

BMJ Open Solving poverty or tackling healthcare inequalities? Qualitative study exploring local interpretations of national policy on health inequalities under new NHS reforms in England

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ABSTRACT

Objectives Major reforms to the organisation of the National Health Service (NHS) in England established 42 integrated care systems (ICSs) to plan and coordinate local services. The changes are based on the idea that cross-sector collaboration is needed to improve health and reduce health inequalities—and similar policy changes are happening elsewhere in the UK and internationally. We explored local interpretations of national policy objectives on reducing health inequalities among senior leaders working in three ICSs.

Design We carried out qualitative research based on semistructured interviews with NHS, public health, social care and other leaders in three ICSs in England.

Setting and participants We selected three ICSs with varied characteristics all experiencing high levels of socioeconomic deprivation. We conducted 32 in-depth interviews with senior leaders of NHS, local government and other organisations involved in the ICS's work on health inequalities. Our interviewees comprised 17 leaders from NHS organisations and 15 leaders from other sectors. **Results** Local interpretations of national policy objectives on health inequalities varied, and local leaders had contrasting—sometimes conflicting—perceptions of the boundaries of ICS action on reducing health inequalities. Translating national objectives into local priorities was often a challenge, and clarity from national policy-makers was frequently perceived as limited or lacking. Across the three ICSs, local leaders worried that objectives on tackling health inequalities were being crowded out by other short-term policy priorities, such as reducing pressures on NHS hospitals. The behaviour of national policy-makers appeared to undermine their stated priorities to reduce health inequalities.

Conclusions Varied and vague interpretations of NHS policy on health inequalities are not new, but lack of clarity among local health leaders brings major risks—including interventions being poorly targeted or inadvertently widening inequalities. Greater conceptual clarity is likely needed to guide ICS action in future.

INTRODUCTION

The Health and Care Act 2022 introduced major changes to the rules and structures of the

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ This is a qualitative study providing in-depth insights from senior leaders in England's new integrated care systems (ICSs)—including leaders from NHS, local government and other community-based organisations.
- ⇒ Our structured sampling approach meant we were able to carry out interviews in three ICSs with varied characteristics all experiencing high levels of socioeconomic deprivation.
- ⇒ Our findings represent specific experiences of leaders in three areas of England where reducing inequalities may be high on the agenda, rather than general experiences of ICSs nationally.
- ⇒ We carried out our fieldwork soon after the reforms, so our research represents leaders' initial interpretations of ICS policy objectives on health inequalities, which are likely to evolve.

National Health Service (NHS) in England, undoing components of the market-based reforms introduced by the Coalition government a decade earlier.^{1 2} The changes are based on the idea that cross-sector collaboration is needed to improve health and reduce health inequalities. Since July 2022, 42 integrated care systems (ICSs)—area-based partnerships between the NHS, social care, public health and other services in England—have been responsible for planning and coordinating health and care services for populations of around 500 000–3 million people.³ Each ICS is made up of a new NHS body and wider committee of NHS, local government and other agencies. The reforms build on a long history of policies on cross-sector collaboration on health,⁴ and echo policy changes across the UK and in other countries.^{5 6}

ICSs have been given explicit objectives by national policy-makers to reduce health inequalities. Gaps in life expectancy between

the most and least socially disadvantaged groups in England are wide and growing,^{7 8} and there are inequalities in access to high-quality healthcare.^{9–11} One of the four ‘core purposes’ of ICSs—defined by NHS England, the national body responsible for the day-to-day running of the English NHS—is to ‘tackle inequalities in outcomes, experience and access’.¹² NHS bodies and new ICSs have various legal duties on health inequalities: some broad (such as to consider the effects of their decisions on inequalities in population health and well-being), some more specific (such as to reduce inequalities in access to health services).¹¹³ NHS England has also produced broad guidance for ICSs on reducing inequalities, setting out priorities for ‘recovering’ services affected by COVID-19¹⁴ and target groups for action on healthcare inequalities (including the 20% most deprived of the population and people with selected clinical conditions—an approach known as Core20PLUS5).¹⁵ Modest additional funding (£200m nationally in 2022–23) has been provided to support these efforts.¹⁶

ICSs are the latest in a long line of local partnerships tasked with delivering national policy objectives on health inequalities.⁴ For example, a mix of area-based partnerships between the NHS, local government and other agencies was established to improve health and reduce health inequalities under Labour governments from 1997 to 2010—including Health Action Zones,^{17 18} Sure Start Local Programmes,^{19 20} Local Strategic Partnerships^{21 22} and more—as part of a broader national strategy to reduce gaps in life expectancy and infant mortality between richer and poorer areas in England.^{23–25} More recently, the NHS Long Term Plan in 2019 committed to stronger NHS action on health inequalities,²⁶ and partnerships between the NHS, local government and community-based organisations—early versions of ICSs—were asked to develop local plans for how to do it.²⁷

But translating national policy into local action is not easy. Health inequalities are complex²⁸ and policy objectives to reduce them are often ambiguous, partial and shifting.^{29–31} Health leaders have competing interpretations of the problem to be solved—for instance, between ‘individualised’ and broader structural interpretations of inequalities.^{32 33} And local plans for action on health inequalities are often vague.^{18 30 34} Even then, policy objectives to tackle health inequalities are rarely matched with the resources needed to achieve them,^{35 36} and are repeatedly drowned out by higher profile and short-term political priorities, like reducing NHS waiting times or balancing hospital budgets.^{37 38} Alongside reducing health inequalities, England’s new ICSs are expected to deliver a mix of other national policy objectives, such as increasing NHS productivity, as well as meeting targets to improve access to urgent and emergency care and reduce long waiting times for routine hospital treatment.^{12 16}

How policy problems are framed and understood shapes action to address them.^{39–42} Competing problem definitions interact and evolve.^{39 40} And lack of clarity on aims and objectives can hold back collaboration between

local agencies expected to work together to deliver them.⁴ Previous studies have examined how past national policies on health inequalities in England have been interpreted by local leaders,^{29 37 43 44} as well as individual and organisational perspectives on health inequalities in the UK and elsewhere.^{32 45–49} More recently, researchers have analysed how health inequalities are conceptualised in local health planning documents^{30 34 50} and tracked the early development of ICSs in England.^{51–54} But in-depth understanding of how England’s new ICSs are interpreting national policy on health inequalities is limited. We conducted qualitative research with NHS, public health, social care and other leaders in three more socioeconomically deprived ICSs to gain insight into local interpretations of national health inequalities objectives, how inequalities relate to other priorities and how these interpretations vary.

METHODS

Design and sample

We used qualitative methods to explore local interpretations of national policy objectives on health inequalities among senior leaders involved in England’s new ICSs. Our sample comprised 32 leaders from NHS, social care, public health and community-based organisations in three ICS areas.

We identified a purposive sample of ICSs with varied characteristics experiencing high levels of socioeconomic deprivation. We collated a mix of publicly available data on the characteristics of each of England’s 42 ICSs³—including geographical context (NHS region and proportion of rural/urban areas), population size, organisational complexity (number of NHS trusts and upper tier local authorities), policy context (number of sites involved in relevant policy initiatives in the ICS, and the date the early version of the ICS was established) and socioeconomic deprivation (proportion of the ICSs’ lower super output areas (LSOAs) in the most deprived 20% of areas nationally, using index of multiple deprivation ranks). We selected these characteristics because of evidence on their likely relevance to how organisations in ICSs work together to reduce health inequalities.^{3 55}

We used these data to identify a subgroup of 14 ICSs experiencing the highest concentration of socioeconomic deprivation relative to other ICSs in England (the top tercile of ICSs with the highest concentration of LSOAs in most deprived 20% of areas nationally). National NHS bodies are seeking to reduce health inequalities by targeting efforts on the most deprived groups¹⁵—and areas with similar levels of socioeconomic deprivation may pursue common approaches. The experiences of ICSs in these areas are, therefore, likely to be particularly relevant to understand and inform policy in England. We then identified three ICSs within this subgroup that varied in population size (which is strongly correlated with organisational complexity), geographical region, rurality and policy context—for example, by avoiding selecting

all three sites from an early ‘wave’ of NHS England’s ICS programme (NHS England established early ICSs in waves based on perceived ‘maturity’⁵⁶ of local partnerships). This gave us a relatively heterogeneous mix of three ICSs all serving more socioeconomically deprived populations. ICS leaders from the three areas we selected all agreed to participate in the research. ICS A is a large system covering a mixed rural/urban area; ICS B is a medium-size system covering a more urban area; and ICS C is a large system covering a more urban area.

In each ICS, we conducted in-depth interviews with senior leaders of NHS, local government and other organisations involved in the ICS’s work on health inequalities. This included leaders from NHS integrated care boards (ICBs) (such as ICB chief executives and directors of strategy), NHS providers (such as NHS Trust chief executives and general practitioners (GPs)), local authorities (such as directors of public health and adult social care) and other community-based organisations (such as leaders of charities working with the ICS to represent the public or provide services)—as well as those involved in the day-to-day management of ICS work on health inequalities. Participants were identified through web-based research and snowball sampling.⁵⁷ Our sample comprised 17 leaders from NHS organisations (including those working within the ICB) and 15 from local government or other organisations outside the NHS. We describe all research participants as ‘leaders’ when reporting the results.

ICSs are complex systems involving a mix of organisations and partnerships between them. ICSs themselves are made up of two bodies: ICBs (area-based NHS agencies responsible for controlling most NHS resources to improve health and care for their local population) and integrated care partnerships (looser collaborations between NHS, local government and other agencies, responsible for developing an integrated care plan to guide local decisions—including those of the ICB). ICSs are expected to deliver their objectives through the work of both bodies and other local agencies.^{3 12 58} In our research, we focused on interpretations of policy objectives and priorities for the ICS as a whole.

Data collection and analysis

We used a semistructured interview guide with questions on leaders’ interpretation of national policy objectives on health inequalities, local priorities and how these linked to other objectives for the ICS (online supplemental material file 1). All participants gave informed consent verbally. Interviews were carried out online, lasted an average of 44 min and took place between August and December 2022. All interviews were recorded, professionally transcribed and anonymised at the point of transcription. We analysed the data using the constant comparative method of qualitative analysis.⁵⁷ We reviewed the transcripts line by line to identify themes in the data and refined them iteratively as new concepts emerged. All authors (HA, NM and AH) reviewed a sample of the transcripts and worked collaboratively to develop the code structure. We used

an integrated approach to do this based on the themes identified in the data and key domains in our interview guide.⁵⁹ One author (HA) then analysed all transcripts and the authors met regularly to discuss interpretation of the data and any changes to the coding framework. We used NVivo (release V.1.3) to facilitate our analysis of the data.

Patient and public involvement

No patients or members of the public were involved in this study.

RESULTS

We found varied interpretations of policy objectives on health inequalities—both within and between ICS areas. Leaders had different perceptions of the boundaries of ICS action on health inequalities—particularly the balance between action on healthcare and wider health inequalities. Leaders everywhere worried that action on health inequalities would be crowded out by other priorities.

Varied and vague interpretations

Interpretations of national policy objectives on health inequalities varied. Some leaders interpreted national policy objectives for ICSs broadly—for example, as being about tackling poverty, improving social and economic conditions and reducing inequalities in life expectancy. One NHS leader in ICS C said they were focusing on poverty as the ‘core driver of the vast majority of health inequalities we’re facing’. Another said, while clinical priorities and access to preventive services were important, ‘we’ve really tried to go at social, you know, broader determinants of health type perspectives’.

Others conceptualised ICSs’ role on health inequalities as a mix of linked objectives within the NHS and beyond. A local authority leader in ICS B, for example, described how the ICS had a role in ‘tackling clinical inequality’ (such as improving diabetes outcomes for marginalised groups), reducing inequalities in risk factors for ill health (such as physical activity) and acting on the ‘wider determinants of health’. An NHS leader in ICS A described similar objectives to prevent disease, reduce healthcare inequalities and support action to improve social and economic conditions.

But several leaders were struggling to interpret national policy objectives. A local authority leader in ICS C said they were unsure which inequalities they were supposed to prioritise—for instance, inequalities within the ‘places’ that made up their ICS, inequalities between these places or inequalities between their ICS and the rest of the country. Another said leaders were ‘struggling to whittle down the big amorphous blob of health inequalities into some actual things that we can do’—and ‘going round in circles’ trying to do it. An NHS leader in ICS A said they were ‘still working it out’, while others pointed to governance structures or planning processes instead of their

interpretation of national policy objectives on health inequalities or planned action to address them.

Translating national policy objectives into local priorities was often a challenge. ICS leaders were in the process of developing their strategies when we carried out our interviews. Some could point to high level objectives on reducing health inequalities, such as reducing gaps in healthy life expectancy, or priority areas, such as improving mental health services. But others said it was too early to articulate priorities or felt in the dark about the process to develop them. Some felt their ICS's priorities on health inequalities were vague. An NHS leader in ICS A, for instance, said:

'I've been to a few meetings and [leader's name], they all trot out the whole 'la la, core20PLUS5, we're going to do this, we're going to make everything better', but I haven't heard anything specific, I haven't heard anybody mention anything rather than just sound bites, in all honesty.'—NHS leader, ICS A.

National guidance for ICSs did not always help provide clarity. Several leaders mentioned NHS England's Core20PLUS5 framework, which identifies priority groups for action on reducing health inequalities, including the 20% most deprived of the population and people with selected clinical conditions. Some found the framework a helpful starting point for local plans. But others thought it focused too narrowly on clinical priorities, might not fit their local context or risked widening inequalities (if the focus was on targeting the 20% most deprived in each ICS rather than nationally). More broadly, leaders often thought national guidance for ICSs on health inequalities was vague:

'Other than the usual broad brush, 'oh, integrated working' and, you know, [...] 'system leadership' and they bandy terms around, like this—personalised care, that's another one. They all talk about these kind of things and then we actually say, 'alright then, well what do you mean?' There's not very much under that.'—NHS leader, ICS A.

'I think the thing that I see most of, and I don't know what its status is, is the kind of core twenty plus five work. That seems to have some level of visibility. Even if I don't really understand what it means in, kind of, how it translates. But beyond that, no I don't have clarity on what the ask is.'—Local authority leader, ICS C.

Lack of clarity was not always seen as a drawback by local leaders, given they often wanted flexibility to address local needs. But several worried about unintended consequences—including lack of clarity on ICS objectives on health inequalities skewing priorities towards other high-profile areas (such as objectives to increase elective care activity), or misinterpretation and inconsistent implementation of policy objectives between ICSs (such as national policy to reduce NHS waiting lists 'inclusively').

Healthcare versus health inequalities

Lack of clarity about policy objectives contributed to conflicting views about the primary role of ICSs and where they should focus their attention. A major tension running throughout our interviews was differing perceptions of the boundaries of ICS action on health inequalities—particularly how far the ICS should extend its focus beyond reducing healthcare inequalities (such as differences in access to care) to address the broader social and economic conditions shaping health inequalities (such as housing conditions). Varying interpretations could be found within ICS areas and professional groups.

For some, ICSs would only succeed if they looked beyond healthcare services:

'Over many years [...] they've been really probably the national ill health service, focussing in on treating illness and disease as opposed to thinking about primary prevention and working more effectively with public health on how do we get population health outcomes improved and therefore reduce health inequalities. And that lens of the wider determinants of health is to my mind the right lens to be looking through in order to improve population health outcomes.'—Local authority leader, ICS C.

Others described how their ICS needed to do both—combining action on reducing healthcare inequalities with broader efforts to tackle underlying social and economic conditions in their area:

'You just look at the healthy life expectancy across the patch and you can see the inequity. You look at things like vaccine uptake, screening uptake, and they're some of the, kind of, proxy measures that you can see that maybe start to explain some of the differences in life expectancy. You look at smoking rates, obesity rates, alcohol, all of that kind of stuff, unemployment, housing situation, and you start to get to grips as to why, and, as I say, it's clear that it's issues greater than just what the health service can manage, so it needs that integrated approach.'—NHS leader, ICS A.

But several leaders—particularly from local government—wanted their ICS to focus primarily on healthcare inequalities, and worried about the consequences of NHS leaders misinterpreting their role and purpose:

'I think there's something for me about ensuring that the ICS is absolutely focused on healthcare inequalities as its first and foremost responsibility. Get the inequalities within the NHS, what's in their grasp. [...] They're not going to solve poverty at an ICS level.'—Local authority leader, ICS A.

'It's an easy get out to say, you know, 'Marmot says that it's the social determinants that matter most'. Well then, and 'we need to focus on housing and jobs and things'. Well, the ICS doesn't do much, doesn't have big levers on housing and jobs and stuff, so yes, we can do a bit on anchor work, but it's fairly marginal

to what we can do to actually try and ensure that our services strive to have the most equitable access and outcomes for our residents.’—Local authority leader, ICS C.

‘I think there is a misconception about what is the role of the NHS in tackling health inequalities. [...] I always kind of giggle in the background, some people might discover health inequalities, and then they go, ‘you know, we need to solve poverty’ and you go ‘Christ, that’d be great. In the meantime, can you just make sure your services are open on an evening and actually the transport routes are fine, and actually the literacy levels of your leaflets are not of a reading age of a 20-year-old?’—Local authority leader, ICS A.

These differences in interpretation created potential conflict between leaders and organisations. Some described the risk of the NHS ‘stepping on toes’ or failing to acknowledge others’ skills and expertise. Others worried about NHS leaders framing health inequalities as ‘new’ and the risk of alienating local authorities and others with a long history of working to address them. One NHS leader described how:

‘I just had a conversation with the DPH [...] We were talking about some of the wider determinant stuff and she said, ‘Well, you know, of course, that’s not really the NHS’s business’, you know, ‘We’ve got all this in our strategies’ you know? So, it was just a little bit of a [...] Just a gentle, sort of, shove back.’—NHS leader, ICS C.

Tension was not always seen as a bad thing. An NHS leader in ICS C gave the example of learning to dance with a partner, saying ‘you have to acknowledge that you will stand on each other’s bloody toes, you know’, otherwise ‘you don’t move anywhere and you don’t learn anything’. Several leaders described ongoing conversations in their ICS to define the roles and responsibilities of different organisations, including work in one area to define the contribution of public health professionals in the ICS. And public health leaders frequently described their efforts to help other partners in their ICS understand different kinds of health inequalities and potential approaches to reducing them.

Threaded throughout or crowded out?

Whatever their interpretation of the boundaries of ICS action on health inequalities, leaders often conceptualised reducing health inequalities as a cross-cutting objective linked to other ICS priorities:

‘So I think whenever we discuss anything, we’ve got this absolute agreement we need to look at it through... so we always look at things through a financial lens, a quality lens, but I think we also need to start—whatever we do—we look through a health inequalities lens. Is this a line to our strategic aim of reducing health inequalities, no matter what it is?’—NHS leader, ICS A.

‘I mean it runs through everything, it literally runs through everything doesn’t it, this inequalities work. Every single strategy, every single plan is what we are looking to make a shift on in terms of this agenda.’—Local authority leader, ICS B.

‘I think we need to get to a strategy which clearly puts population health management and understanding and tackling health inequalities as the core of our overarching strategy, and inequalities needs to be threaded through all of our other pieces of work.’—NHS leader, ICS C.

But—in reality—leaders frequently described how other priorities risked crowding out action on health inequalities. Interviewees in every ICS described how responding to acute pressures in the NHS and social care, such as long waiting lists for elective care, tended to dominate the agenda. This ‘crowding out’ effect happened at a mix of levels—from senior leaders to front-line staff. An NHS leader in ICS B, for example, described how the limited ‘bandwidth’ of the ICS team was being taken up with a series of meetings on ambulance response times, elective waiting lists, and other operational pressures—and said they were ‘increasingly spending more time on those short-term issues’ over longer-term objectives. Another NHS leader in ICS C described how their clinicians ‘would love to be spending more time’ on initiatives to reduce health inequalities, such as a local programme where respiratory consultants visited a community hub to provide clinical advice alongside other services focused on housing, food, benefits and other social needs—‘but they are saying we can’t because we’ve got these clinics to do and we’ve got these patients to see and we’ve got a full ED department’.

Leaders gave a mix of explanations for this crowding out effect. One was that pressures on the NHS, like long ambulance response times, were the most visible priorities. Another was that pressures on the NHS were so extreme—so ‘unacceptably bad’, as one local authority leader in ICS A put it—that short-term action to address them was understandable, and might even be needed to create space for work on health inequalities. One NHS leader in ICS C said: ‘if we don’t get through winter, then, you know, nobody’s going to give us the time of day to do the other stuff’. Others pointed to the lack of resources—people and money—to deliver objectives on health inequalities. An NHS leader in ICS A described the risk ‘that the secondary care hospital sector sucks every possible penny of growth’.

But the approach of national policy-makers was also identified as a major factor shaping local priorities and behaviour. Despite the presence of health inequalities in national policy documents, local leaders frequently described how the overriding focus from national NHS bodies and politicians was on holding ICSs to account for NHS performance—a focus that appeared to be increasing:

'I don't think I've had a conversation on health inequalities or population health with NHS England since we've been in existence, but I'd need more than my fingers and toes to count the number of conversations I've had on ambulance handover. We're really being driven to be focused on optimising the existing system's delivery.' —NHS leader, ICS A.

'I mean, the chair of the ICS, [name], I think is fine. I think [they] gets it but, of course, you know, the way the NHS, because they're part of the NHS, the NHS is the NHS, so, they call the chiefs and chief executives in and berate them for their performance on ambulances. You know what I mean? That's the top of the priority. I don't know if they even talk at these meetings about inequalities, you know? It's all about performance.' —Local authority leader, ICS B.

'I cannot explain in seven weeks, eight weeks, how much their focus has changed, it's unbelievable. It's almost as if, if you came into one job as an ICB chief exec, and you've got another job now, which is basically being the chief operating officer for the system, and that is the absolute focus from them, you know. So I'm on, you know, regular phone calls with them about those short-term issues, whether it's private care access, ambulance turnaround times, 104 week wait, 78 week waits, cancer waiting times. That is the absolute focus.' —NHS leader, ICS B.

DISCUSSION

We analysed local interpretations of national health inequalities objectives in three more socioeconomically deprived ICSs in England. Overall, we found local interpretations of policy objectives on health inequalities varied, and local leaders had contrasting—sometimes conflicting—perceptions of the boundaries of ICS action. Translating national objectives into local priorities was often a challenge, and clarity from national policy-makers was frequently perceived as limited or lacking. Across the three ICSs, local leaders worried that objectives on reducing health inequalities were being crowded out by other policy priorities, such as pressures on NHS hospitals. The behaviour of national policy-makers appeared to undermine their stated priorities on reducing health inequalities.

Vagueness in NHS policy on health inequalities is nothing new. National NHS bodies in England committed to stronger action to reduce health inequalities in 2019,^{26 27} but lacked a systematic approach to achieving it³¹ and expected local leaders—early versions of ICSs—to develop their own approaches. Olivera *et al* analysed the local plans that followed and found health inequalities were conceptualised vaguely and inconsistently, echoing the broader vagueness in national NHS policy.³⁰ Warwick-Giles *et al* found that the NHS's new clinical commissioning groups—organisations established to purchase local health services under the Lansley reforms

in 2012, before being scrapped under the latest round of NHS reforms in 2022—were unclear on their duties to tackle health inequalities, and suffered from limited guidance from national policy-makers.⁴⁸ Looking further back, Exworthy and Powell found similarly 'muddy' NHS objectives on health inequalities in the 1990s and 2000s.²⁹ This is, perhaps, unsurprising. How local agencies 'translate' national policy in their own context is a central part of the policy process—and often an intentional policy feature.^{60–62} Varied understandings of concepts linked to health inequalities and their causes are widespread.^{32 33}

But lack of clarity among ICS leaders on health inequalities brings major risks. Health inequalities are complex and deeply rooted. Reducing them is challenging, but possible.^{63 64} Yet progress on reducing health inequalities will not happen unless national and local agencies take a coherent and systematic approach—including clarity on the 'problem' to be addressed, priorities and principles for action, and potential interventions at different levels.^{31 65–67} Without this, there is a risk of interventions being poorly targeted, conflict and confusion between local agencies, and broad strategies that fail to translate into action. Local leaders also risk being judged against measures they have limited power or resources to improve.⁶⁸ ICSs may even inadvertently widen inequalities—for instance, if some groups receive disproportionate attention, individual-level interventions are pursued without wider system-level changes, or efforts to tackle inequalities within ICSs are not matched with wider policy to reduce inequalities between them.^{30 31 69 70} National NHS bodies have produced guidance for ICSs on reducing health inequalities, including priorities for 'recovering' services after COVID-19 and the Core20PLUS5 framework.^{15 16} But our research suggests that more clarity is needed to guide ICS action—including the respective roles of NHS-led ICBs and other partnership groups and bodies at a local level.

Some of these risks appeared to be playing out already in our research. A major unresolved tension among local leaders was differing perceptions of the boundary for ICS action on health inequalities—particularly how far the ICS should extend its focus beyond reducing healthcare inequalities (such as differences in access to healthcare) to address the broader social and economic conditions shaping health inequalities (such as housing conditions). Studies often report that health system leaders predominantly focus on individual-level interpretations of health inequalities—for instance, emphasising individual risk factors for ill health and the importance of improving access to services.³² Recent analysis of local health system plans in England, produced by early versions of ICSs, also found that areas tended to frame action on preventing ill health and reducing health inequalities narrowly—for instance, focusing on individual behaviour change or better disease management.^{30 34}

Our research painted a more complex picture. Leaders from across professional groups—including the NHS, public health and social care—held varied views about ICSs' remit on health inequalities. NHS leaders often

emphasised social and economic factors, like poverty or housing, as key drivers of health inequalities to be tackled by the ICS. Yet several local authority leaders were concerned about the NHS misunderstanding its role and focus—for instance, NHS leaders ‘discovering’ health inequalities and social determinants of health but failing to sufficiently recognise their primary role in tackling the healthcare inequalities more firmly within the NHS’s control. Unclear or unrealistic aims, competing agendas and failure to understand other organisations’ expertise can all hold back partnership working.⁵⁵ NHS reforms in 2012 transferred public health functions out of the NHS and into local government.^{71 72} Yet the complex structure of England’s new ICSs—each made up of several overlapping partnership bodies, including an NHS-led agency coupled with a broader partnership of local organisations—risks causing confusion.⁷³ There are also broader risks from greater NHS action on social determinants of health, such as medicalising poverty and other social issues (eg, by framing structural social issues as problems that can be diagnosed and treated by clinicians) and inefficient allocation of resources to address them.^{69 74} Future research should explore this tension further and how the framing of NHS plans on health inequalities may be shifting.

Finally, our research highlights how ICS objectives on reducing health inequalities are being crowded out by higher profile policy objectives, such as reducing pressure on acute hospitals and improving ambulance performance. Pressures on the NHS are extreme: by September 2023, the waiting list for routine hospital treatment in England had reached almost 8 million—the highest since records began—and 28% of people attending EDs waited more than 4 hours to be seen.⁷⁵ Evidence from a long line of policy initiatives in England tells us that broader goals on improving health and reducing inequalities often fade as pressures on NHS services and finances increase.^{37 76} Despite rhetoric about long-term policy, national NHS bodies and government frequently focus on ‘hard’ targets (like the size of waiting lists) and short-term political priorities instead.^{37 54 77} Our research suggests the same phenomenon was happening to ICSs almost as soon as they were introduced. This represents a repeated failure among national policy-makers to learn from past policy.

Limitations

Our study has several limitations. First, we focused on gaining in-depth insights from three ICSs (out of 42 in total), so our findings represent the specific experiences of leaders in these case study sites rather than general experiences of ICSs across England. However, our structured sampling approach meant we were able to target ICSs with varied characteristics all experiencing high levels of socioeconomic deprivation. Leaders in these ICSs are likely to be particularly aware of their role in reducing health inequalities—and our findings are likely to have strong relevance to ICSs serving similar populations. The findings are also relevant to national policy-makers

targeting efforts to reduce health inequalities at more socioeconomically deprived groups.¹⁵

Second, our interviews focused on senior leaders in ICSs. This meant we were able to understand the high-level perspectives of the most senior leaders responsible for overseeing and directing the ICSs work on health inequalities. Our sample included a diverse mix of leaders from NHS providers, ICBs, local authorities and other community-based groups. However, our research does not focus on the perspectives of people directly providing services or patients and service users experiencing inequalities.

Third, we carried out our fieldwork between August and December 2022—early in the evolution of ICSs (formally established in July 2022). This allowed us to understand leaders’ perspectives as they developed their system’s plans, and—in some cases—new teams to deliver them. But it also means our research represents leaders’ initial interpretations of policy objectives on health inequalities—interpretations that are likely to evolve. That said, ICSs have existed informally for several years^{50 54 73} and national policy initiatives over decades have encouraged local partnerships on health inequalities.⁴

CONCLUSION

Reforms to the NHS in England established 42 ICSs responsible for planning and coordinating local health and care services. The changes are based on the idea that cross-sector collaboration is needed to improve health and reduce health inequalities—and similar policy changes are happening elsewhere in the UK and internationally. We used qualitative methods to explore local interpretations of national policy objectives on health inequalities in England among senior leaders working in three ICSs—including from the NHS, social care, public health and community-based organisations. Local leaders had varying interpretations of national policy objectives and different views on the boundaries for ICS action. Clarity from national policy-makers was frequently perceived as limited or lacking. Across all three ICS areas, local leaders were concerned that objectives on reducing health inequalities were being crowded out by other policy priorities. Our findings have implications for policy and practice—including the need for greater conceptual clarity as ICSs and other national policies encouraging cross-sector collaboration to reduce health inequalities evolve.

Contributors HA, NM and AH identified the research question and led the design and development of the study. HA carried out the interviews with ICS leaders. HA, NM and AH reviewed interview transcripts, identified themes in the data, developed the code structure and interpreted the data. HA coded and analysed all interview transcripts. HA wrote the first draft of the manuscript and incorporated comments from AH and NM. All authors read and approved the final manuscript. All authors are researchers in health policy and public health in the UK and have experience carrying out qualitative and mixed methods research—including research into similar policy initiatives in England. HA is the guarantor.

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