley, 2020). Cross-sector collaboration, long-term funding, and inclusive planning processes are critical for ensuring health benefits endure. Equity must be embedded in design, as evidence consistently shows that more advantaged groups are often better placed to use and benefit from environmental improvements (Smith et al., 2017; McGowan et al., 2021). Without safeguards, interventions can lead to gentrification or displacement, undermining health gains (Pollack et al., 2024; Gelormino et al., 2015b).

The policy challenge is therefore twofold: first, to integrate health objectives into regeneration and planning decisions at every level, and second, to reform governance and funding systems that currently favour short-term economic gains over long-term population health. Structural barriers—such as centralised control, siloed departmental priorities, and private sector dominance—limit local authorities' ability to design healthy places (Bates et al., 2025). Addressing these constraints, potentially through devolution with adequate powers and resources, is essential if well-designed built environment interventions are to deliver both health improvement and health equity at scale.

Community Interventions

"…neighbourhood-level action can address wider determinants of health through local leadership and multi-sector coordination."

Investing in social infrastructure—encompassing community amenities, civic participation, and collective service provision—offers a powerful route to improving health and narrowing inequalities. When designed with local context in mind, such interventions can strengthen social capital, promote wellbeing, and create healthier environments, particularly in disadvantaged areas. With renewed UK government commitment to regenerating up to 350 communities, there is a clear opportunity to embed health outcomes in community-led development (HM Treasury, 2025). As the evidence shows, neighbourhood-level action can address wider determinants of health through local leadership and multi-sector coordination.

Strengthening social capital and civic engagement is consistently associated with improved health outcomes. Initiatives that build group identity, enable shared decision-making, and foster social connection can reduce depression and anxiety, enhance cognitive function, and improve overall wellbeing (Steffens et al., 2021). Such benefits arise not only from psychological mechanisms, such as belonging and mutual support, but also from the way strong social ties can increase access to resources, information, and collective problem-solving capacity. Volunteer-led schemes like Baltimore's Experience Corps have shown that intergenerational connections can deliver gains for both younger and older participants—improving educational outcomes for children and mental wellbeing for older adults (Fried et al., 2004). Similarly, participatory initiatives such as social prescribing (Chatterjee et al., 2018) and community arts projects (Daykin et al., 2020) demonstrate the value of embedding activities in everyday community life, with co-designed and culturally relevant delivery helping to ensure benefits reach those most in need.

The structure and integration of community-based services matter greatly. Local models that combine participation with partnership working—such as the Well London programme—have used collaborative planning and environmental improvements to promote healthier eating, physical activity, and wellbeing in deprived areas (Phillips et al., 2014). Programmes that co-locate welfare advice and mental health support in trusted settings have been effective in reducing financial strain and improving wellbeing, particularly when targeted at groups experiencing disadvantage (McGrath et al., 2022). Evidence from job skills training and active labour market programmes suggests these can reduce depression among long-term unemployed groups, while link worker referral schemes improve access to community resources. Across these interventions, the strongest mental health improvements were observed where material conditions—such as financial security—improved, underscoring the importance of tackling underlying social and economic constraints.

Changes to local environments can also shape health behaviours and perceptions. The opening of a supermarket in a Leeds "food desert" improved access to fresh produce and modestly improved diets (Wrigley et al., 2003), while walking initiatives such as Fitter for Walking engaged local residents in making streets more walkable and safer (Adams et al., 2017). These examples illustrate the importance of combining community enthusiasm with enabling policy structures, sustained resources, and integration into broader transport and planning frameworks.

Larger, multi-domain programmes that integrate interventions across housing, employment, education, and safety offer strong potential to address health inequalities. England's New Deal for Communities helped stabilise mental health and life satisfaction in disadvantaged areas, particularly for people experiencing unemployment or low education (Walthery et al., 2015). Wales's Communities First programme also improved mental health for long-term residents, with its bottom-up, community-prioritised approach enabling cumulative gains (White et al., 2017). A

systematic review by Nickel and von dem Knesebeck (2020) found that more than half of multi-level, multi-component interventions improved health outcomes for disadvantaged communities, with tailored design, adequate implementation "dose", and integration with environmental or regulatory strategies identified as important success factors.

The way activities are structured can influence both reach and sustainability. For example, a Danish intervention for inactive women found that football, as a cooperative, team-based sport, fostered stronger bonding and bridging social capital than running, and was more likely to lead to sustained participation (Ottesen et al., 2010). Intergenerational programmes in Brazil improved perceived health and trust among adolescents and older adults, but also highlighted potential unintended effects, such as heightened awareness of inequality, underscoring the need for careful facilitation and context sensitivity (De Souza & Grundy, 2007). Arts-based initiatives further show that cultural relevance, participant agency, and removal of practical barriers—such as transport and scheduling—are crucial for equitable participation and sustained benefits (Hampshire & Matthijsse, 2010).

Across the evidence base, several factors consistently underpin success: tangible improvements to material conditions; integration of services across sectors; cultural and contextual fit; sustained and adequately resourced delivery; and strong partnerships that give communities genuine influence. While evaluation quality remains uneven, particularly in smaller-scale or pilot initiatives, the combined evidence suggests that embedding psychosocial, environmental, and financial support in trusted, community-based settings is a promising pathway to improving health and reducing inequalities—provided programmes are designed and delivered in ways that reflect local realities and priorities.

Labour Market Interventions

> "Participatory reforms that increase control over working conditions can improve mental health, especially among lower-status workers."

Secure, high-quality employment is a foundation for good health. Beyond access to work, the structure, stability, and quality of jobs are central to mental wellbeing, income security, and the reduction of health inequalities. With the rise of precarious work and widening labour market disparities, employment and skills policies are increasingly recognised as public health interventions. Devolved adult skills funding and the development of Local Skills Improvement Plans create new opportunities for UK localities to shape more inclusive and healthier labour markets.

A growing body of evidence shows that active labour market programmes (ALMPs)—such as job search support, training, and employment incentives—not only help people into work, but also improve mental health and wellbeing. These gains often arise before participants secure employment, driven by greater purpose, routine, and social contact. Studies across Europe indicate that ALMPs enhance self-rated health and life satisfaction, particularly in countries with strong welfare systems, gender equality, and coordinated labour market institutions (Sahnoun & Abdennadher, 2020; Palència et al., 2014). UK evidence links ALMP participation to reduced psychological distress and higher life satisfaction (Sage, 2015), with reviews showing that tailored psychosocial elements and voluntary access produce the strongest benefits, especially for people with pre-existing mental health conditions (Puig-Barrachina et al., 2020). For example, targeted support in Germany increased employment among those with severe mental health problems by nearly 19 percentage points, likely through enhanced confidence, social connection, and labour market integration (Tübbicke & Schiele, 2024).

However, design and delivery matter. Poorly implemented or coercive programmes can erode wellbeing, while inclusive approaches—offering choice, personalised guidance, and trained staff—are more likely to succeed. At a population level, higher ALMP spending can also buffer the health impacts of economic shocks, mitigating rises in suicide during recessions (Stuckler et al., 2009). This underscores ALMPs' dual role as both economic and public health resilience tools. Yet they often overlook structural drivers such as low pay, insecure contracts, and occupational segregation—factors that influence who benefits most (MacIntyre et al., 2024).

Job quality itself is a critical determinant of health. Precarious employment—marked by insecurity, low wages, and limited control—is consistently associated with worse mental and physical health outcomes, disproportionately affecting women, migrants, young people, and low-skilled workers (Julià et al., 2019). Informal employment carries similar risks, although its health impacts remain under-researched. Policy measures to improve employment conditions—such as regulating temporary contracts, enforcing labour standards, and extending protections to informal workers—show promise, especially when backed by strong unions and political commitment (Gunn et al., 2025). However, their direct health impacts need further study.

Employers themselves also have levers over job quality and health which can be encouraged by governments at national and local level. Working time reduction (WTR) is emerging as one of these potential levers. Trials of four-day weeks or reduced hours, especially when pay is protected, report improvements in mental health, work–life balance, and productivity (Hanbury et al., 2023). These benefits are strongest when implemented at team level with organisational buy-in, and may also support gender equality and environmental sustainability. But design is crucial: without safeguards, WTR could exclude low-paid workers or exacerbate inequalities.

Workplace and occupational health interventions can also enhance employee wellbeing. Participatory reforms that increase control over working conditions can improve mental health, especially among lower-status workers (Egan et al., 2007). Examples include self-rostering, compressed weeks, and improved shift scheduling, which can enhance sleep quality, reduce stress, and support work–life balance (Bambra et al., 2008). Smoke-free workplace policies have also reduced smoking rates and improved health (Fichtenberg & Glantz, 2002).

Evidence from participatory models such as German health circles suggests that structured employee involvement in diagnosing problems and designing solutions can drive measurable improvements in health and organisational outcomes, including reduced sickness absence and cost savings (Aust & Ducki, 2004). Success depends on strong management commitment, institutional backing, and integration of recommendations into decision-making; without these, adoption rates fall.

Wage policy may also shape health outcomes indirectly. For example, higher minimum wages in the United States have been associated with small but significant reductions in BMI, potentially via shifts in food affordability and consumption patterns, though effects appear greater among higher-income groups (Meltzer & Chen, 2011). This raises both equity considerations and opportunities for linking wage policy to broader health strategies.

Across all approaches, interventions work best when they combine individual support with structural change, integrate equity into design, and adapt to the organisational and economic context. The evidence suggests that protecting job quality, embedding participation, and sustaining investment are essential to maximising both employment and health gains.

Welfare Policy

"…generous systems with broad eligibility and high replacement rates function as health interventions by buffering financial stress and uncertainty."

Welfare policies influence far more than income: they shape mental health, family stability, and resilience to economic shocks. While the previous section examined labour market programmes, this section focuses on the broader welfare architecture—income protection, conditionality regimes, cash transfers, and return-to-work (W2W) support. While employment support is changing slowly and becoming more devolved, these remain largely national-level design choices outside local authority control. Yet they define the context in which strategic and local policies operate and evidence shows that both policy generosity and administrative design matter for health, particularly among vulnerable groups.

Income replacement systems—particularly unemployment insurance—are associated with reduced psychological distress during periods of joblessness. As O'Campo et al. (2015a) note, "…generous systems with broad eligibility and high replacement rates function as health interventions by buffering financial stress and uncertainty." However, punitive or complex systems can reverse these gains. The UK's Universal Credit reforms increased psychological distress by 6.6 percentage points among unemployed adults, with digital-only access, payment delays, and frequent reassessments creating anxiety and financial strain (Wickham et al., 2020). Qualitative work confirms that sanctions and assessments can be traumatising, particularly for people with mental health conditions, undermining treatment adherence and recovery (Dwyer et al., 2020).

Cash transfer programmes, both conditional and unconditional, can alleviate poverty and influence health-related behaviours, though effects are often modest and uneven. Conditional models such as Opportunity NYC increased preventive healthcare use—especially dental visits—and reduced reliance on emergency care, while also improving certain educational and financial outcomes (Riccio et al., 2013; Riccio et al., 2010). The health gains were incremental and skewed towards better-resourced families, suggesting the need for complementary supports for the most disadvantaged. Earlier guaranteed income trials in North America reported selective improvements (e.g. in birth outcomes) but lacked consistent health effects, often due to weak integration of health measures (Connor et al., 1999).

Recent UK evidence warns that even income-focused reforms can harm health if poorly designed. Song et al. (2024) found that Universal Credit increased children's mental health problems, particularly in large families, with delays, sanctions, and digital exclusion implicated. Minimum wage policy offers another potential lever, with some studies suggesting reductions in unmet medical needs or obesity (McCarrier et al., 2011), though findings remain inconsistent and sensitive to wider welfare context.

Simplifying benefit access can improve wellbeing by reducing financial strain. Welfare advice services co-located in primary care have been shown to increase income, reduce stress, and, in some cases, improve mental health (Adams et al., 2006; Mackintosh et al., 2006). Greasley & Small (2005) found that such services were particularly valued by groups facing cultural or structural barriers, such as South Asian women and people with mental health problems, while also reducing GP workload. Abbott et al. (2006) observed modest but significant mental health improvements among chronically ill, low-income adults who increased their income after receiving advice. However,

success depends on more than physical co-location—clear referral pathways, feedback loops, and culturally competent advisers are key to equitable uptake.

Specialised W2W models for people with disabilities and chronic illness can improve employment outcomes but show mixed health impacts. Supported employment programmes (e.g. job coaching, tailored placements) have increased earnings and job stability among people with severe mental illness, though without consistent clinical gains (Crowther et al., 2001). UK schemes like Access to Work receive positive user feedback but suffer from weak evaluation and variable outcomes, often benefiting those closer to the labour market (Bambra et al., 2005). Comparative evidence from Denmark's "flex-jobs" model shows that integrated occupational health, employer engagement, and income guarantees can outperform more fragmented approaches (Etherington & Ingold, 2012).

The evidence highlights that welfare's health impacts depends on many factors other than their headline generosity. Features that promote stability, simplicity, and dignity—such as timely payments, minimal bureaucracy, and supportive conditionality—can reduce stress and protect mental health. Conversely, punitive designs, digital exclusion, or fragmented service delivery risk widening inequalities. For local and national decision-makers, this means that welfare systems should be viewed not only as economic safety nets but as integral public health infrastructure. Aligning benefit design with health goals—through predictable income, accessible advice, and integrated return-to-work pathways—offers a route to improving population health, especially for those most at risk of poor outcomes.

Early Childhood and Family Policy Interventions

> "Parenting and family-strengthening interventions can improve child development and caregiver wellbeing when well-targeted and adequately supported… However, universal implementation presents cost and coordination challenges."

Early childhood and family-centred policies are increasingly recognised as critical levers for improving health trajectories, reducing inequalities, and strengthening long-term social and economic outcomes. By combining direct child-focused services with broader caregiver supports, these interventions address multiple determinants of health—from early development and parental wellbeing to poverty reduction and labour market participation. While national governments control many policy levers, UK local and strategic authorities play a growing role in early years provision, offering opportunities to embed health goals in service design.

High-quality, centre-based early education programmes—especially those integrating health and family support—can generate lasting health and developmental benefits. In the United States, Head Start participation has been linked to lower child mortality (Ludwig & Miller, 2007), healthier behaviours, such as a lower probability that an individual smokes cigarettes as a young adult, (Anderson, Foster & Frisvold, 2004), and improved parenting and cognitive outcomes (Gelber & Isen, 2013), often via educational gains and reduced criminal involvement (Currie & Thomas, 1993; Garces et al., 2002). In England, Sure Start Children's Centres reduced hospital admissions among children in deprived areas (Cattan et al., 2021), with later analysis showing lifetime benefits exceeding twice the programme's cost (Carneiro et al., 2025). More intensive models, such as the Abecedarian Project (Campbell

et al., 2014) and Infant Health and Development Program (McCormick et al., 2006), improved cognitive outcomes and reduced adult hypertension in targeted groups. Universal schemes, like pre-kindergarten, can raise cognitive scores (Gormley & Gayer, 2005), but the Quebec experience (Baker et al., 2008) shows that scaling without safeguarding quality risks undermining benefits.

Family income is a major driver of child health, influencing both material conditions and parental stress. Earned Income Tax Credit expansions in the US have improved birth weight, reduced maternal smoking, and enhanced child cognitive outcomes (Dahl & Lochner, 2012; Hoynes, Miller & Simon, 2015; Strully et al., 2010) by enabling healthier prenatal behaviours and reducing economic strain. Unconditional cash transfers often deliver the strongest gains, while conditional programmes show mixed results. Poorly designed reforms can create harm: the UK's Universal Credit increased mental health problems among children in eligible households, especially large families, due to payment delays, sanctions, and digital barriers (Song et al., 2024).

Parenting and family-strengthening interventions can improve child development and caregiver wellbeing when well-targeted and adequately supported… However, universal implementation presents cost and coordination challenges. Models like Triple P and the Durham Family Initiative have reduced maltreatment, hospitalisations, and behavioural problems (Dodge et al., 2004; Sanders, 2008), while behavioural parent training generally produces consistent improvements—though delivery format matters, with individually delivered support more effective for disadvantaged families (Lundahl et al., 2006). Relationship-focused approaches can outperform parenting-only models: Supporting Healthy Marriage improved couple quality and reduced psychological distress (Hsueh et al., 2012), though other trials found mixed or adverse effects, such as increased IPV reports in Building Strong Families (Wood et al., 2012; 2014). Home visiting schemes like Nurse–Family Partnership reduce child injuries and maltreatment (Olds, 2006), with group-based training such as Incredible Years showing sustained behavioural gains (Webster-Stratton & Taylor, 2001).

Paid parental leave is associated with lower infant mortality and better long-term outcomes, particularly when job-protected and adequately compensated (Ruhm, 2000; Tanaka, 2005; Khan, 2020). In Norway, expansions improved educational outcomes for disadvantaged children (Carneiro, Løken & Salvanes, 2010), and in California, paid leave significantly increased breastfeeding duration and exclusivity (Huang & Yang, 2015). However, design influences equity: in Sweden, extended leave improved outcomes only for children of tertiary-educated mothers (Liu & Skans, 2009), and in Canada, a major extension produced little change in early development (Baker & Milligan, 2010). Evidence on paternity leave remains mixed—maternal mental health and bonding gains are often offset by low uptake where wage replacement is inadequate (Heshmati et al., 2023).

Community-driven prevention initiatives further show the value of addressing family wellbeing at a structural level. Los Angeles' Prevention Initiative Demonstration Project (McCroskey et al., 2012) improved protective factors, reduced re-referrals, and enhanced family economic stability by linking agencies, faith groups, and local organisations. This success was linked to universal access (reducing stigma), embedding economic empowerment alongside parenting support, and tailoring delivery to local contexts. Similar arguments are made by Daro & Dodge (2009), who highlight the role of community capacity and collective responsibility in preventing maltreatment at scale.

Child support arrangements also influence family stability and child development. Informal payments—direct transfers from non-resident fathers to mothers—have been linked to better cognitive outcomes, particularly in low-income, immigrant, and Hispanic families, partly due to increased father involvement (Nepomnyaschy et al., 2012). By contrast, inconsistent or low formal support can be linked to more behavioural problems, particularly when adversarial enforcement heightens parental conflict. Balancing enforcement with flexibility and addressing

employment barriers for non-resident parents may therefore protect both economic and relational benefits for children.

Across this body of evidence, a consistent pattern emerges: policies work best when they combine high-quality service delivery with structural supports that reduce stress, improve economic stability, and strengthen family relationships. Health improvements often flow indirectly—via enhanced parental capacity, reduced conflict, and better service access—rather than through clinical outcomes alone. This underscores the need for integrated, equity-focused approaches that protect quality during scale-up, align generosity with accessibility, and address both immediate needs and the wider environments in which children grow. The challenge for policymakers is not only to choose effective interventions, but to embed them in coherent systems that families experience as seamless, supportive, and responsive to their lived realities.

Fiscal Policy

> "A promising strategy involves combining taxes with subsidies on healthy alternatives... Importantly, subsidies may also offset the regressive financial burden of taxation, thereby enhancing equity while supporting healthier behaviours."

While fiscal policy is outside the scope of local government powers in England, devolved administrations in Scotland, Wales, and Northern Ireland already exercise such powers, and fiscal devolution is common among other high-income countries, including the US. In the public health domain, fiscal measures are among the best-studied levers, with a body of evidence from at least 26 studies demonstrating varying degrees of success. The design, magnitude, and targeting of these interventions are critical to whether they deliver measurable health gains.

Health-related taxes—applied to products such as sugar-sweetened beverages (SSBs), ultra-processed foods, and items high in fat, salt, or caffeine—are intended to reshape consumption patterns by making unhealthy options more expensive and healthier options relatively more attractive. Drawing on the well-documented impact of tobacco and alcohol taxation (Wagenaar et al., 2010), the underlying mechanism is price elasticity: higher prices reduce demand, especially among more price-sensitive groups (Mytton et al., 2013). While modelling studies assuming large tax increases and ideal policy conditions predict significant reductions in disease burden (Wang et al., 2012; Ford et al., 2015), real-world evaluations often find smaller effects because implemented rates are typically low and designs prioritise revenue over health outcomes. In Denmark, for example, a fat tax delivered only modest cardiovascular risk changes before being repealed (Smed et al., 2016), and in the US, soda taxes averaging 3–4% produced minimal BMI reductions (Fletcher et al., 2010). Nonetheless, even modest taxes may slow the rise in obesity—states without snack or soda taxes were more likely to see sharp increases in obesity prevalence (Kim & Kawachi, 2006).

Impact also varies by age and risk group. Among young people, small or hidden taxes often fail to reduce consumption because of substitution to equally calorie-dense alternatives, such as flavoured milk (Powell et al., 2009; Fletcher et al., 2010). Yet higher-risk subgroups—such as overweight children from low-income households—are more responsive, particularly when taxed items are readily available in schools (Sturm et al., 2010). Evidence suggests that tax visibility, salience, and targeting of high-consumption environments amplify effectiveness. For adults, larger health gains can accrue even where responsiveness is lower: heavy SSB consumers, while less price elastic, reduce absolute consumption more when taxes are volumetric and applied per unit (Étilé & Sharma, 2015).

The magnitude and structure of the tax are pivotal. Mytton et al. (2012) suggest that a price rise of at least 20% is necessary to produce meaningful health impacts, and that specific excise taxes based on product volume or nutrient content outperform ad valorem taxes tied to price. Targeting the nutrient itself, as in Miao et al. (2010), can push manufacturers toward reformulation without creating sharp consumer price shocks. Hungary's nutrient-threshold taxes prompted 40% of manufacturers to adjust recipes and 30% to remove targeted ingredients entirely (ECORYS, 2014), demonstrating how upstream measures can alter the food environment before products reach shelves. In contrast, Scotland's public health supplement on large retailers had negligible impact due to its low rate (Hellowell et al., 2016).

A promising strategy involves combining taxes with subsidies on healthy alternatives. Several studies show that pairing taxes on sugary or high-fat products with subsidies for fruits, vegetables, or whole grains enhances dietary improvements (Gustavsen & Rickertsen, 2013), with combined approaches outperforming single measures (Härkänen et al., 2011; Ni Mhurchu et al., 2015). Importantly, subsidies may also offset the regressive financial burden of taxation, thereby enhancing equity while supporting healthier behaviours. Experimental evidence indicates that subsidies can improve the nutritional profile of shopping baskets beyond the subsidised items themselves, whereas taxes alone may be undermined by substitution towards other unhealthy products (Epstein et al., 2015).

Equity impacts are a recurring theme. Lower-income households tend to be more price-sensitive and can experience proportionally greater health benefits from consumption taxes (Smed et al., 2007; Colchero et al., 2016). In Mexico, the introduction of 10% SSB and 8% snack taxes reduced taxed beverage purchases by 6% in the first year, with the largest decreases among low-income households (Colchero et al., 2016). However, the same groups also bear a heavier financial burden, prompting calls for targeted subsidies or reinvestment of tax revenues into community health programmes. The Finnish modelling study by Härkänen et al. (2011) illustrates how this can be achieved: a €1/kg sugar tax produced the greatest weight loss and diabetes reduction in low-income groups, with treatment savings outweighing the extra tax paid; pairing it with VAT exemptions on healthy foods further improved cardiovascular outcomes.

Outside direct consumer taxes, fiscal measures can shape supply. By targeting ingredients or imposing retailer levies, governments can incentivise reformulation, product removal, or healthier placement. However, the effect depends on both the scale of the levy and the extent to which it is designed with health, rather than revenue, as the primary objective.

Across the literature, the "how" of fiscal design emerges as decisive. Health gains are larger when taxes are: (a) substantial enough to alter purchasing behaviour, (b) structured to avoid easy substitution, (c) applied in environments where unhealthy options dominate, and (d) paired with subsidies or reinvestment to improve equity. In other words, fiscal policy works not simply by raising prices but by reshaping both the economic incentives and the physical availability of healthier alternatives. The most promising strategies are those that treat pricing not as an isolated lever but as part of a broader food system approach—one that engages producers, retailers, and consumers in shifting norms and options towards health.

5. Discussion

5.1. Cross-Cutting Findings

Improving population health through socioeconomic interventions depends not only on what is delivered, but how it is implemented. As evidence accumulates across policy domains, it points to the critical importance of integration, intensity, and infrastructure. Yet, policy discourse tends to emphasise intervention content while paying insufficient attention to delivery systems, the sequencing and interaction of components, and the institutional and social conditions in which programmes are embedded. This section brings together cross-cutting findings from across the evidence base to examine the enabling and constraining factors that shape implementation—how interventions are structured, adapted, and sustained over time; how delivery infrastructure, workforce capacity, and funding models influence their effectiveness; and how policies interact with the complex environments into which they are introduced.

Cross-cutting Approaches and Minimum Implementation Thresholds

"Programmes that combine complementary interventions and sustain engagement over time consistently outperform fragmented or short-lived efforts."

Implementation quality plays a decisive role in determining the health impact of social and economic interventions. Two core features consistently emerge as critical: multi-component integration and sufficient intensity or duration of the intervention. Programmes that combine complementary interventions and sustain engagement over time consistently outperform fragmented or short-lived efforts.

Evidence across sectors shows that synergistic, cross-cutting approaches yield effects greater than the sum of their parts. The Dutch District Approach illustrates this clearly, combining interventions in employment, education, housing, public space, safety, and social cohesion to address structural disadvantage holistically (Kramer et al., 2017). Similarly, the Nurse-Family Partnership's sustained effectiveness reflects not just its home visitation model but also its integration of health education, parenting support, and service coordination (Olds, 2006). Multi-pronged early years programmes, such as the Carolina Abecedarian Project, achieve long-term metabolic and cardiovascular gains by coupling education with nutrition and parental support (Campbell et al., 2014). This finding holds across domains: housing interventions combining physical upgrades with social support yield stronger outcomes than single-focus repairs (Thomson et al., 2001), and employment programmes that integrate psychological support with job search assistance improve both mental health and employability (Puig-Barrachina et al., 2020).

While traditional approaches have treated interventions as fixed bundles of services, more recent work has emphasised complexity, where effects emerge through interaction between components, delivery systems, and local contexts. Hawe et al. (2015) argue that interventions should be standardised by function—not form—allowing flexibility in delivery while maintaining core mechanisms. This requires a shift from linear "evidence-into-practice" models to iterative processes of adaptation, feedback, and co-production with implementers. These insights are echoed in the European review by Pons-Vigués et al. (2014), which found that integrated approaches—particularly those addressing structural determinants like housing, transport, or education—were more likely to reduce health

inequalities than those focused solely on behaviour change. Yet in practice, most interventions targeted individual behaviours, often in health settings, rather than engaging with broader social contexts. The authors call for cross-sectoral collaboration and participatory governance, underpinned by tools such as Health in All Policies and the WHO framework 'Urban HEART' or the Urban Health Equity Assessment and Response Tool.

Temporal dimensions emerge as equally critical determinants of success. The analysis identifies clear minimum thresholds below which interventions fail to generate meaningful health improvements. Effective home visiting programmes maintain engagement for 18–36 months with regular contact schedules—weekly, initially, then fortnightly (Olds, 2006; Harding et al., 2007). The Experience Corps demonstrates that volunteers contributing a minimum of 15 hours weekly across a full academic year achieve significant impacts on both student achievement and volunteer health (Rebok et al., 2004). Employment programmes require minimum six-month engagement periods (O'Campo et al., 2015b), while housing improvements necessitate comprehensive rather than piecemeal approaches (Thomson et al., 2001). Early childhood interventions may yield stronger health benefits when delivered at higher daily intensity, as shown by Frisvold and Lumeng (2011), who found that full-day Head Start participation significantly reduced childhood obesity compared to half-day attendance.

Programme Fidelity, Local Adaptation, and Professional Capacity

> "Underinvestment in workforce development consistently undermines programme effectiveness…"

Successful programmes demonstrate a sophisticated balance between maintaining core components and enabling local adaptation. The Triple P parenting programme's multi-tiered approach permits communities to select intervention levels matching local needs while preserving programme elements that are essential for its effective delivery (Sanders, 2008). The flexibility of Sure Start's service delivery, initially criticised for apparent inconsistency, ultimately enabled local authorities to address community-specific challenges while maintaining focus on child development and family support, achieving reduced hospitalisations worth approximately one-third of programme costs (Cattan et al., 2021). The Building Strong Families programme illustrates how local adaptation determines outcomes—Oklahoma City's distinctive approach, incorporating larger group sizes and financial incentives, produced positive effects, while other sites demonstrated negative outcomes (Wood et al., 2012; Wood et al., 2014).

Professional qualifications, training, and ongoing support fundamentally shape intervention outcomes. Programmes utilising trained professionals—nurses, social workers, teachers—consistently achieve superior results compared to those relying predominantly on paraprofessionals or volunteers. The Nurse-Family Partnership's requirement for registered nurses with programme-specific training exemplifies effective workforce development (Olds, 2006). Beyond initial qualifications, continuous supervision and support prove essential: programmes providing regular consultation, team meetings, and professional development maintain implementation quality and staff retention. German workplace health circles succeeded partly through trained facilitators receiving ongoing support (Aust & Ducki, 2004). Underinvestment in workforce development consistently undermines programme effectiveness across multiple policy domains.

Delivery Infrastructure and Financial Sustainability

> "Sustainable funding mechanisms and appropriate financial architectures fundamentally influence implementation success. Programmes with secured multi-year funding achieve more consistent results…"

Successful interventions invest substantially in delivery infrastructure rather than operating as isolated initiatives. Quebec's childcare reform created new ministerial structures and reorganised existing services into integrated systems, demonstrating the transformative potential of comprehensive infrastructure development (Baker et al., 2008). Head Start's effectiveness partly derives from robust infrastructure spanning national, regional, and local levels with clear accountability mechanisms (Ludwig & Miller, 2007). Integration with existing services proves particularly crucial: welfare advice services co-located in GP practices achieved exceptional reach and impact, with over two-thirds of participants accessing new entitlements averaging £1,026 additional annual income (Adams et al., 2006). The HUD-VASH programme for homeless veterans succeeded through integrating housing assistance with Veterans Administration healthcare services, demonstrating incremental cost-effectiveness ratios of between $45 and $74 per day housed, depending on perspective (Rosenheck et al., 2003).

Sustainable funding mechanisms and appropriate financial architectures fundamentally influence implementation success. Programmes with secured multi-year funding achieve more consistent results than those facing annual budget uncertainty. The Earned Income Tax Credit's integration into the taxation system ensures stable, predictable delivery surviving political transitions, contributing to improved birth weights and reduced maternal smoking (Hoynes et al., 2015). The Communities First regeneration programme in Wales demonstrates how sustained investment over a decade improves mental health outcomes, particularly when residents direct regeneration activities (Greene et al., 2020). Where economic analysis exists, compelling returns on investment emerge: housing insulation programmes demonstrate health and energy benefits outweighing costs by factors approaching 2:1 (Howden-Chapman et al., 2007); community arts programmes show returns of 50p per £1 invested (Chatterjee et al., 2018); and teen pregnancy prevention programmes and Medicaid family planning coverage save more public funds than they cost (McLanahan et al., 2010).

Contextual Sensitivity and Unintended Consequences

> "Implementation strategies and approaches require careful calibration to local economic conditions, governance structures, and population characteristics. Urban regeneration programmes succeed when addressing neighbourhood-specific challenges rather than applying standardised approaches."

Implementation strategies and approaches require careful calibration to local economic conditions, governance structures, and population characteristics. Urban regeneration programmes succeed when addressing neighbourhood-specific challenges rather than applying standardised approaches. The Moving to Opportunity programme's varied results across sites highlight how intervention effects depend critically on local housing markets, employment opportunities, and neighbourhood characteristics (Kling et al., 2007; Sanbonmatsu et al., 2011). Immigration policy research demonstrates how exclusionist approaches in Denmark correlate with elevated mortality rates among immigrants compared to the impacts of inclusive Dutch policies, underscoring macro-level policy contexts' influence on health outcomes (Ikram et al., 2015; Malmusi et al., 2017).

Several interventions produce unexpected adverse outcomes requiring adaptive responses. Quebec's universal childcare expansion, while increasing maternal employment, generated negative effects on child behaviour and parental wellbeing through rapid implementation without quality controls (Baker et al., 2008). Urban regeneration efforts occasionally increase stress during construction phases, with one Manchester trial reporting increased mental distress following housing improvements due to environmental disruption (Thomas et al., 2005). The Woods In and Around Towns intervention, which sought to lower stress levels and increase physical activity through making woodland more accessible, unexpectedly increased stress levels despite improving physical activity and social cohesion (Ward Thompson et al., 2019). WTR potentially harms women's career trajectories more than men's, requiring careful policy design to avoid reinforcing gender inequalities (Hanbury et al., 2023).

Continuous Learning and Political Considerations

Programmes incorporating robust monitoring systems enabling real-time adjustments consistently outperform those with rigid implementation protocols. The District Approach's systematic tracking of intervention intensity and reach in the Netherlands permitted mid-course corrections improving outcomes (Kramer et al., 2017). The GoWell programme in Glasgow demonstrates how a decade-long evaluation commitment captures complex regeneration impacts, revealing empowerment effects stronger for wellbeing than clinical mental health outcomes (Egan et al., 2010; Kearns & Whitley, 2020). Evaluation methodologies must accommodate complexity—contribution analysis proves valuable for understanding pathways in dynamic contexts (Bond et al., 2013).

Sustained political commitment across electoral cycles proves essential for complex interventions. Sure Start's persistence through multiple political transitions, albeit with modifications, enabled detection of long-term benefits including reduced hospitalisations emerging only after several years (Cattan et al., 2021). Policy coherence across governmental levels enhances effectiveness: Denmark's flex-jobs programme succeeded through coordinating national policy, local implementation, and social partner involvement, with Denmark investing 1.3% of GDP in activation measures compared to the UK's 0.3% (Etherington & Ingold, 2012). Conversely, fragmented approaches create contradictory incentives—Universal Credit's adverse mental health impacts result partly from poor coordination between employment, housing, and health support systems, increasing psychological distress by 6.57 percentage points among unemployed individuals (Wickham et al., 2020).

5.2. Distribution of impact and equity considerations

> "the review points to a persistent strategic tension between coverage and equity. Universal, flat-rate interventions — such as untargeted regeneration schemes or blanket food subsidies — are politically appealing and administratively simple, but often underserve those with the greatest need."

The equity effects emerging from the review reveal a pattern that is far from straightforward. Interventions that improve health at the population level do not always narrow health gaps; in many cases, they appear to do the opposite. Several large-scale programmes generated greater relative gains for groups already better positioned to benefit, even when the intention was universal improvement. Labour market policies such as active labour market programmes, for instance, improved life satisfaction among men but not women in the UK, and in Finland delivered better outcomes for workers with higher socioeconomic status than for those already disadvantaged (Puig-Barrachina et al., 2020). Urban regeneration initiatives that upgraded infrastructure and public space

sometimes strengthened the wellbeing of long-term, better-resourced residents while triggering displacement pressures on lower-income tenants (Mehdipanah et al., 2013; McCartney et al., 2017). These cases illustrate a recurrent resource-filter effect: people with more education, stable employment, or stronger social networks are better able to access, navigate, and sustain the benefits of an intervention, regardless of whether that intervention was designed to be open to all.

This is not simply about individual motivation or awareness — it reflects the way implementation processes interact with pre-existing advantage. Where policy delivery relies heavily on voluntary uptake, complex application processes, or the ability to absorb short term costs for long term gains, it tends to favour those who already have the time, literacy, confidence, and stability to engage. Hanbury et al. (2023) show this in the context of working time reduction, where women reported significant wellbeing improvements but also faced career penalties and foregone income in settings without adequate employer support. The same mechanism plays out in neighbourhood renewal: Mehdipanah et al. (2013) found that physical upgrades combined with social programmes created inclusive spaces for many, but also catalysed rising property values and commercial rents that squeezed out small businesses and vulnerable households. Without careful attention to such knock on effects, equity gains risk being eroded even as headline health indicators improve.

Another striking feature of the evidence base is that health equity is overwhelmingly operationalised in socioeconomic terms — income, education, occupation — with much less systematic analysis of race, ethnicity, migration status, gender, disability, or geography. While there are exceptions, such as the clear gender patterns in parental leave and early years interventions (Rossin, 2011; Heshmati et al., 2023) and the integration policy effects on migrant health gaps (Malmusi, 2015; Ikram et al., 2014, 2015), these are the minority. This narrow framing risks obscuring intersectional dynamics, where overlapping disadvantages alter both the scale and the nature of an intervention's impact. For example, the same labour market programme may deliver modest income gains to low income men but negligible or even negative effects for low-income women juggling unpaid care work, and entirely different benefits or harms for older migrants in precarious jobs. Without routine analysis along multiple dimensions of inequality, these divergences remain hidden in aggregate averages.

Patterns in the review also echo a broader distinction between interventions that act "downstream" by targeting individual behaviour change and those that act "upstream" by shifting the structural conditions in which behaviours occur. Downstream approaches — such as mass media health campaigns or voluntary educational programmes — are more prone to intervention-generated inequalities because they assume a baseline capacity to respond. Niederdeppe et al. (2008) found that smoking-cessation media campaigns consistently produced larger behaviour changes in higher-income, better-educated populations, who were more able to translate awareness into sustained quitting.[1] In contrast, upstream measures that alter the cost, availability, or quality of environments — from tobacco pricing to structural workplace reforms — tend to deliver proportionally larger benefits to disadvantaged groups (Mytton et al., 2012; Bambra et al., 2009). The equity advantage here comes from reducing or removing barriers that weigh more heavily on those with fewer resources, rather than relying on voluntary uptake or self-funded change.

Even when structural measures are in play, the review shows that equity gains are often incidental rather than deliberate. Many of the most successful examples — Head Start's stronger crime reduction effects for African American participants (Garces et al., 2002), regeneration projects that strengthened social capital in low income districts (Mehdipanah et al., 2015), or integration policies narrowing migrant-native health gaps (Malmusi, 2015) — achieved these outcomes as a byproduct of broader goals like poverty reduction, urban competitiveness, or

citizenship reform. This limits the scope for intentionally targeting those with the greatest health disadvantage. If an intervention's equity effects are accidental, they are also fragile: shifts in delivery priorities, budget lines, or political leadership can quickly erode them.

Timing and durability also matter. Some targeted redistribution policies — such as conditional or unconditional cash transfers — yield rapid narrowing of gaps by providing immediate resources to those in need, with accompanying gains in child nutrition or maternal mental health (Dahl & Lochner, 2012; Hoynes et al., 2015). But these effects tend to fade without sustained support or parallel structural reforms to address the underlying drivers of inequality. By contrast, upstream strategies — like inclusive national integration regimes that offer citizenship access, labour market rights, and cultural recognition — take longer to show measurable health impacts but are more likely to embed them over time (Malmusi, 2015; Ikram et al., 2014, 2015). The review's migrant health evidence makes this clear: exclusionist regimes were associated with persistently worse mortality and mental health outcomes for long-settled migrants, while inclusive regimes narrowed these gaps even without targeted health programming.

The evidence also highlights cases where policies are financially regressive but health-progressive. Taxation of unhealthy foods or sugary drinks places a higher proportional financial burden on low-income households, yet because these groups are more price-sensitive and have higher baseline rates of diet-related disease, the resulting health benefits can be greater for them (Mytton et al., 2012; Fletcher et al., 2010; Ni Mhurchu et al., 2015). The evidence of mixed and complex effects — where policies can be simultaneously financially regressive but health-progressive — highlights the need for sophisticated policy design that anticipates and addresses differential impacts. This might mean pairing taxes with subsidies on healthy foods, as in combined fiscal measures that offset costs for disadvantaged consumers while preserving behavioural incentives (Ecorys, 2014).

Intersectionality runs through many of these dynamics. ALMPs benefitted high-SES participants more, but their effects also varied by gender within the same SES group (Puig-Barrachina et al., 2020). Elderly residents in gentrifying neighbourhoods were more vulnerable to displacement pressures yet could benefit from targeted age-friendly upgrades (Melis et al., 2015b; de Souza & Grundy, 2007). Early-years programmes had stronger cognitive effects for children of more educated mothers, but larger crime-reduction effects for African American boys (Garces et al., 2002). These examples underscore that equity effects cannot be fully understood by looking at single dimensions of disadvantage in isolation.

Finally, the review points to a persistent strategic tension between coverage and equity. Universal, flat-rate interventions — such as untargeted regeneration schemes or blanket food subsidies — are politically appealing and administratively simple, but often underserve those with the greatest need (Mehdipanah et al., 2013; Ecorys, 2014). Highly targeted approaches, like income-tested early years programmes or neighbourhood-specific employment schemes, can narrow gaps quickly but risk stigma, lower political viability, and smaller total population gains (Puma et al., 2010; Dahl & Lochner, 2012). The designs that balanced these tradeoffs most effectively combined universal coverage with proportionate intensity, ensuring everyone was eligible while delivering more to those facing the steepest barriers. Inclusive urban regeneration that embedded targeted outreach within citywide infrastructure upgrades is one example (Mehdipanah et al., 2015). Without such proportionality, even well-intentioned policies risk reproducing the very inequalities they set out to dismantle.

Policy Domain	Policy Intervention	Gender	Socioeconomic Status	Old-age	Rural	Race/ Ethnicity
Housing	Housing Mobility Programmes					
	Housing Quality & Energy Efficiency					
	Housing-Led Urban Regeneration					
	Supported & Crisis Housing					
Regeneration and Built Environment	Active Travel Infrastructure					
	Area-Based Regeneration					
	Neighbourhood Design & Walkability					
	Neighbourhood Renewal Policies					
	Road Infrastructure & Safety					
	Urban Green & Blue Space Regeneration					
	Urban Planning & Public Infrastructure					
Community Infrastructure	Arts & Cultural Programmes					
	Community Engagement for Health					
	Intergenerational Programmes					
	Social Identification & Group Interventions					
	Social Prescribing & Volunteer Health Promotion					
Labour Market Interventions	Active Labour Market Programmes (ALMPs)					
	Supported Employment & Transitions					
	Wage Policy					
	Working Time Reduction					
	Workplace Health Promotion					
	Workplace Participation & Organisation					
Welfare	Conditional Cash Transfers					
	Disability & Unemployment Benefits					
	Income Maintenance & Supplements					
	Tax Credits & Income Support					
	Universal Credit & Conditionality					
	Welfare Benefits Advice					
Early Childhood and Family	Child Maltreatment & Support Systems					
	Childcare Affordability					
	Community-Based Child Protection					
	Early Childhood Education (ECE)					
	Family & Relationship Education					
	Parental Leave Policies					
	Parenting Programmes					
	School Nutrition & Food Access					
Fiscal Policy	Alcohol & Tobacco Taxation					
	Combined Food Fiscal Strategies					
	Food & Beverage Taxation					

Figure 8. *Heatmap of health equity impacts by policy intervention type*

	Positive Evidence
	Strong Positive Evidence
	No Evidence
	Negative Evidence
	Strong Negative Evidence
	Mixed Evidence

Note: Positive Evidence: Assigned when there are 1–2 studies showing positive outcomes for the domain in question.

Strong Positive Evidence: Assigned when there are more than 2 positive studies.

Negative Evidence: Assigned when there are 1–2 studies showing negative outcomes.

Strong Negative Evidence: Assigned when there are more than 2 negative studies.

Mixed Evidence: Classified as mixed when positive and negative findings are nearly balanced (e.g. 1:1 or 2:1 in either direction), but shifts to Positive or Negative when three or more studies clearly outweigh one opposing study, with a net score calculated as the difference (e.g. 3–1 = 2).

6. Leveraging the UK evidence base

> "The UK evidence base on the relationship between socioeconomic policy and health is broad, often rigorous, and increasingly policy-relevant… It spans multiple domains—most notably regeneration and the built environment, welfare, community-led approaches, housing, early years, and fiscal levers—and reflects two decades of evolving national and local policy experiments.."

The UK evidence base on the relationship between socioeconomic policy and health is broad, often rigorous, and increasingly policy-relevant, though uneven in methodology and consistency of outcomes. It spans multiple domains—most notably regeneration and the built environment, welfare, community-led approaches, housing, early years, and fiscal levers—and reflects two decades of evolving national and local policy experiments. Together, these studies provide a valuable, albeit complex, foundation for the next phase of devolved policy-making, especially under the statutory health and health inequalities responsibilities that will be assigned to England's emerging strategic authorities under the English Devolution and Community Empowerment Bill.

Nowhere is the scale of the evidence base more visible than in regeneration and the built environment, yet findings of such interventions impact on health are mixed. Evaluations of area-based initiatives such as the New Deal for Communities and Northern Ireland's Neighbourhood Renewal Programme suggest that while modest gains in socioeconomic indicators are achievable, consistent improvements in self-rated health, mental wellbeing, or life satisfaction remain elusive (Walthery et al., 2015; Mohan et al., 2017). The reasons are varied: short timeframes, partial implementation, or disruption to social networks often mitigate or even reverse expected benefits (Thomas et al., 2005; Egan et al., 2015; Kearns et al., 2020). Yet more robust models—such as Wales's Communities First—demonstrate that when regeneration improves local infrastructure, reduces neighbourhood disorder, and is sustained over time, it can enhance mental wellbeing and reduce disparities (White et al., 2017; Greene et al., 2019). Similarly, the Connswater Community Greenway in Belfast showed that quality green and blue space can support mental wellbeing, mediated by enhanced perceptions of safety, amenities, and social cohesion (Wang et al., 2023).

These mixed results are not simply about 'what' is done, but 'how' and 'under what conditions' interventions are delivered. The effectiveness of regeneration is strongly contingent on fidelity, stability, and community empowerment. For instance, Kearns and Whitley (2020) found that collective empowerment in Scottish regeneration zones was linked to wellbeing gains—yet these were reversed by post-2011 austerity and welfare reforms. A key lesson is that empowerment is not just a delivery mechanism; it is itself a health determinant. Where regeneration succeeds, it is typically long-term, participatory, cross-sectoral, and locally adapted. Place-based experimentation, real-time learning, and cross-sector alignment are recurring features of effective initiatives. Yet austerity and structural underinvestment have eroded many of the local institutional capacities required for this type of governance.

> "For local and regional government, the implication is that the mere availability of powers is insufficient; realising health benefits requires institutional capacity, sustained engagement, and flexible delivery architectures."

These findings are highly salient in the context of the English Devolution White Paper (Ministry of Housing, Communities and Local Government, 2024), which places strategic authorities at the heart of health improvement and public service reform. For these authorities to meet their new statutory duties on health and health inequalities, they must not only access devolved powers but demonstrate the institutional maturity required to sustain long-term regeneration strategies. For local and regional government, the implication is that the mere availability of powers is insufficient; realising health benefits requires institutional capacity, sustained engagement, and flexible delivery architectures.

The same principle applies to welfare reform, where evidence of harm is clearer and more consistent. Studies of Universal Credit show significant adverse effects on mental health, particularly among unemployed adults and children in low-income households. Wickham et al. (2020) found a 6.6 percentage point increase in psychological distress following rollout, while Song et al. (2024) identified an 8 percentage point rise in mental health problems among children, particularly in larger and workless families. Dwyer et al. (2020) add qualitative depth, documenting how complex administrative systems and conditionality lead to disengagement and anxiety, especially among disabled people. These findings point to systemic flaws in welfare governance, where policy designed at the national level generates localised health harms.

Despite limited local discretion, some mitigation has been attempted through locally integrated welfare rights services. Advice embedded in healthcare or community settings can improve income and reduce stress, with secondary benefits for emotional wellbeing (Adams et al., 2006; Greasley & Small, 2005; Abbott et al., 2005). However, these initiatives remain compensatory and relatively small in scale. They illustrate both the promise and limits of local mitigation in the absence of coherent, multi-level governance. Devolved strategic authorities—particularly mayoral ones—may now be better placed to push for upstream alignment across welfare, housing, and health, ensuring that national reforms do not undercut local strategies.

Community-based interventions—particularly those addressing social isolation, wellbeing, and civic participation—are promising but under-evidenced. Arts engagement, green space activation, and social prescribing are among the most frequently piloted interventions, with some showing positive effects on social confidence, community bonding, and isolation (Chatterjee et al., 2018; Daykin et al., 2021; Hampshire & Matthijsse, 2010). However, the evidence base remains fragmented. Evaluations are often small-scale, short-term, and lack control groups. Lee et al. (2022) highlight that mental health promotion schemes for older adults, while theoretically sound, are poorly evaluated and weakly integrated into mainstream provision. The Well London trial similarly found no significant effects on population-level health behaviours or wellbeing, largely due to programme dilution and residential mobility (Phillips et al., 2014).

> "Place-based experimentation, real-time learning, and cross-sector alignment are recurring features of effective initiatives. Yet austerity and structural underinvestment have eroded many of the local institutional capacities required for this type of governance."

These findings emphasise that community interventions require not just funding but strategic coherence, local anchoring, and delivery through trusted institutions. The new devolution framework offers an opportunity to embed such interventions into Local Growth Plans and anchor strategies, provided they are supported by shared accountability structures and long-term settlements. Where health improvement has been achieved, it is typically

underpinned by coherent action across local, regional, and national levels, as well as by leadership that views health as a cross-cutting outcome of social and economic policy.

Housing and physical infrastructure, as integral components of place, also offer levers for health improvement—though again, effects vary by intervention type, quality, and context. Older evidence found modest respiratory and mental health benefits from basic housing improvements (Thomson et al., 2001), but large-scale renewal schemes like the New Deal for Communities rarely delivered health benefits commensurate with their investment. Where physical improvements are made without parallel attention to tenure mix, displacement, or local amenities, expected health gains can be blunted or even reversed (Thomas et al., 2005; Egan et al., 2015). Built environment schemes promoting active travel, such as separated cycling infrastructure, have shown success in shifting behaviour (Aldred, 2019), while others—like the Fitter for Walking programme—highlight the importance of local capacity in delivering physical activity improvements (Adams et al., 2017).

What emerges from these studies is that physical transformation is a necessary but insufficient condition for health improvement. Environmental changes must be combined with relational and behavioural supports, especially in deprived areas. Ward Thompson et al. (2019) and Moore et al. (2018) underscore that the mental and physical health effects of built environment change are highly context-specific, and often require complementary investment in social infrastructure and trust-building.

In this context, the devolution framework's emphasis on aligning public service geographies, and ambition in the 2025 NHS 10 Year Plan to anchor mayors in Integrated Care Boards (ICBs), is welcome. For these mechanisms to realise their potential, strategic authorities must act not only as delivery vehicles but as coordinators of multi-domain strategies that integrate housing, infrastructure, employment, and community resilience.

> "Where health improvement has been achieved, it is typically underpinned by coherent action across local, regional, and national levels, as well as by leadership that views health as a cross-cutting outcome of social and economic policy."

Though smaller in number, studies on early childhood policy provide some of the strongest causal evidence of long-term health gains. Sure Start, for example, reduced hospitalisations and improved mental health outcomes among children, especially boys in deprived areas (Cattan et al., 2021; Carneiro et al., 2025). The programme also enhanced educational outcomes and generated positive spillovers for families and communities. These findings make a compelling case for place-based reinvestment in early years provision—something that could now be championed through Family Hubs under strategic authority leadership.

Finally, fiscal policy, while under-represented in UK evaluations, offers important insight. Briggs et al. (2013) modelled a 20% sugar-sweetened beverage tax and projected reductions in obesity, particularly among younger adults, with no regressive substitution effects. Though a national lever, this example highlights the potential for strategic authorities to influence public health through coordinated advocacy, evidence mobilisation, and local implementation of fiscal incentives.

Across these domains, one structural insight persists: successful health-oriented interventions are rarely the product of isolated programmes or singular powers. They require multilevel coordination, institutional coherence, sustained delivery capacity, and embedded learning. The new devolution architecture in England—especially with its statutory

focus on health improvement and public service reform—offers an opportunity to systematise these conditions. But realising this opportunity will require more than delegated authority; it will demand strategic clarity, outcome-oriented governance, and robust local institutions capable of integrating economic, social, and health goals.

---

7. Strengths and Limitations

7.1. Evidence Review

This structured evidence review represents one of the most comprehensive syntheses examining relationships between socioeconomic policies and population health outcomes. Several methodological strengths enhance confidence in the findings. The search strategy employed multiple academic databases alongside grey literature sources, capturing both peer-reviewed evidence and policy evaluations often excluded from traditional reviews. The inclusion of 144 studies spanning diverse policy domains provides unprecedented breadth, while the temporal coverage ensures contemporary relevance for current policy debates. The development of a novel transferability assessment framework specifically evaluating UK applicability addresses a critical gap in international evidence synthesis, moving beyond simple quality assessment to consider contextual factors influencing implementation feasibility.

The rigorous quality assessment employing a three-dimensional framework evaluating credibility, methodology, and relevance provides more nuanced evaluation than traditional tools. By requiring minimum scores across all dimensions while permitting flexibility for locally relevant interventions, the approach balances rigour with pragmatism. The development of a novel transferability framework specifically evaluating UK applicability addresses a critical gap in international evidence synthesis, moving beyond simple quality assessment to consider contextual factors influencing implementation feasibility.

A particular strength lies in the consistent equity focus throughout the review. The systematic coding of differential impacts across population subgroups reveals patterns of advantage and disadvantage often overlooked in effectiveness-focused syntheses. This equity lens, combined with attention to implementation factors and economic outcomes across all 144 studies, enables identification of cross-cutting patterns typically obscured in domain-specific reviews.

However, several limitations warrant consideration. The broad scope, while enabling cross-domain learning, necessarily sacrifices depth within individual policy areas. More focused reviews might uncover nuanced mechanisms or contextual factors specific to particular interventions. The quality threshold requirements, while ensuring evidence robustness, excluded studies that might offer valuable implementation insights despite methodological limitations. The transferability assessment, while innovative, relies on reviewer judgement about contextual similarities, introducing potential subjectivity despite structured criteria. The review's focus on population-level interventions excludes individual-level programmes that might scale effectively, potentially overlooking innovative approaches to improving health through economic mechanisms.

7.2. Evidence Base

The evidence base demonstrates several strengths supporting policy application. The predominance of quasi-experimental and experimental designs provides reasonable confidence in causal inference, particularly important

given the complex pathways linking economic policies to health outcomes. The geographical concentration in OECD countries with similar institutional structures to the UK enhances transferability, while the inclusion of multiple systematic reviews and meta-analyses provides aggregated evidence beyond individual studies. Long-term follow-up in several landmark studies, such as the Carolina Abecedarian Project and Moving to Opportunity, reveals sustained impacts often invisible in short-term evaluations.

The evidence spans diverse populations and contexts, enabling examination of differential effects across demographic groups. Studies increasingly incorporate implementation process evaluation alongside outcome assessment, providing crucial insights into why interventions succeed or fail. The inclusion of natural experiments and policy evaluations captures real-world implementation conditions often absent from controlled trials. Multiple studies examining similar interventions across different contexts enable assessment of which components remain stable versus context-dependent.

Nevertheless, important limitations persist across the evidence base. Most evaluations are conducted over relatively short time periods, with long-term or lifecycle studies remaining rare. This constrains understanding of sustained or intergenerational impacts. Economic evaluation is another major gap: few studies incorporate rigorous cost-effectiveness analyses, undermining efforts to assess value for money—especially when resource allocation must be justified amid competing budgetary pressures. Where economic assessments do exist, they often rely on inconsistent methodologies and timeframes, limiting comparability across interventions. This is particularly problematic in domains requiring significant investment and careful weighing of opportunity costs, such as labour market measures.

Moreover, certain populations and policy areas remain significantly understudied. For example, despite their relevance to health policy, immigration policies are rarely evaluated for health impacts. Similarly, inconsistent use of gender-disaggregated analysis obscures differential effects that warrant tailored responses. Entire domains—such as industrial strategy, spatial economic planning, and labour market restructuring—also receive limited attention, despite their potential to shape health outcomes through employment, income distribution, and local investment patterns.

Finally, questions of context and transferability are often overlooked. Broader system-level enablers—such as administrative capacity, data infrastructure, and inter-agency coordination—are rarely examined. So too are political economy factors, including stakeholder resistance, electoral incentives, and shifting policy priorities. These omissions hinder assessments of real-world feasibility and scale-up potential. Taken together, these limitations underline the need for caution in translating evidence into policy—and highlight the importance of investing in context-sensitive, methodologically robust evaluations across a broader set of domains.

8. Conclusion

This review demonstrates that socioeconomic policy plays a significant role in shaping population health. Across a range of domains—including housing, employment, early years, welfare, fiscal policy, transport, and community development—economic decisions influence health outcomes through multiple and interrelated pathways. The 144 studies assessed provide robust evidence that health is affected not only by healthcare and individual behaviours but also by the broader structural conditions shaped by economic policy: the quality and affordability of housing, the security and nature of employment, access to childcare and social protection, and the design of neighbourhoods and infrastructure. While the mechanisms vary and are shaped by context, the overall pattern is consistent: socioeconomic policies can support improvements in physical and mental health, influence health behaviours, and contribute to the narrowing—or widening—of health inequalities.

Effective interventions typically share several characteristics. They are integrated, multi-component, and sustained over time, combining material improvements (e.g. income, housing, services) with attention to psychosocial, behavioural, and environmental factors. The review also highlights the central importance of implementation. Interventions that are well-resourced, contextually adapted, and delivered by trained professionals are more likely to achieve their intended outcomes. The artificial dichotomy between 'policy' and 'implementation' obscures the reality that delivery mechanisms often matter more than intervention content.

"The artificial dichotomy between 'policy' and 'implementation' obscures the reality that delivery mechanisms often matter more than intervention content."

The findings also point to persistent gaps in both evidence and practice. Some population groups—particularly immigrants, disabled people, and low-income ethnic minorities—are underrepresented in the literature. Similarly, certain domains, such as industrial strategy, spatial planning, and supply-side labour market interventions, remain relatively underexplored despite their policy relevance. Moreover, some policies have led to unintended adverse effects—for instance, increased stress during poorly managed regeneration, or negative child outcomes in low-quality childcare expansion—highlighting the need for equity-sensitive, context-aware design and ongoing evaluation.

The UK evidence reviewed aligns with these broader patterns, but also reflects the particularities of national governance structures. In domains where central government retains control—such as welfare—local responses have often been limited to mitigation rather than systemic change. Conversely, in areas with stronger subnational levers—such as housing, regeneration, transport, and skills—there is clearer potential for aligning economic strategy with health objectives at regional and local government levels. Initiatives such as Sure Start, Communities First, and GoWell demonstrate that locally led, well-resourced, and contextually adapted interventions can yield meaningful health improvements. However, these examples also underscore the fact that local capacity—financial, institutional, and analytical—is a prerequisite for effective place-based policymaking. Without sustained investment, coherent governance, and mechanisms for learning and adaptation, many local strategies will struggle to deliver their full potential.

In this respect, this review makes three key contributions. First, it consolidates a diverse and often fragmented evidence base, offering an integrated view of how socioeconomic policy affects health across sectors and contexts.

Second, it provides a structured resource for policymakers, particularly at local and regional levels, to support the design of economic strategies that also contribute to health improvement and health equity. By combining a structured quality and transferability assessment with thematic synthesis, it identifies not only which interventions are effective but also under what conditions, for whom, and through which mechanisms. Third, it offers an empirical foundation for the development of a more integrated policy framework—one that treats economic development and public health not as separate agendas, but as interdependent and mutually reinforcing goals.

As the UK continues to broaden and deepen its commitment to devolution of economic development, the findings of this review are especially relevant. They highlight the need to embed health considerations into economic policymaking and to ensure that local strategies are supported by the necessary governance structures, delivery capacity, and evaluative tools. Rather than being treated as incidental or secondary, health outcomes should be seen as central to the success and sustainability of national, regional and local economic development policies. This review provides both the conceptual rationale and the practical evidence base to inform that shift.

References

Abbott, S., Hobby, L. and Cotter, S., 2006. What is the impact on individual health of services in general practice settings which offer welfare benefits advice? Health & Social Care in the Community, 14(1), pp.1–8.

Acevedo-Garcia, D., Osypuk, T.L., Werbel, R.E., Meara, E.R., Cutler, D.M. and Berkman, L.F., 2004. Does housing mobility policy improve health? Housing Policy Debate, 15(1), pp.49–98.

Adams, E.J., Cavill, N. and Sherar, L.B., 2017. Evaluation of the implementation of an intervention to improve the street environment and promote walking for transport in deprived neighbourhoods. BMC Public Health, 17(1), p.655.

Adams, J., White, M., Moffatt, S., Howel, D. and Mackintosh, J., 2006. A systematic review of the health, social and financial impacts of welfare rights advice delivered in healthcare settings. BMC Public Health, 6(1), p.81.

Aldred, R., 2019. Built environment interventions to increase active travel: a critical review and discussion. Current Environmental Health Reports, 6(4), pp.309–315.

Anderson, Kathryn & Foster, James & Frisvold, David. (2004). Investing in Health: The Long-Term Impact of Head Start. Department of Economics, Vanderbilt University, Working Papers.

Anderson, L.M., Charles, J.S., Fullilove, M.T., Scrimshaw, S.C., Fielding, J.E., Normand, J. and Task Force on Community Preventive Services, 2003. Providing affordable family housing and reducing residential segregation by income: a systematic review. American Journal of Preventive Medicine, 24(3), pp.47–67.

Aust, B. and Ducki, A., 2004. Comprehensive health promotion interventions at the workplace: experiences with health circles in Germany. Journal of Occupational Health Psychology, 9(3), pp.258–270.

Baker, M. and Milligan, K., 2010. Evidence from maternity leave expansions of the impact of maternal care on early child development. Journal of Human Resources, 45(1), pp.1–32.

Baker, M., Gruber, J. and Milligan, K., 2008. Universal child care, maternal labor supply, and family well-being. Journal of Political Economy, 116(4), pp.709–745.

Bambra, C., Egan, M., Thomas, S., Petticrew, M. and Whitehead, M., 2007. The psychosocial and health effects of workplace reorganisation. 2. A systematic review of task restructuring interventions. Journal of Epidemiology & Community Health, 61(12), pp.1028–1037.

Bambra, C., Whitehead, M. and Hamilton, V., 2005. Does 'welfare-to-work' work? A systematic review of the effectiveness of the UK's welfare-to-work programmes for people with a disability or chronic illness. Social Science & Medicine, 60(9), pp.1905–1918.

Bambra, C.L., Whitehead, M.M., Sowden, A.J., Akers, J. and Petticrew, M.P., 2008. Shifting schedules: the health effects of reorganizing shift work. American Journal of Preventive Medicine, 34(5), pp.427–434.

Barth, R.P., 2009. Preventing child abuse and neglect with parent training: Evidence and opportunities. The Future of Children, pp.95–118.

Bates, G., Black, D., Ayres, S., Bondy, K., Carhart, N. and Kidger, J., 2025. Identifying intervention areas to shape healthier urban development in the United Kingdom. PLOS Sustainability and Transformation, 4(6), p.e0000176.

Bond, L., Egan, M., Kearns, A. and Tannahill, C., 2013. GoWell: the challenges of evaluating regeneration as a population health intervention. Preventive Medicine, 57(6), pp.941–947.

Borrell, C., Palència, L., Bartoll, X., Ikram, U. and Malmusi, D., 2015. Perceived discrimination and health among immigrants in Europe according to national integration policies. International Journal of Environmental Research and Public Health, 12(9), pp.10687–10699.

Briggs, A.D., Mytton, O.T., Kehlbacher, A., Tiffin, R., Rayner, M. and Scarborough, P., 2013. Overall and income specific effect on prevalence of overweight and obesity of 20% sugar sweetened drink tax in UK: econometric and comparative risk assessment modelling study. BMJ, 347.

Brückner, A., Falkenberg, T., Heinzel, C. and Kistemann, T., 2022. The regeneration of urban blue spaces: a public health intervention? Reviewing the evidence. Frontiers in Public Health, 9, p.782101.

Bunn, F., Collier, T., Frost, C., Ker, K., Roberts, I. and Wentz, R., 2003. Traffic calming for the prevention of road traffic injuries: systematic review and meta-analysis. Injury Prevention, 9(3), pp.200–204.

Campbell, F., Conti, G., Heckman, J.J., Moon, S.H., Pinto, R., Pungello, E. and Pan, Y., 2014. Early childhood investments substantially boost adult health. Science, 343(6178), pp.1478–1485.

Camprubí, L., Malmusi, D., Mehdipanah, R., Palència, L., Molnar, A., Muntaner, C. and Borrell, C., 2016. Façade insulation retrofitting policy implementation process and its effects on health equity determinants: A realist review. Energy Policy, 91, pp.304–314.

Carneiro, P., Cattan, S., Conti, G., Crawford, C., Farquharson, C. and Ridpath, N., 2025. The short- and medium-term effects of Sure Start on children's outcomes. London: Institute for Fiscal Studies.

Carneiro, P., Løken, K.V. and Salvanes, K.G., 2010. A flying start? Long term consequences of maternal time investments in children during their first year of life. Working Papers in Economics, 06/10, University of Bergen, Department of Economics.

Cattan, S., Conti, G., Farquharson, C. and Krutikova, S., 2021. The health impacts of Sure Start. London: Institute for Fiscal Studies. Available at: https://ifs.org.uk/publications/health-impacts-sure-start

Chang, J.T., Morton, S.C., Rubenstein, L.Z., Mojica, W.A., Maglione, M., Suttorp, M.J., Roth, E.A. and Shekelle, P.G., 2004. Interventions for the prevention of falls in older adults: systematic review and meta-analysis of randomised clinical trials. BMJ, 328(7441), p.680.

Chatterjee, H.J., Camic, P.M., Lockyer, B. and Thomson, L.J., 2018. Non-clinical community interventions: a systematised review of social prescribing schemes. Arts & Health, 10(2), pp.97–123.

Chriqui, J.F., Pickel, M. and Story, M., 2014. Influence of school competitive food and beverage policies on obesity, consumption, and availability: a systematic review. JAMA Pediatrics, 168(3), pp.279–286.

Colantuoni, F. and Rojas, C., 2015. The impact of soda sales taxes on consumption: evidence from scanner data. Contemporary Economic Policy, 33(4), pp.714–734.

Colchero, M.A., Popkin, B.M., Rivera, J.A. and Ng, S.W., 2016. Beverage purchases from stores in Mexico under the excise tax on sugar sweetened beverages: observational study. BMJ, 352.

Connor, J., Rodgers, A. and Priest, P., 1999. Randomised studies of income supplementation: a lost opportunity to assess health outcomes. Journal of Epidemiology & Community Health, 53(11), pp.725–730.

Cowan, P. and Cowan, C., 2008. Diverging family policies to promote children's well-being in the UK and US: Some relevant data from family research and intervention studies. Journal of Children's Services, 3(4), pp.4–16.

Crowther, R.E., Marshall, M., Bond, G.R. and Huxley, P., 2001. Helping people with severe mental illness to obtain work: systematic review. BMJ, 322(7280), p.204.

Currie, Janet & Thomas, Duncan. (1998). Does Head Start Make a Difference?. The American Economic Review. 85. 10.3386/w4406.

Dahl, G.B. and Lochner, L., 2012. The impact of family income on child achievement: Evidence from the earned income tax credit. American Economic Review, 102(5), pp.1927–1956.

Daro, D. and Dodge, K.A., 2009. Creating community responsibility for child protection: Possibilities and challenges. The Future of Children, 19(2), pp.67–93.

Daykin, N. et al. (2020) 'The role of social capital in participatory arts for wellbeing: findings from a qualitative systematic review', Arts & Health, 13(2), pp. 134–157. doi: 10.1080/17533015.2020.1802605.

de Souza, E.M. and Grundy, E., 2007. Intergenerational interaction, social capital and health: Results from a randomised controlled trial in Brazil. Social Science & Medicine, 65(7), pp.1397–1409.

Dodge, K.A., Berlin, L.J., Epstein, M., Spitz-Roth, A., O'Donnell, K., Kaufman, M., Amaya-Jackson, L., Rosch, J. and Christopoulos, C., 2004. The Durham Family Initiative: A preventive system of care. Child Welfare, 83(2), pp.109–128.

Dwyer, P., Scullion, L., Jones, K., McNeill, J. and Stewart, A.B., 2020. Work, welfare, and wellbeing: The impacts of welfare conditionality on people with mental health impairments in the UK. Social Policy & Administration, 54(2), pp.311–326.

Dzúrová, D., Winkler, P. and Drbohlav, D., 2014. Immigrants' access to health insurance: no equality without awareness. International Journal of Environmental Research and Public Health, 11(7), pp.7144–7153.

Ecorys and IDEA, 2014. Food taxes and their impact on competitiveness in the agri-food sector. Rotterdam: DG Enterprise and Industry.

Egan, M., Bambra, C., Thomas, S., Petticrew, M., Whitehead, M. and Thomson, H., 2007. The psychosocial and health effects of workplace reorganisation. 1. A systematic review of organisational-level interventions that aim to increase employee control. Journal of Epidemiology & Community Health, 61(11), pp.945–954.

Egan, M., Kearns, A., Mason, P., Tannahill, C., Bond, L., Coyle, J., Beck, S. et al., 2010. Protocol for a mixed methods study investigating the impact of investment in housing, regeneration and neighbourhood renewal on the health and wellbeing of residents: the GoWell programme. BMC Medical Research Methodology, 10(1), p.41.

Egan, M., Lawson, L., Kearns, A., Conway, E. and Neary, J., 2015. Neighbourhood demolition, relocation and health: A qualitative longitudinal study of housing-led urban regeneration in Glasgow, UK. Health & Place, 33, pp.101–108.

Egan, M., Petticrew, M., Ogilvie, D. and Hamilton, V., 2003. New roads and human health: a systematic review. American Journal of Public Health, 93(9), pp.1463–1471.

Epstein, L.H., Finkelstein, E., Raynor, H., Nederkoorn, C., Fletcher, K.D., Jankowiak, N. and Paluch, R.A., 2015. Experimental analysis of the effect of taxes and subsidies on calories purchased in an online supermarket. Appetite, 95, pp.245–251.

Etherington, D. and Ingold, J., 2012. Welfare to work and the inclusive labour market: a comparative study of activation policies for disability and long-term sickness benefit claimants in the UK and Denmark. Journal of European Social Policy, 22(1), pp.30–44.

Etilé, F. and Sharma, A., 2015. Do high consumers of sugar-sweetened beverages respond differently to price changes? A finite mixture IV-Tobit approach. Health Economics, 24(9), pp.1147–1163.

Fichtenberg, C.M. and Glantz, S.A., 2002. Effect of smoke-free workplaces on smoking behaviour: systematic review. BMJ, 325(7357), p.188.

Fletcher, J.M., Frisvold, D. and Tefft, N., 2010. Can soft drink taxes reduce population weight? Contemporary Economic Policy, 28(1), pp.23–35.

Ford, C.N., Ng, S.W. and Popkin, B.M., 2015. Targeted beverage taxes influence food and beverage purchases among households with preschool children. The Journal of Nutrition, 145(8), pp.1835–1843.

Fried, L.P., Carlson, M.C., Freedman, M., Frick, K.D., Glass, T.A., Hill, J. et al., 2004. A social model for health promotion for an aging population: initial evidence on the Experience Corps model. Journal of Urban Health, 81(1), pp.64–78.

Frisvold, D.E. and Lumeng, J.C., 2011. Expanding exposure: Can increasing the daily duration of Head Start reduce childhood obesity? Journal of Human Resources, 46(2), pp.373–402.

Garces, E., Thomas, D. and Currie, J., 2002. Longer-term effects of Head Start. American Economic Review, 92(4), pp.999–1012.

Gelber, A. and Isen, A., 2013. Children's schooling and parents' behavior: Evidence from the Head Start Impact Study. Journal of Public Economics, 101, pp.25–38.

Gelormino, E., Melis, G., Marietta, C. and Costa, G., 2015. From built environment to health inequalities: An explanatory framework based on evidence. Preventive Medicine Reports, 2, pp.737–745.

Gormley, W.T. and Gayer, T., 2005. Promoting school readiness in Oklahoma: An evaluation of Tulsa's pre-k program. Journal of Human Resources, 40(3), pp.533–558.

Greasley, P. and Small, N., 2005. Establishing a welfare advice service in family practices: views of advice workers and primary care staff. Family Practice, 22(5), pp.513–519.

Greene, G., Fone, D., Farewell, D., Rodgers, S., Paranjothy, S., Carter, B. and White, J., 2020. Improving mental health through neighbourhood regeneration: the role of cohesion, belonging, quality and disorder. European Journal of Public Health, 30(5), pp.964–966.

Gunn, V., Matilla-Santander, N., Kreshpaj, B., et al., 2025. A systematic review of evaluated labor market initiatives addressing precarious employment: Findings and public health implications. International Journal of Social Determinants of Health and Health Services, 55(3), pp.268–288. https://doi.org/10.1177/27551938241310120

Gustavsen, G.W. and Rickertsen, K., 2013. Adjusting VAT rates to promote healthier diets in Norway: A censored quantile regression approach. Food Policy, 42, pp.88–95.

Hampshire, K.R. and Matthijsse, M., 2010. Can arts projects improve young people's wellbeing? A social capital approach. Social Science & Medicine, 71(4), pp.708–716.

Hanbury, H. et al. (2023) 'Working less for more? A systematic review of the social, economic, and ecological effects of working time reduction policies in the global North', Sustainability: Science, Practice and Policy, 19(1). doi: 10.1080/15487733.2023.2222595.

Harding, K., Galano, J., Martin, J., Huntington, L. and Schellenbach, C.J., 2007. Healthy Families America effectiveness: a comprehensive review of outcomes. Journal of Prevention & Intervention in the Community, 34(1–2), pp.149–179.

Härkänen, T., Kotakorpi, K., Pietinen, P., Pirttilä, J., Reinivuo, H. and Suoniemi, I., 2014. The welfare effects of health-based food tax policy. Food Policy, 49(Part 1), pp.196–206. https://doi.org/10.1016/j.foodpol.2014.07.001

Hawe, P., 2015. Lessons from complex interventions to improve health. Annual Review of Public Health, 36(1), pp.307–323.

Hellowell, M., Smith, K.E. and Wright, A., 2016. Hard to avoid but difficult to sustain: Scotland's innovative health tax on large retailers selling tobacco and alcohol. The Milbank Quarterly, 94(4), pp.800–831. https://doi.org/10.1111/1468-0009.12200

Heshmati, A., Honkaniemi, H. and Juárez, S.P., 2023. The effect of parental leave on parents' mental health: a systematic review. The Lancet Public Health, 8(1), pp.e57–e75.

HM Treasury, 2025. *Spending Review 2025*. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/spending-review-2025-document/spending-review-2025-html

Howden-Chapman, P., Matheson, A., Crane, J., Viggers, H., Cunningham, M., Blakely, T., Cunningham, C. et al., 2007. Effect of insulating existing houses on health inequality: cluster randomised study in the community. BMJ, 334(7591), p.460.

Hoynes, H., Miller, D. and Simon, D., 2015. Income, the earned income tax credit, and infant health. American Economic Journal: Economic Policy, 7(1), pp.172–211.

Hsueh, J., Alderson, D.P., Lundquist, E., Michalopoulos, C., Gubits, D., Fein, D. and Knox, V., 2012. The Supporting Healthy Marriage Evaluation: Early impacts on low-income families. OPRE Report 2012-11.

Huang, R. and Yang, M., 2015. Paid maternity leave and breastfeeding practice before and after California's implementation of the nation's first paid family leave program. Economics & Human Biology, 16, pp.45–59.

Ige-Elegbede, J., Pilkington, P., Orme, J., Williams, B., Prestwood, E., Black, D. and Carmichael, L., 2022. Designing healthier neighbourhoods: a systematic review of the impact of the neighbourhood design on health and wellbeing. Cities & Health, 6(5), pp.1004–1019.

Ikram, U.Z., Malmusi, D., Juel, K., Rey, G. and Kunst, A.E., 2014. Integration policies and mortality differences among Turkish and Moroccan migrants in three European countries: a test-of-concept study. European Journal of Public Health, 24(suppl_2), p.cku162-013.

Ikram, U.Z., Malmusi, D., Juel, K., Rey, G. and Kunst, A.E., 2015. Association between integration policies and immigrants' mortality: an explorative study across three European countries. PLoS ONE, 10(6), p.e0129916.

Julià, M., Belvis, F., Vives, A., Tarafa, G. and Benach, J., 2019. Informal employees in the European Union: working conditions, employment precariousness and health. Journal of Public Health, 41(2), pp.e141–e151.

Kearns, A. and Whitley, E., 2020. Are housing and neighbourhood empowerment beneficial for mental health and wellbeing? Evidence from disadvantaged communities experiencing regeneration. SSM - Population Health, 12, p.100645.

Kearns, A., Ghosh, S., Mason, P. and Egan, M., 2020. Urban regeneration and mental health: Investigating the effects of an area-based intervention using a modified intention to treat analysis with alternative outcome measures. Health & Place, 61, p.102262.

Khan, M.S., 2020. Paid family leave and children health outcomes in OECD countries. Children and Youth Services Review, 116, p.105259.

Kim, D. and Kawachi, I., 2006. Food taxation and pricing strategies to "thin out" the obesity epidemic. American Journal of Preventive Medicine, 30(5), pp.430–437.

Kling, J.R., Liebman, J.B. and Katz, L.F., 2007. Experimental analysis of neighborhood effects. Econometrica, 75(1), pp.83–119.

Knox, V., Cowan, P.A., Cowan, C.P. and Bildner, E., 2011. Policies that strengthen fatherhood and family relationships: What do we know and what do we need to know? The Annals of the American Academy of Political and Social Science, 635(1), pp.216–239.

Kramer, D., Lakerveld, J., Stronks, K. and Kunst, A.E., 2017. Uncovering how urban regeneration programs may stimulate leisure-time walking among adults in deprived areas: a realist review. International Journal of Health Services, 47(4), pp.703–724.

Kramer, D., Maas, J., Wingen, M. and Kunst, A.E., 2013. Neighbourhood safety and leisure-time physical activity among Dutch adults: a multilevel perspective. International Journal of Behavioral Nutrition and Physical Activity, 10(1), p.11.

Lake, A.A., 2018. Neighbourhood food environments: food choice, foodscapes and planning for health. Proceedings of the Nutrition Society, 77(3), pp.239–246.

Lee, C., Kuhn, I., McGrath, M., Remes, O., Cowan, A., Duncan, F., Baskin, C. et al., 2022. A systematic scoping review of community-based interventions for the prevention of mental ill-health and the promotion of mental health in older adults in the UK. Health & Social Care in the Community, 30(1), pp.27–57.

Leventhal, T. and Brooks-Gunn, J., 2003. Moving to opportunity: an experimental study of neighborhood effects on mental health. American Journal of Public Health, 93(9), pp.1576–1582.

Liu, Q. and Skans, O.N., 2009. The duration of paid parental leave and children's scholastic performance. Working Paper No. 2009:14, IFAU-Institute for Evaluation of Labour Market and Education Policy.

Ludwig, J. and Miller, D.L., 2007. Does Head Start improve children's life chances? Evidence from a regression discontinuity design. The Quarterly Journal of Economics, 122(1), pp.159–208.

Lundahl, B.W., Nimer, J. and Parsons, B., 2006. Preventing child abuse: A meta-analysis of parent training programs. Research on Social Work Practice, 16(3), pp.251–262.

Macintyre, A.K., Shipton, D., Sarica, S., Scobie, G., Craig, N. and McCartney, G., 2024. Assessing the effects of population-level political, economic and social exposures, interventions and policies on inclusive economy outcomes for health equity in high-income countries: A systematic review of reviews. Systematic Reviews, 13(1), p.58.

Mackintosh, J., White, M., Howel, D., Chadwick, T., Moffatt, S., Deverill, M. and Sandell, A., 2006. Randomised controlled trial of welfare rights advice accessed via primary health care: pilot study [ISRCTN61522618]. BMC Public Health, 6(1), p.162.

MacMillan, F., George, E.S., Feng, X., Merom, D., Bennie, A., Cook, A., Sanders, T. et al., 2018. Do natural experiments of changes in neighborhood built environment impact physical activity and diet? A systematic review. International Journal of Environmental Research and Public Health, 15(2), p.217.

Malmusi, D., 2015. Immigrants' health and health inequality by type of integration policies in European countries. The European Journal of Public Health, 25(2), pp.293–299.

Malmusi, D., Drbohlav, D., Dzúrová, D., Palència, L. and Borrell, C., 2014. Inequalities in healthcare access by type of visa in a context of restrictive health insurance policy: the case of Ukrainians in Czechia. International Journal of Public Health, 59(5), pp.715–719.

Malmusi, D., Palència, L., Ikram, U.Z., Kunst, A.E. and Borrell, C., 2017. Inequalities by immigrant status in depressive symptoms in Europe: the role of integration policy regimes. Social Psychiatry and Psychiatric Epidemiology, 52(4), pp.391–398.

McCarrier, K.P., Zimmerman, F.J., Ralston, J.D. and Martin, D.P., 2011. Associations between minimum wage policy and access to health care: Evidence from the Behavioral Risk Factor Surveillance System, 1996–2007. American Journal of Public Health, 101(2), pp.359–367.

McCartney, G., Hearty, W., Taulbut, M., Mitchell, R., Dryden, R. and Collins, C., 2017. Regeneration and health: a structured, rapid literature review. Public Health, 148, pp.69–87.

McClure, R.J., Turner, C., Peel, N., Spinks, A., Eakin, E. and Hughes, K., 2005. Population-based interventions for the prevention of fall-related injuries in older people. Cochrane Database of Systematic Reviews, (1).

McCormick, M.C., Brooks-Gunn, J., Buka, S.L., Goldman, J., Yu, J., Salganik, M., Scott, D.T. et al., 2006. Early intervention in low birth weight premature infants: results at 18 years of age for the Infant Health and Development Program. Pediatrics, 117(3), pp.771–780.

McCroskey, J., Pecora, P., Franke, T., Christie, C. and Lorthridge, J., 2012. Can public child welfare help to prevent child maltreatment? Promising findings from Los Angeles. Journal of Family Strengths, 12(1), p.5.

McGowan, V.J., Buckner, S., Mead, R., McGill, E., Ronzi, S., Beyer, F. and Bambra, C., 2021. Examining the effectiveness of place-based interventions to improve public health and reduce health inequalities: an umbrella review. BMC Public Health, 21, p.1888. https://doi.org/10.1186/s12889-021-11852-z

McGrath, M., Duncan, F., Dotsikas, K., Baskin, C., Crosby, L., Gnani, S., Hunter, R.M. et al., 2021. Effectiveness of community interventions for protecting and promoting the mental health of working-age adults experiencing financial uncertainty: a systematic review. Journal of Epidemiology & Community Health, 75(7), pp.665–673.

McLanahan, S., Garfinkel, I., Mincy, R., Donahue, E., Garret, R. and Paxson, C., 2010. Strengthening fragile families. The Future of Children, 20(2), pp.1–8. [online] Available at: http://www.jstor.org/stable/20773702 [Accessed 4 Aug. 2025].

Mehdipanah, R., Malmusi, D., Muntaner, C. and Borrell, C., 2013. An evaluation of an urban renewal program and its effects on neighborhood resident's overall wellbeing using concept mapping. Health & Place, 23, pp.9–17.

Mehdipanah, R., Manzano, A., Borrell, C., Malmusi, D., Rodriguez-Sanz, M., Greenhalgh, J., Muntaner, C. and Pawson, R., 2015. Exploring complex causal pathways between urban renewal, health and health inequality using a theory-driven realist approach. Social Science & Medicine, 124, pp.266–274.

Mehdipanah, R., Rodríguez-Sanz, M., Malmusi, D., Muntaner, C., Díez, E., Bartoll, X. and Borrell, C., 2014. The effects of an urban renewal project on health and health inequalities: a quasi-experimental study in Barcelona. Journal of Epidemiology & Community Health, 68(9), pp.811–817.

Melis, G., Gelormino, E., Marra, G., Ferracin, E. and Costa, G., 2015. The effects of the urban built environment on mental health: A cohort study in a large northern Italian city. International Journal of Environmental Research and Public Health, 12(11), pp.14898–14915.

Meltzer, D.O. and Chen, Z., 2011. The impact of minimum wage rates on body weight in the United States. In: M. Grossman and N. Mocan, eds., Economic Aspects of Obesity. Chicago: University of Chicago Press, pp.17–34.

Miao, Z., Beghin, J.C. and Jensen, H.H., 2012. Taxing sweets: sweetener input tax or final consumption tax? Contemporary Economic Policy, 30(3), pp.344–361.

Ministry of Housing, Communities and Local Government, 2024. English Devolution White Paper: Power and partnership—Foundations for growth. London: Ministry of Housing, Communities and Local Government. Available at: https://www.gov.uk/government/publications/english-devolution-white-paper-power-and-partnership-foundations-for-growth/english-devolution-white-paper.

Mohan, G., Longo, A. and Kee, F., 2017. Evaluation of the health impact of an urban regeneration policy: Neighbourhood Renewal in Northern Ireland. Journal of Epidemiology & Community Health, 71(9), pp.919–927. https://doi.org/10.1136/jech-2017-209087

Moore, T.H.M., Kesten, J.M., López-López, J.A., Ijaz, S., McAleenan, A., Richards, A., Gray, S., Savović, J. and Audrey, S., 2018. The effects of changes to the built environment on the mental health and well-being of adults: Systematic review. Health & Place, 53, pp.237–257.

Moya, A.R.Z. and Yáñez, C.J.N., 2017. Impact of area regeneration policies: performing integral interventions, changing opportunity structures and reducing health inequalities. Journal of Epidemiology & Community Health, 71(3), pp.239–247.

Mytton, O.T., Clarke, D. and Rayner, M., 2012. Taxing unhealthy food and drinks to improve health. BMJ, 344.

Nepomnyaschy, L., Magnuson, K.A. and Berger, L.M., 2012. Child support and young children’s development. Social Service Review, 86(1), pp.3–35.

Ni Mhurchu, C., Eyles, H., Genc, M., Scarborough, P., Rayner, M., Mizdrak, A., Nnoaham, K. and Blakely, T., 2015. Effects of health-related food taxes and subsidies on mortality from diet-related disease in New Zealand: an econometric-epidemiologic modelling study. PLoS ONE, 10(7), p.e0128477.

Nickel, S. and von dem Knesebeck, O., 2020. Do multiple community-based interventions on health promotion tackle health inequalities? International Journal for Equity in Health, 19(1), p.157.

Niederdeppe, J., Kuang, X., Crock, B. and Skelton, A., 2008. Media campaigns to promote smoking cessation among socioeconomically disadvantaged populations: what do we know, what do we need to learn, and what should we do now? Social Science & Medicine, 67(9), pp.1343–1355.

Novoa, A.M., Amat, J., Malmusi, D., Díaz, F., Darnell, M., Trilla, C., Bosch, J. and Borrell, C., 2017. Changes in health following housing improvement in a vulnerable population in Spain: A follow-up study. International Journal of Health Services, 47(1), pp.83–107.

O'Campo, P., Molnar, A., Ng, E., Renahy, E., Mitchell, C., Shankardass, K., St John, A., Bambra, C. and Muntaner, C., 2015. Social welfare matters: a realist review of when, how, and why unemployment insurance impacts poverty and health. Social Science & Medicine, 132, pp.88–94.

Office for Budget Responsibility, 2024. Fiscal risks and sustainability—September 2024. London: Office for Budget Responsibility. Available at: https://obr.uk/frs/fiscal-risks-and-sustainability-september-2024/.

Office for Budget Responsibility, 2024. Public debt projected to exceed 270 per cent of GDP by the mid 2070s. London: Office for Budget Responsibility. Available at: https://obr.uk/public-debt-projected-to-exceed-270-per-cent-of-gdp-by-the-mid-2070s/.

Office for National Statistics (ONS), 2023. Rising ill-health and economic inactivity because of long-term sickness, UK: 2019 to 2023. [online] Office for National Statistics. Available at: https://www.ons.gov.uk/releases/risingillhealthandeconomicinactivitybecauseoflongtermsicknessuk2019to2023

Ogilvie, D., Egan, M., Hamilton, V. and Petticrew, M., 2004. Promoting walking and cycling as an alternative to using cars: systematic review. BMJ, 329(7469), p.763.

Olds, D.L., 2006. The nurse–family partnership: An evidence-based preventive intervention. Infant Mental Health Journal, 27(1), pp.5–25.

Ottesen, L., Jeppesen, R.S. and Krustrup, B.R., 2010. The development of social capital through football and running: studying an intervention program for inactive women. Scandinavian Journal of Medicine & Science in Sports, 20, pp.118–131.

Palència, L., Malmusi, D., De Moortel, D., Artazcoz, L., Backhans, M., Vanroelen, C. and Borrell, C., 2014. The influence of gender equality policies on gender inequalities in health in Europe. Social Science & Medicine, 117, pp.25–33.

Peralta, A., Camprubí, L., Rodríguez-Sanz, M., Basagaña, X., Borrell, C. and Marí-Dell'Olmo, M., 2017. Impact of energy efficiency interventions in public housing buildings on cold-related mortality: a case-crossover analysis. International Journal of Epidemiology, 46(4), pp.1192–1201.

Phillips, G., Bottomley, C., Schmidt, E., Tobi, P., Lais, S., Yu, G., Lynch, R. et al., 2014. Well London Phase-1: results among adults of a cluster-randomised trial of a community engagement approach to improving health behaviours and mental well-being in deprived inner-city neighbourhoods. Journal of Epidemiology & Community Health, 68(7), pp.606–614.

Pilkington, P. and Kinra, S., 2005. Effectiveness of speed cameras in preventing road traffic collisions and related casualties: systematic review. BMJ, 330(7487), p.331.

Pollack, R., Olsen, J.R., Heppenstall, A., Hoehn, A., Boyd, J., Ponce Hardy, V., Littlejohn, J. et al., 2024. How could 20-minute neighbourhoods impact health and health inequalities? A policy scoping review. BMC Public Health, 24(1), p.3426.

Pons-Vigués, M., Diez, È., Morrison, J., Salas-Nicás, S., Hoffmann, R., Burström, B., Van Dijk, J.P. and Borrell, C., 2014. Social and health policies or interventions to tackle health inequalities in European cities: a scoping review. BMC Public Health, 14(1), p.198.

Powell, L.M., Chriqui, J. and Chaloupka, F.J., 2009. Associations between state-level soda taxes and adolescent body mass index. Journal of Adolescent Health, 45(3), pp.S57–S63.

Puig-Barrachina, V., Giró, P., Artazcoz, L., Bartoll, X., Cortés-Franch, I., Fernández, A., González-Marín, P. and Borrell, C., 2020. The impact of active labour market policies on health outcomes: a scoping review. European Journal of Public Health, 30(1), pp.36–42.

Puma, M., Bell, S., Cook, R., Heid, C., Shapiro, G., Broene, P., Jenkins, F. et al., 2010. Head Start Impact Study. Final Report. Administration for Children & Families.

Rebok, G.W., Carlson, M.C., Glass, T.A., McGill, S., Hill, J., Wasik, B., Ialongo, N., Frick, K.D., Fried, L.P. and Rasmussen, M.D., 2004. Short-term impact of Experience Corps® participation on children and schools: Results from a pilot randomized trial. Journal of Urban Health, 81(1), pp.79–93.

Riccio, J., Dechausay, N., Miller, C., Nuñez, S., Verma, N. and Yang, E., 2013. Conditional Cash Transfers in New York City: The Continuing Story of the Opportunity NYC–Family Rewards Demonstration. MDRC.

Riccio, J.A., Dechausay, N., Greenberg, D.M., Miller, C., Rucks, Z. and Verma, N., 2010. Toward reduced poverty across generations: Early findings from New York City's conditional cash transfer program. MDRC, March.

Robertson, L.B., Ward Thompson, C., Aspinall, P., Millington, C., McAdam, C. and Mutrie, N., 2012. The influence of the local neighbourhood environment on walking levels during the Walking for Wellbeing in the West pedometer-based community intervention. Journal of Environmental and Public Health, 2012(1), p.974786.

Rosenheck, R., Kasprow, W., Frisman, L. and Liu-Mares, W., 2003. Cost-effectiveness of supported housing for homeless persons with mental illness. Archives of General Psychiatry, 60(9), pp.940–951.

Rossin, M., 2011. The effects of maternity leave on children's birth and infant health outcomes in the United States. Journal of Health Economics, 30(2), pp.221–239.

Rossin-Slater, M., Ruhm, C.J. and Waldfogel, J., 2013. The effects of California's paid family leave program on mothers' leave-taking and subsequent labor market outcomes. Journal of Policy Analysis and Management, 32(2), pp.224–245.

Ruhm, C.J., 2000. Parental leave and child health. Journal of Health Economics, 19(6), pp.931–960.

Sadowski, L.S., Kee, R.A., VanderWeele, T.J. and Buchanan, D., 2009. Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial. JAMA, 301(17), pp.1771–1778.

Sage, D., 2015. Do active labour market policies promote the well-being, health and social capital of the unemployed? Evidence from the UK. Social Indicators Research, 124(2), pp.319–337.

Sahnoun, M. and Abdennadher, C., 2020. Do active labor market policies increase the subjective well-being of the unemployed? Evidence from OECD countries. Ekonomický časopis, 69(5), pp.447–471.

Sanbonmatsu, L., Katz, L.F., Ludwig, J., Gennetian, L.A., Duncan, G.J., Kessler, R.C., Adam, E.K., McDade, T. and Lindau, S.T., 2011. Moving to Opportunity for Fair Housing Demonstration Program: Final Impacts Evaluation. U.S. Department of Housing and Urban Development.

Sanders, M.R., 2008. Triple P-Positive Parenting Program as a public health approach to strengthening parenting. Journal of Family Psychology, 22(4), pp.506–517.

Smed, S., Jensen, J.D. and Denver, S., 2007. Socio-economic characteristics and the effect of taxation as a health policy instrument. Food Policy, 32(5–6), pp.624–639.

Smed, S., Scarborough, P., Rayner, M. and Jensen, J.D., 2016. The effects of the Danish saturated fat tax on food and nutrient intake and modelled health outcomes: an econometric and comparative risk assessment evaluation. European Journal of Clinical Nutrition, 70(6), pp.681–686.

Smith, M., Hosking, J., Woodward, A., Witten, K., MacMillan, A., Field, A., Baas, P. and Mackie, H., 2017. Systematic literature review of built environment effects on physical activity and active transport – an update and new findings on health equity. International Journal of Behavioral Nutrition and Physical Activity, 14(1), p.158.

Song, H., Zhang, A., Barr, B. and Wickham, S., 2024. Effect of Universal Credit on young children's mental health: quasi-experimental evidence from Understanding Society. Journal of Epidemiology & Community Health, 78(12), pp.764–771.

Stead, M., Gordon, R., Angus, K. and McDermott, L., 2007. A systematic review of social marketing effectiveness. Health Education, 107(2), pp.126–191.

Steffens, N.K., LaRue, C.J., Haslam, C., Walter, Z.C., Cruwys, T., Munt, K.A., Haslam, S.A., Jetten, J. and Tarrant, M., 2021. Social identification-building interventions to improve health: A systematic review and meta-analysis. Health Psychology Review, 15(1), pp.85–112.

Strully, K.W., Rehkopf, D.H. and Xuan, Z., 2010. Effects of prenatal poverty on infant health: state earned income tax credits and birth weight. American Sociological Review, 75(4), pp.534–562.

Stuckler, D., Basu, S., Suhrcke, M., Coutts, A. and McKee, M., 2009. The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis. The Lancet, 374(9686), pp.315–323.

Sturm, R., Powell, L.M., Chriqui, J.F. and Chaloupka, F.J., 2010. Soda taxes, soft drink consumption, and children's body mass index. Health Affairs, 29(5), pp.1052–1058.

Tanaka, S., 2005. Parental leave and child health across OECD countries. The Economic Journal, 115(501), pp.F7–F28.

Thomas, R., Evans, S., Huxley, P., Gately, C. and Rogers, A., 2005. Housing improvement and self-reported mental distress among council estate residents. Social Science & Medicine, 60(12), pp.2773–2783.

Thomson, H., Atkinson, R., Petticrew, M. and Kearns, A., 2006. Do urban regeneration programmes improve public health and reduce health inequalities? A synthesis of the evidence from UK policy and practice (1980–2004). Journal of Epidemiology & Community Health, 60(2), pp.108–115.

Thomson, H., Petticrew, M. and Morrison, D., 2001. Health effects of housing improvement: systematic review of intervention studies. BMJ, 323(7306), p.187.

Tübbicke, S. and Schiele, M., 2024. On the effects of active labour market policies among individuals reporting to have severe mental health problems. Social Policy & Administration, 58(3), pp.404–422.

Wagenaar, A.C., Tobler, A.L. and Komro, K.A., 2010. Effects of alcohol tax and price policies on morbidity and mortality: a systematic review. American Journal of Public Health, 100(11), pp.2270–2278.

Walthery, P., Stafford, M., Nazroo, J., Whitehead, M., Dibben, C., Halliday, E., Povall, S. and Popay, J., 2015. Health trajectories in regeneration areas in England: the impact of the New Deal for Communities intervention. Journal of Epidemiology & Community Health, 69(8), pp.762–768.

Wang, R., Browning, M.H., Kee, F. and Hunter, R.F., 2023. Exploring mechanistic pathways linking urban green and blue space to mental wellbeing before and after urban regeneration of a greenway: Evidence from the Connswater Community Greenway, Belfast, UK. Landscape and Urban Planning, 235, p.104739.

Wang, Y.C., Coxson, P., Shen, Y.M., Goldman, L. and Bibbins-Domingo, K., 2012. A penny-per-ounce tax on sugar-sweetened beverages would cut health and cost burdens of diabetes. Health Affairs, 31(1), pp.199–207.

Ward Thompson, C., de Oliveira, E.S., Tilley, S., Elizalde, A., Botha, W., Briggs, A., Cummins, S. et al., 2019. Health impacts of environmental and social interventions designed to increase deprived communities' access to urban woodlands: A mixed-methods study. Public Health Research, 7(2), pp.1–172.

Webster-Stratton, C. and Taylor, T., 2001. Nipping early risk factors in the bud: Preventing substance abuse, delinquency, and violence in adolescence through interventions targeted at young children (0–8 years). Prevention Science, 2(3), pp.165–192.

White, J., Greene, G., Farewell, D., Dunstan, F., Rodgers, S., Lyons, R.A., Humphreys, I. et al., 2017. Improving mental health through the regeneration of deprived neighborhoods: a natural experiment. American Journal of Epidemiology, 186(4), pp.473–480.

Whitley, R. and Prince, M., 2005. Fear of crime, mobility and mental health in inner-city London, UK. Social Science & Medicine, 61(8), pp.1678–1688.

Wickham, S., Bentley, L., Rose, T., Whitehead, M., Taylor-Robinson, D. and Barr, B., 2020. Effects on mental health of a UK welfare reform, Universal Credit: a longitudinal controlled study. The Lancet Public Health, 5(3), pp.e157–e164.

Wilkinson, R. and Marmot, M., 2003. Social determinants of health: The solid facts. 2nd ed. Copenhagen: World Health Organization Regional Office for Europe. Available at: https://iris.who.int/bitstream/handle/10665/326568/9789289013710_eng.pdf.

Wolitski, R.J., Kidder, D.P., Pals, S.L., Royal, S., Aidala, A., Stall, R., Holtgrave, D.R., Harre, D., Courtenay-Quirk, C. and Housing and Health Study Team, 2010. Randomized trial of the effects of housing assistance on the health and risk behaviors of homeless and unstably housed people living with HIV. AIDS and Behavior, 14(3), pp.493–503.

Wood, R.G., Moore, Q., Clarkwest, A. and Killewald, A., 2014. The long-term effects of Building Strong Families: A program for unmarried parents. Journal of Marriage and Family, 76(2), pp.446–463.

Wood, R.G., Moore, Q., Clarkwest, A., Killewald, A. and Monahan, S., 2012. The long-term effects of Building Strong Families: A relationship skills education program for unmarried parents. Mathematica Policy Research.

Wrigley, N., Warm, D. and Margetts, B., 2003. Deprivation, diet, and food-retail access: Findings from the Leeds 'food deserts' study. Environment and Planning A, 35(1), pp.151–188.

Appendix: PRISMA 2020 flow diagram

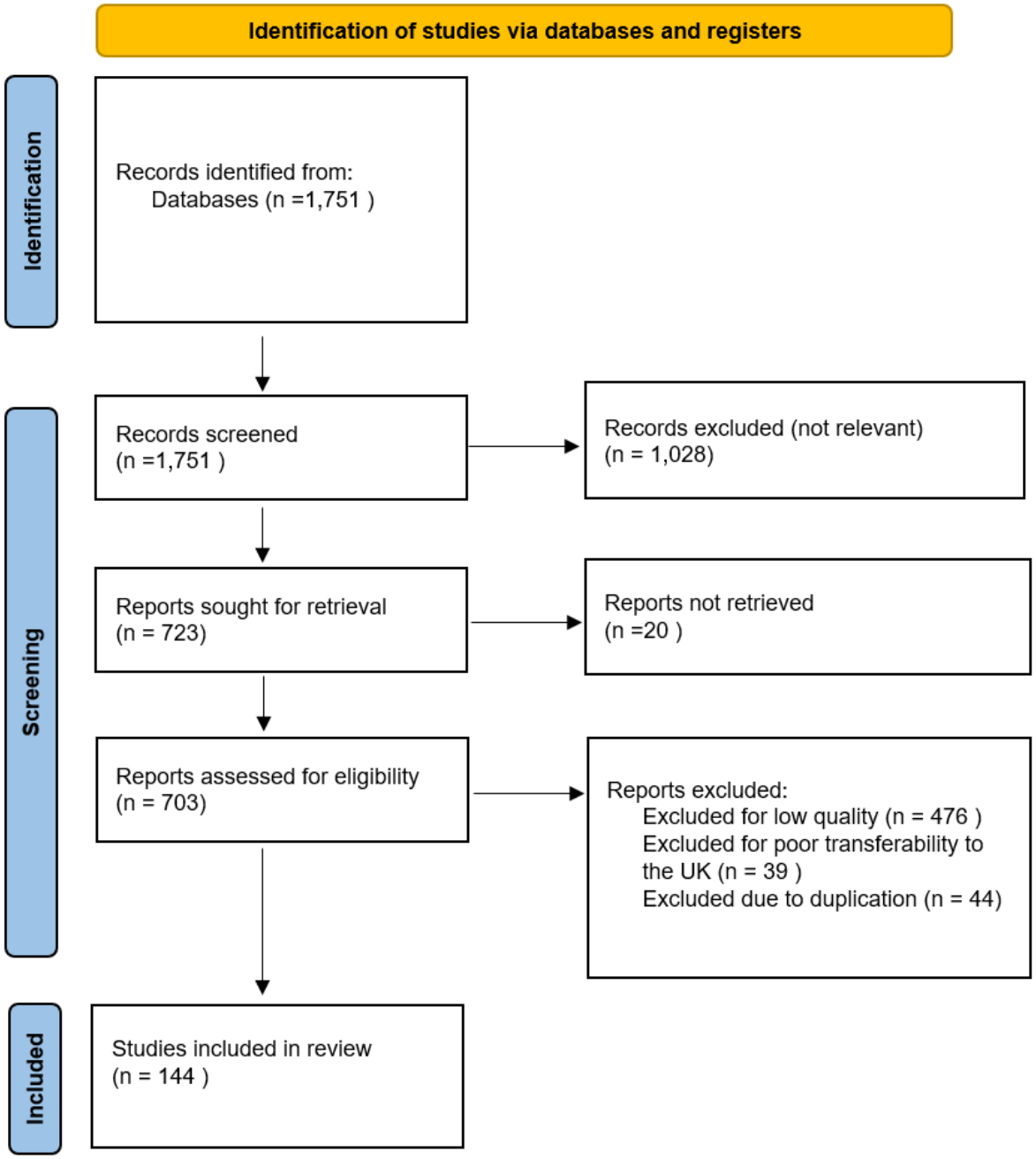

Figure 7. *PRISMA 2020 flow diagram for new systematic reviews*

Source: Page MJ, et al. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

Glossary

Term	Definition

Active Labour Market Programmes (ALMPs)	Government interventions aimed at improving employability and reducing unemployment, such as job search assistance, vocational training, wage subsidies, and employment services.
Causal Mechanism	The process through which a policy leads to changes in outcomes. Mechanisms may be material (e.g. income), behavioural (e.g. diet), psychosocial (e.g. stress), or environmental.
Community policy	Policies that help promote and improve social capital and community cohesion
Conditionality	Rules that require recipients of welfare benefits or public support to meet certain conditions, such as job searching or attending appointments.
Contribution Analysis	An evaluation method that assesses the contribution of a policy or programme to observed outcomes, especially where multiple influencing factors exist.
Co-Production	A model of policy or service design in which professionals and service users collaborate to shape, deliver, and evaluate interventions.
Cost-Effectiveness Analysis (CEA)	A method for comparing the costs and health outcomes of interventions to determine which provides better value for money.
Deprivation	A multidimensional concept referring to a lack of material resources, social opportunities, or access to services.
Devolution	The transfer of decision-making powers and resources from central government to regional, local, or city-level authorities.
Downstream Intervention	An approach that targets individual behaviour change or treatment (e.g. smoking cessation campaigns), rather than addressing underlying structural factors.
Earned Income Tax Credit (EITC)	A refundable tax credit (primarily in the US) that supplements income for low-wage workers.
Economic Development	The process of improving economic wellbeing and quality of life through job creation, income growth, infrastructure investment, and enhanced productivity.
Economic Development Policy	Strategic public action to enhance a region's economic capacity through investment, innovation, infrastructure, and skills, with the aim of improving productivity, employment, and long-term wellbeing.
Economic Inactivity	When working-age individuals are not in employment and not actively seeking work—for reasons including illness, disability, education, or caregiving.
Employment Quality	The characteristics of jobs, including pay, security, autonomy, progression opportunities, and work–life balance.
Equity / Health Equity	A normative concept referring to the absence of systematic disparities in health—or in the major social determinants of health—between groups with different levels of social advantage or disadvantage. Health equity is achieved when all individuals have a fair and just opportunity to attain their highest possible standard of health, irrespective of socioeconomic status, geographic location, or other structural determinants
External Validity / Transferability	The potential for applying evidence or policy lessons from one setting to another, taking into account context-specific factors.
Fiscal Policy	The use of government taxation and spending decisions to influence economic activity, redistribute income, and shape incentives. Can include taxes on unhealthy goods or subsidies for health-promoting behaviour.

Gentrification	A process in which urban areas are regenerated in ways that attract more affluent residents, often raising property values and displacing long-term, lower-income residents.
Health in All Policies (HiAP)	A policy approach that integrates health considerations into decision-making across all sectors, not just healthcare.
Income Replacement Rate	The proportion of a worker's previous income provided by welfare benefits, such as unemployment insurance or sick pay.
Income Support	Financial assistance aimed at maintaining a minimum standard of living for individuals or households with low or no income.
Informal Employment	Work that is not regulated, taxed, or protected by formal labour laws.
Intersectionality	The way different forms of social disadvantage—such as poverty, racism, sexism, or disability—interact and compound, shaping how policies affect different groups.
Labour Market Institutions	Structures and rules governing employment relationships, such as unions, employment protection laws, and minimum wages.
Material Pathway	A causal route through which changes in material conditions (such as income, housing, food, or energy) affect health outcomes.
Minimum Wage Policy	A legal floor on hourly pay intended to prevent exploitation and raise incomes among low-paid workers.
Multi-Component Intervention	A policy or programme that combines several elements—such as housing upgrades, income support, and health services—to tackle complex social problems.
Observational Analytical Study	A study design that examines associations between exposures and outcomes without manipulating variables or assigning interventions. Common types include cohort, case-control, and cross-sectional studies. These designs can suggest potential causal links but are limited by confounding and bias.
Participatory Governance	A form of governance that gives citizens and communities a meaningful voice in policymaking.
Policy Coherence	The alignment and mutual reinforcement of policies across different government departments, sectors, or tiers of government.
Precarious Employment	Jobs with low wages, limited rights, no job security, and poor working conditions.
Price Elasticity of Demand	A measure of how much demand for a good or service changes when its price changes.
Public Value	The value created by government through the provision of services, infrastructure, and policy, including economic, social, and health outcomes.
Quasi-Experimental Design	A method used to estimate causal effects in situations where randomisation is not possible.
Randomised Controlled Trial (RCT)	An evaluation method in which participants are randomly assigned to intervention or control groups, allowing for rigorous causal inference.
Regeneration	A set of policies or investments that aim to renew physical environments and improve social and economic conditions in a defined area.
Resource Filter Effect	The phenomenon where more advantaged groups are better able to access and benefit from universal policies or services.

Return on Investment (ROI)	A measure of the financial return generated by an intervention relative to its cost.
Social Determinants of Health	The social, economic, and environmental factors that influence health outcomes, including education, income, employment, housing, and the built environment.
Social Infrastructure	Community-level assets such as libraries, parks, community centres, and civic groups that foster social connection, wellbeing, and resilience.
Socioeconomic Policy	Government interventions that shape economic and social conditions—such as income, employment, housing, and education—which influence the structural determinants of health and social inequality.
Structural Determinants of Health	The broader socioeconomic and political systems that shape access to health-promoting resources and opportunities.
Structured Evidence Review	A structured evidence review is a systematic, transparent method for identifying, selecting, and synthesising research on a specific topic. It follows predefined steps to ensure rigour and consistency, often including clear inclusion criteria, quality appraisal, and thematic analysis. While less exhaustive than a full systematic review, it aims to provide reliable, policy-relevant insights.
Systematic Review	A comprehensive and methodical synthesis of evidence across studies that meet pre-defined inclusion criteria.
Targeted Intervention	A programme or policy aimed specifically at a defined group (e.g. low-income families, unemployed adults) based on need or risk profile.
Universal Intervention	A policy or programme made available to the whole population, regardless of need or risk.
Upstream Intervention	Policies or programmes that tackle the root causes of poor health, such as income inequality, housing insecurity, or labour market exclusion.
Vertical Equity	The principle that people with greater needs or disadvantages should receive proportionally more support in order to achieve fairness.

Growth and Reform Network

Metro —— Dynamics

Future Governance Forum

The Growth and Reform Network

Operated by Centre for Progressive Policy Ltd

58 Victoria Embankment, Temple, London, EC4Y 0DS

Registered in England 10754581