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Commentary

Are place-based approaches to reducing health inequalities a highway to success or a policy dead-end?

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Place-based approaches to reducing health inequalities have become increasingly common in the UK. It is likely that this is because area deprivation indices have highlighted spatial areas, rather than social groups, for policy focus; and because local agencies have until recently at least had a greater policy focus on reducing health inequalities than national government. Place-based approaches at the neighbourhood level have been characterised by a combination of civic-level, community-centred, and service-based interventions. We identify several important factors that limit their effectiveness for reducing health inequalities, including: socioeconomic and power relationships that are unrestricted by spatial boundaries; most disadvantaged individuals not living in areas with the highest deprivation scores; a pre-existing gradient in community capacity which many community development approaches exacerbate; stigmatisation of areas with high deprivation scores; and the potential for partnership approaches to undermine genuine community-led organisation and challenge. We argue that for place-based approaches to be successful in reducing health inequalities, they must challenge economic and power relationships that exacerbate inequalities and catalyse emancipation of currently disempowered and alienated communities.

Population Health Trends and the Focus on Place-Based Responses

Health inequalities are:

> systematic, avoidable and unfair differences in health outcomes that can be observed between populations, between social groups within the same population or as a gradient across a population ranked by social position. (McCartney, Popham et al. 2019)

Since around 2012 in the UK, and in some other countries for which measures are available, inequalities in mortality have been worsening (de Haro Moro et al. 2025). Not only have absolute (gap) and relative (ratio) measures of inequality been worsening, mortality for people living in the most disadvantaged 30-

40% of areas *has actually been deteriorating* (de Haro Moro et al. 2025). The scale of the resulting additional mortality in the UK is staggering, with the impact of inequality far exceeding even the worse-case scenario estimates of deaths during the COVID-19 pandemic (McCartney, Leyland et al. 2021). It is now clear that these changed trends in mortality are largely a result of the austerity policies introduced across countries after around 2010 (Walsh & McCartney 2025).

In the face of these trends, there has been a renewed focus by the UK and Scottish Governments on local, place-based actions to reduce health inequalities which, as we discuss further below, are implemented at different spatial levels (Scottish Government 2023, Our Place 2023, PHE 2021). There may be a number of different reasons for this shift from the national to the local as settings for action to address inequalities.

First, changes in political economy after around 1980 led to the residualisation of public services and the welfare state as part of a broader neoliberal project (Schrecker & Bambra 2015). This created a dominant political and public narrative that dictates that funding universal public services, which meet the needs of all social groups in proportion to their needs, is no longer possible (Scott-Samuel et al. 2014). Instead, public services and the social security system have increasingly been understood as residual 'safety-nets' which provide minimal, and often temporary, support. Simultaneously, citizens have been encouraged to purchase their own public services, moving society from a model of public luxury and private sufficiency (e.g., through well-funded state education, council housing and healthcare) to an alternative model of private luxury and public sufficiency (Olma & O'Connor 2023). Following the financial crisis in 2007-8, this dominant political and economic outlook facilitated the imposition of austerity measures, and in particular a reduction in government spending on social security and local government, cuts which were skewed towards areas of greater disadvantage (Taylor-Robinson & Gosling 2011). This in turn created an ever-greater need to better target services, support, and interventions to areas and groups of greater need (Meade 2021). The shift in policy has also been associated with an ideological opposition to reducing inequalities in income, wealth and power, alongside increased emphasis on an individualistic framing of the causes of health inequalities, leading to a shift in responsibility for addressing health inequalities away from national government. Yet, the apparent abandonment of government concern for those impacted most by growing inequalities arguably creates a legitimation crisis, requiring at the least the appearance of interest and action (Bexell 2014, Jönsson 2014). In the UK this recently manifested as the woeful 'Levelling Up' agenda (UK Government 2022), alongside a pushing of responsibility for action to local level and place-based 'community' interventions.

Second, for those working at devolved and local levels, the increased focus on place-based actions may be seen to offer more opportunities for people and institutions to use the agency they do have to take actions that they perceive to be within their sphere of influence.

Third, the dominance of area-based statistics in describing and monitoring health inequalities foregrounds a spatial understanding of inequalities, contributing to increased interest in place-based approaches as a solution (de Haro Moro et al. 2025). This framing also encourages 'communities' to be defined by the boundaries of small area statistics, rather than by 'shared' interests, social positions such as social class and/or social and economic relationships (Scambler & Scambler 2013).

Fourth, in the UK, individual measures of socioeconomic position are not routinely linked to health and mortality outcomes, and certainly not at the scale and frequency requested by policy stakeholders, and so health inequality monitoring is undertaken using small area statistics. Arguably, this has created an overwhelming focus, and potentially a misunderstanding, that there is something about the 'place' that is causing the unequal health outcomes rather than the social position of the people that live there and the socioeconomic relationships they have with other social groups outside their neighbourhood.

Place-Based Approaches

In the period 2010-2024, the UK Government conceptualised place-based approaches to reducing health inequalities. In England this approach was labelled 'place-based planning' and comprised a combination of civic/local government-level interventions 'that aim to strengthen community action, integrate civic services and promote service *engagement* with communities' (See Table 1 for further details)[1] (PHE 2021). The implementation of Place Based Planning has involved the establishment of spatially-based partnerships between the National Health Service (NHS), Local Government and the Third (Not for Profit) sector with collective responsibility to co-ordinate services, improve health and reduce health inequalities. The primary legal entities are 42 Integrated Care Partnerships (ICPs) with responsibility for strategic planning and commissioning of services and covering populations ranging from 0.5 to 3 million people. All ICPs have established neighbourhood partnerships, covering populations of around 30-50,000, where small scale *community-centred interventions* have proliferated. As set out in policy documents, these community-centred interventions have a central role in place-based strategies to reduce health inequalities. Their focus is on *building the capacity of communities* to understand their potential and how their assets such as skills and knowledge, social networks, local groups and community organisations can provide the building blocks for good health. To support these interventions, guidance on a 'family of community centred approaches' was published in 2015 (PHE 2015) (Figure 1).

Interventions that aim to 'build' community capacity are found well beyond the public sector. In 2010, for example, the UK's national lottery spent more than £1billion on a series of large programmes focused explicitly on community building and continues to spend in this area in the pursuit of enhanced population health and wellbeing. Larger NGOs are also involved. Local Trust, for example, has recently argued for a Community Wealth Fund to be established to build the capacity of the most disadvantaged (*'left behind'*) communities by investing in their social infrastructure, in order to 'sow the seeds for the transformation of neighbourhoods' (Local Trust 2023). Another group of NGOs has produced a framework focused on 'community spirit' or '…the feelings of connection and belonging to a community and our ability to come together to improve wellbeing for everybody' (Araujo 2021 p.8). These neighbourhood level approaches are riddled with ambiguities. Whilst, for example, the dominant discourse claims they have transformative potential – a discourse believed by many of the paid workers involved and the community members engaged – the positive impacts they do have are far from transformational, and rarely reduce social or health inequities. As Craig (2014) noted some years ago, this ambiguity has been exploited by governments, using manipulative language to promise communities something which was never intended to be delivered: full participation in issues affecting their lives, and some control over the forces which shape their communities.

The health of populations is influenced and structured by a broad range of societal exposures operating through long and complicated causal pathways, including international relationships and commercial interests (Krieger 2021). However, the scale of inequalities in health tracks what have been termed the fundamental causes (Phelan et al. 2010): inequalities in power (Friel et al. 2021, McCartney, Dickie et al. 2021), including the economic power represented by income and wealth, and the extent of discrimination between social groups. Given this, what is the potential for local, place-based approaches, particularly those operating at the level of a single local authority or neighbourhood to reduce health inequalities?

[1] In the rest of the UK, similar structures were put in place to co-ordinate public services at local authority level, and in Scotland a general Place Principle was promoted for use by local agencies. However, new place-based structures at neighbourhood level were not generally introduced (although there were some exceptions).

Component	Description
Place-based planning and leadership	The generation and implementation of a strategy, including co-ordination and management of resources, data sharing, and governance.
Civic-level interventions	The wide range of powers local government has, including local by-laws, licencing decision, spatial planning, economic development and planning decisions, and as an employer.
Civic service integration (at the boundary of civic level interventions and service-based interventions)	The co-ordination of provision across different agencies at local level.
Service-based interventions	The provision of services (including education, leisure, health, social care, etc.), the quality, and the appropriate use across the population, within local areas.
Service engagement with communities (at the boundary of service-based interventions and community-centred interventions)	How trust can be built, and how communities can influence the design and delivery of services.
Community-centred interventions	How place-based and interest-based communities can be strengthened (e.g., through community development and asset-based approaches), how volunteering and peer support can be encouraged, how communities can be involved in partnerships and collaborations, and how access to community resources can be increased.
Strengthen community action (at the boundary of civic-level interventions and community-centred interventions)	The empowerment of community organisations by local state functions and organisations.

Table 1: Components of place-based planning (PHE 2021)

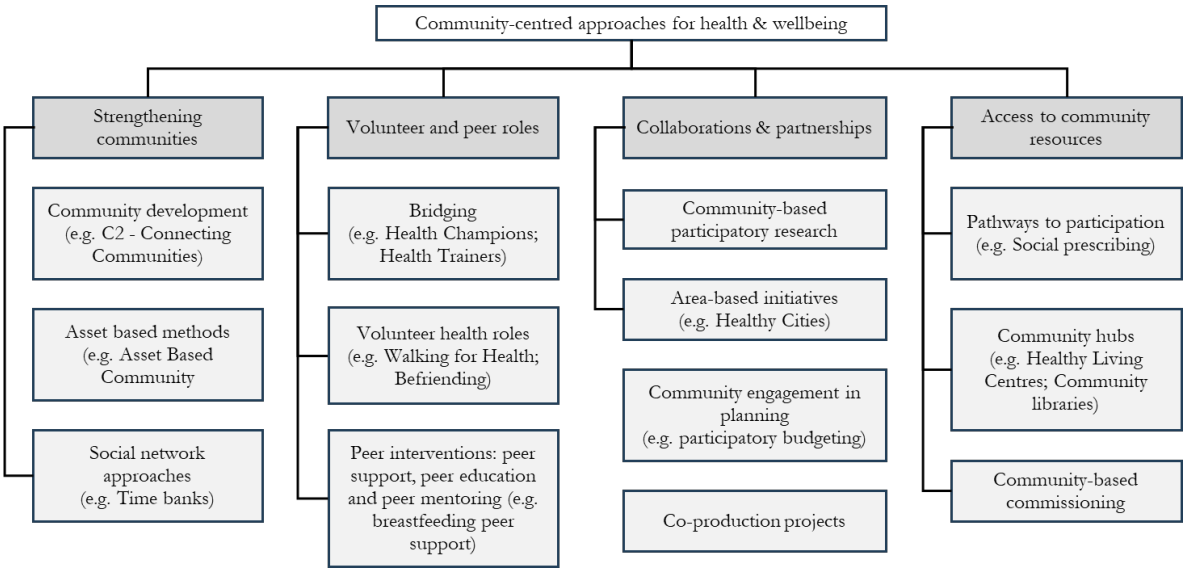

Figure 1: The Family of Community Centred Approaches (redrawn from PHE 2015)

What is the Evidence for Small Scale Placed-Based Approaches in Reducing Health Inequalities?

There is evidence that place-based approaches at local authority and neighbourhood levels can have positive impacts on important social determinants of health – including housing, the physical environment and active travel infrastructure (such as walking and cycling routes) – and these have been linked in turn to improvements in health (McGowan et al. 2021). However, there is sparse evidence that they have narrowed *inequalities* in health. Regeneration programmes, the archetypical place-based initiative, have limited evidence of any positive impacts on population health with the exception of some housing retrofit programmes (McCartney et al. 2017).

This lack of any impact on health inequality from small scale place-based interventions fits with fundamental cause theory, whereby action that does not address inequalities in fundamentals of income, wealth and power will not reduce health inequalities. This is because the successful elimination of intermediary mechanisms between the fundamentals and health outcomes will be replaced by others, maintaining the scale of inequality, although average health across a population will improve (Phelan et al. 2010). For example, water-borne infectious disease was a very important cause of health inequalities before public investment in clean drinking water systems, but as this specific cause of death declined, others (such as cardiovascular disease and cancer) increased, with the inequalities in the total burden of disease continuing to reflect the scale of inequalities in the fundamental causes (Phelan et al. 2010).

The Challenges to a Successful Place-Based Approach to Reducing Health Inequalities

It is against this background that we argue that there are a number of important challenges to small scale place-based approaches being effective at reducing health inequalities.

First, socioeconomic and power relationships are not bound within small spatial areas. This is the case for most economic mechanisms that reinforce inequalities, including rent, profit, speculation, monopoly interest and capital gains (Sayer & McCartney 2021); and for broader social class relationships (McCartney, Bartley et al. 2019). Thus, place-based approaches bound into small spatial communities will struggle to have impact on the fundamental causes of health inequalities. This is partly because local actors do not have ready access to the levers required to shift these power relationships. Equally importantly, however, even where they could have such access these local interventions typically 'gaze inwards' on the characteristics, conditions and often behaviours of the most disadvantaged groups rather than taking an external gaze onto the *economic and social relationships* they have with more advantaged groups (McCartney, Bartley et al. 2019, McCartney, Dickie et al. 2021; Popay et al. 2021, Sayer & McCartney 2021).

Second, most people who are socioeconomically disadvantaged and who live on incomes that are too low to sustain health do not live in the most disadvantaged areas of the UK (i.e., the areas with highest deprivation scores) (McCartney et al. 2023). For example, 57% of income-deprived people live outside of the most deprived fifth of areas in England (McCartney et al. 2023). Therefore, any targeting strategy which seeks to focus attention on particularly disadvantaged neighbourhoods as a means to reaching those with the greatest needs is very limited in reach.

Third, there is a socioeconomic gradient in the resources required to activate individual and 'community' agency. This means that many initiatives aimed at 'community empowerment', particularly if they do not address fundamental power relationships (characterised by an 'inward gaze' (Popay et al. 2021)), exacerbate inequalities between more and less disadvantaged areas, and between more and less disadvantaged individuals within areas, by empowering those who are already more advantaged (Ponsford et al. 2021, Popay et al. 2021, 2023, Powell et al. 2021).

Fourth, there is the potential for place-based approaches, particularly when they target the most disadvantaged areas, to stigmatise those areas. This has a negative impact on the life chances and health of the resident population and creates resentment amongst others towards any additional spending and attention given to these areas (Halliday et al. 2021, Meade 2021).

Fifth, there is evidence that many attempts at community-led action in 'partnership' with local agencies have served to disempower community organisations by co-opting them into formal structures and creating disincentives for vibrant and imaginative protest and resistance (McCartney et al. 2017).

Finally, creating a focus on local action in particular neighbourhoods and occupying the energy of communities, politicians, public health professionals and researchers on the design, implementation and evaluation of such interventions, creates a distraction from forms of collective action on political economy that would be more effective at reducing health inequalities (Bambra et al. 2019, Beeston et al. 2013, Sayer & McCartney 2021). This is particularly the case when place-based working involves (well-meaning) calls for investment in early-years services (for example), in the context of stark austerity cuts to public service funding (Alexiou et al. 2021) – making attempts for improvement at local level next to impossible.

Clearly, effective action on health inequalities (i.e., actions that reduced inequalities in income, wealth and power) would be tangible at a neighbourhood level (e.g., through action to eradicate child poverty, investment in retrofit of housing, improved public transport, investment in local government services such as schools and libraries, an adequate and respectful benefit system, etc.). However, such interventions are outside the purview of local neighbourhood actors unless part of a nationally led and funded programme of co-ordinated action. It is also true that local actors, by joining with others in collective actions, can gain agency at national level (e.g., through protest movements, trade-union action, party politics, etc.) (Bambra et al. 2019). Indeed, arguably facilitating such larger scale collective action to challenge dominant power relationships by linking groups and communities up across areas is likely to be far and away the most effective form of local action.

The Opportunity for Larger-Scale Place-Based Approaches

Local authorities and the NHS do have power to act on some of the fundamental causes of health inequalities and are able to shape economic development approaches within their communities, but to be effective these actions cannot be confined to a single small neighbourhood spatial area.

A prominent recent example of this is Community Wealth Building, which seeks to use changes in economic ownership, procurement, pension funds, employment practices and land ownership to improve the economic situation of those with the greatest needs and to reduce economic outflows to companies and individuals who are already wealthy (Table 2). This approach in Preston in North-West England has been found to improve some measures of mental health in comparison to other similar populations across England (Rose et al. 2023). Unlike the small scale spatial approaches noted above, Community Wealth Building takes place across entire local authorities, and is a good example of 'equity-sensitive universalism' because whilst universal in its reach across a population, it 'designs-in' disproportionate benefits for those populations groups with greater needs, rather than requiring targeting (Mead et al. 2022). It is also an attempt to address the fundamental causes of health inequalities, by addressing inequalities in the ownership and control of economic resources (Rose et al. 2023, Sayer & McCartney 2021). It is also worth noting that Community Wealth Building (CWB) is not inconsistent with the place-based actions described in Table 1, but unlike many of the place-based interventions implemented as part of that policy initiative, the emphasis of CWB is firmly on economic redesign (and thus on addressing the fundamental causes of health inequalities), and on equalising economic power (McCartney, Dickie, et al. 2021). Unlike the approaches described in Table 1 there is also substantial and actionable detail on how to implement the CWB approach, perhaps in contrast to higher-level aspirations which too often ignore the economic realities of austerity.

Principles	**Description**
Plural ownership of the economy	Implement different ownership models within the local economy, including municipalisation (i.e., bring provisioning under local government control, including in-sourcing of functions), creating and supporting co-operatives (including workers' co-operatives) and social enterprises in place of profit-driven and extractive firms.
Making financial power work for local places	Use local pension funds to invest in productive economic activity which benefits local people; and create and support credit unions, mutual and community banks to reduce financial extraction from local economies and to provide financing for new forms of economic ownership and activity.
Fair employment and just labour markets	Implementing increased wage floors, good employment charters, and recruiting workers from more diverse backgrounds. This can be supported by changing employment and procurement policies of local 'anchor' organisations (organisations committed to operating locally, including local government and universities).
Progressive procurement of goods and services	Implementing procurement policies amongst anchor organisations to support better employment, and to create demand along local supply chains, including the newly created plurally-owned economic entities.
Socially productive use of land and property	Bring land and property back into productive use, including through communing and the creation of local community trusts, again supporting plural ownership and fair employment.

Table 2: The principles of Community Wealth Building (CLES, n.d.)

The NHS is also able to implement most elements of Community Wealth Building as it is a substantial employer, procurer of goods and services, has large pension funds, and often owns land and buildings. In addition, through the relationships the NHS has with the public, it can facilitate access to 'fundamentals', for example by increasing the uptake of welfare benefits which people are entitled to (Burley et al. 2021). Sadly, however, most NHS organisations fail to see or act on this potential.

Finally, and most importantly, genuine emancipatory processes put in place at any spatial level which begin to redress power imbalances between social groups (including social classes, women, and discriminated-against ethnicities) would also be effective, but not if emancipatory processes simply further empower those communities who are already advantaged (Friel et al. 2021, McCartney, Dickie et al. 2021, Ponsford et al. 2021, Popay et al. 2021, Powell et al. 2021). As Mark Fisher said in 2009:

> Emancipatory politics must always destroy the appearance of a 'natural order', must reveal what is presented as necessary and inevitable to be a mere contingency, just as it must make what was previously deemed to be impossible seem attainable. (Fisher 2009, p.23)

Conclusion

Place-based neighbourhood scale approaches to reducing health inequalities are an understandable response by local agencies, particularly in the context of inadequate, or indeed highly damaging (Walsh & McCartney 2025), national policy. By working with the policy tools they have available, they can improve the average health of their populations. Furthermore, if this local action can address the fundamental causes of health inequalities and prove most emancipatory for communities who are currently disenfranchised and alienated, addressing the economic mechanisms and power dynamics that drive social inequalities - then it may also be able to reduce health inequalities. However, this is more likely across spatial scales above the neighbourhood level. Place-based approaches which do not dismantle the barriers that prevent the most disadvantaged communities using their capacities, which don't address the fundamental causes, which neuter existing community-led activism and organisation, or which fail to understand that most disadvantaged individuals do not live in the most disadvantaged areas, are highly unlikely to make any positive difference to social or health inequalities. The national and international policy forces acting in the opposite direction, exacerbating inequalities in income, wealth and power, are strong (Riddell et al. 2024). In this context, even the best designed and implemented place-based approaches at neighbourhood level are highly unlikely to be effective in reducing health inequalities (Beeston et al. 2013).

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