PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Solving poverty or tackling health care inequalities? Qualitative study exploring local interpretations of national policy on health inequalities under new NHS reforms in England
AUTHORS	Alderwick, Hugh; Hutchings, Andrew; Mays, Nicholas

VERSION 1 – REVIEW

REVIEWER	Ford, John University of Cambridge, Public Health
REVIEW RETURNED	28-Nov-2023

GENERAL COMMENTS	Thank you for inviting me to review this manuscript. It is a qualitative exploration of the views of health professionals who work in ICSs on health inequalities actions. The manuscript asks an important question, the authors have used appropriate methods and the findings are useful. I have a few major comments 1. The results are interesting, although i felt that they were a bit too descriptive. i.e. the depth of analysis could have been greater. For example the authors could reflect on why do ICSs find translating national objectives into local priorities. Is there anything in the text that suggests that local leaders have been given the responsibility, but without the power to enact change? (see https://pubmed.ncbi.nlm.nih.gov/37131506/) Or is there a fatalism about inequalities and local leaders do not want to be held accountable for something they don't feel it is within their gift to change? 2. There is an assumption in the paper that health inequalities is the right conceptualisation of the problem of unequal health across different groups. Perhaps the findings suggest that the current approach to inequalities is not working because the conceptualisation is wrong. Would a national policy approach which targeted patients with greatest need, disadvantaged groups and conditions/risk factors intrinsically associated with poverty be a more effective approach, rather than asking local systems to explore the rather nebulous concept of unfair and avoidable differences. 3. I wonder if a diagram or figure would be useful in trying to pull together the findings in a more coherent manner. Such as the barriers or forces that local systems face to make progress on health inequalities. 4. The manuscript as written ties the findings to the English NHS landscape. I think there is a risk that the manuscript will go out of date quickly when there is a change in NHS organisations or policy. I would encourage the authors to where possible focus on the science and theory of the problem, rather than trying it too

	closely to the here and now. For example, I'd suggest not using terms like "ICS leaders" in the conclusion of the abstract, but rather something like local health decision makers (i.e. a term that is likely to have more longevity). Minor - The references in presented in an unusual way – rather than having a single number for each reference, the same reference has several numbers. For example, Oliveria 2022 is both reference number 30 and 34

REVIEWER	Hasman, Andreas UNICEF, Programme Group
REVIEW RETURNED	06-Dec-2023

GENERAL COMMENTS	Thank you for a very interesting and well-written study. You raise highly relevant issues around 1) the interpretations of national objectives pertaining to health inequalities, 2) resource availability and prioritization at local level, and 3) the extend of organizational powers, scope, mandate etc. in addressing health inequalities at local level You rightly highlight the central choice (for local leaders) between narrow action to reduce inequalities in health care outcomes and broader efforts to tackle underlying social and economic conditions, or rather the prioritization of these. Your study also refers to other (non-equality) organizational decisions relating to e.g., the balancing of objectives pertaining to reduced inequality and other issues, such as reduced waiting times, budgetary constraints, adoption of new and costly technologies etc., which I think are highly important. As you find, concern for these other issues can 'crowd out' concerns for health inequality but I sense the relationship can even more complex, also involving tradeoff. Including more of this discussion would be helpful. You conclude that local leaders have contrasting—sometimes conflicting— perceptions of the boundaries of ICS action and interpretations of needed actions to reduce inequalities. This is probably not surprising since disagreement on the fundamental issues such as those relating to health equality is widespread. The question for me is what are the solutions to this fundamental problem (over and above local leaders muddling through)? One important finding in this study is that some local decision-makers and interviewees found vague language in national documents provided flexibility to interpret local needs. I don't find it evidently true when you argue that "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." A key question for me is if we should expect local leaders to make these kinds of decisions (i.e., prioritizing action on health inequalities) in the first place, or whether decision-making on such issues will have to have broader foundations – for examples in some form of a process to ascertain procedural fairness. For such a process to be legitimate, it would arguably have to involve engagement of a range of stakeholders – and possibly beyond the narrow group of organizational leaders interviewed for this study. You could mention the prospective benefits of local processes for priority decision-making on health inequalities rather than ruling out such an approach in favor of a more centralized approach dictated by national policymakers.

	It would be helpful to have more details on ICSs' policy objectives pertaining to health inequalities, as well as other objectives on which they are expected to deliver (you hint that there may be tradeoffs between these different objectives, which could also be further explored). And I also miss in the introduction the historical background to the English NHS focus on health and health care inequities, which is provided in the discussion. Having this perspective, potentially expanded, early on would provide a framework to better understand the findings. Why did the study select ICSs with similar socioeconomic profile (higher level of social deprivation) for inclusion? Would it be helpful to compare these ICSs with areas with less socioeconomic deprivation? Arguably, a different interpretation of equality objectives in less deprived areas lends further support to a decentralized and inclusive process for decision-making.

REVIEWER	Exworthy, Mark University of Birmingham, HSMC
REVIEW RETURNED	06-Dec-2023

GENERAL COMMENTS	This article assesses the perceptions of local stakeholders regarding tackling health inequalities. Using 3 ICSs in England as the case-studies, the article considers these issues in relation to 3 sets of findings: (i) varied and vague interpretations, (ii) health care versus health inequalities, and (iii) threaded throughout or crowded out. It is largely descriptive and evaluative (though not against explicit criteria), avoiding explicit policy prescription; instead it focuses on the consequences (including those which are unintentional and dysfunctional) and implications of the current ICS approaches towards tackling health inequalities. Methodology: • The process is sound. It is well described and consistent with other similar studies. It is worthy of publication in BMJ Open. • Interviews with key stakeholders are the obvious method and 32 interviews across 3 case-studies seems reasonable. But there is little corroboration with documentary or observational evidence. • A stronger justification and statement of the implications of choosing 3 ICSs with high levels of deprivation should be included. There are arguments and counter-arguments about choosing a homogeneous or a heterogeneous sample. This is complicated by the geographical and population size of ICSs which comprise many different neighbourhoods and communities. Might tackling health inequalities be `harder' in areas with mixed levels of deprivation? Crowding out of policy (in favour of other "priorities") might be harder in these places. Likewise, little information of the socio-demographic characteristics is given of the 3 ICSs; eg. rural/urban/coastal community, previous collaborative maturity. While it is understandable that they are not named, some further contextual evidence is merited. Findings: • Generally, there is a good balance between direct evidence (through quotes) and interpretation of the findings. However, some quotes are presented sometimes with little/no interpretation, one after the other. In most cases, the (multiple) quotes are drawn from contrasting case-studies but the differences and similarities could be drawn more clearly. More contrast between / within ICSs could be presented notwithstanding the word limit of the journal. • The findings tend to focus on whether or not health inequalities are being `tackled' and possibly how they are being tackled. They are more reticent about the types of inequality that ICSs are pursuing. For example, access and outcomes are mentioned in the findings section but mostly briefly as part of a quote. Since the types of equity are effectively choices to be made, the process by which they do so would be insightful. • In the section "threaded throughout…", the argument fails to draw on a reasonably extensive body of evidence regarding `mainstreaming.' Whilst much of this knowledge

	is ostensibly found in social policy (including gender and environment), there are numerous applications in terms of health inequalities. Examples of the mainstream research include the following: o Evans and Killoran: https://www.tandfonline.com/doi/abs/10.1080/09581590050075899?casa_token=sTSgfKqddtoAAAAA:2RgnIb4_VGXfrOeG-xBedXi_tWMtcD4g84fdUbhJ-ZkUD7FrsJBYbeNtu6DJ7oxqjLPus6GF73OVVw o Cairney et al: https://www.tandfonline.com/doi/full/10.1080/21622671.2020.1837661 o Popay: https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-020-00648-z Implications: • The authors set a legitimate remit to focus on ICSs, but there could be some mention of the need for better collaboration centrally between government departments and agencies. To date, such coordination has been patchy but may be essential for better local coordination. Equally, the most appropriate geographical / organisational scale for tackling health inequalities (within ICSs (place or neighbourhood or entire ICS) could also have been broached. • It is reasonable to focus on ICSs but it is equally legitimate to ask whether the ICS approach is the only or most effective mechanism to reduce health inequalities? ICS are the primary vehicle for planning and organising NHS efforts to do so, but other actors and agents (such as general practice) might also deliver. Likewise, what has been learnt other (previous) `vehicles'? These might include, for example, public health (now a local government function); the evidence of (current and planned) local government cutbacks does not augur well for public health's contribution to tackling health inequalities. Overview and Scrutiny Committees, Health and Wellbeing Boards as well as the VCSE sector might also be addressed here. • Many of the findings and much of the Discussion is substantively similar to what studies found in recent policy `waves' tackling health inequalities. The article acknowledges this (eg line 60 onwards) but why did policy-makers fail to learn from this substantial body of evidence? This is not simply describing the causes and manifestations of health inequalities but more crucially for this article, how to tackle them. This lack of policy learning (or repeating similar issues such as vagueness) would appear to be an important implication for evidence-based policy-making. • The article does not distinguish clearly enough between health inequalities and the social determinants of health (SDH). For example, the quote (line 243) cites Michael Marmot's emphasis on SDH without acknowledging that such SDH are inequitably distributed. Policy could address "housing and jobs and things" without necessarily addressing the equity dimension. The article fails to mention the "social gradient", an emblematic feature of Marmot's overall thesis. This relates to a distinction which is implicit in the title, viz. between poverty and health. Similarly, the work of Hilary Graham is instructive in this regard: o GRAHAM, H. (2004). Tackling Inequalities in Health in England: Remedying Health Disadvantages, Narrowing Health Gaps or Reducing Health Gradients? Journal of Social Policy, 33(1), 115-131. doi:10.1017/S0047279403007220 I recommend publication of this article subject to revisions.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1	
3 *The results are interesting, although i felt that they were a bit too descriptive. i.e. the depth of analysis could have been greater.*	We are glad the reviewer found the results interesting. The reviewer's questions about why local leaders found it difficult to translate national policy

For example the authors could reflect on why do ICSs find translating national objectives into local priorities. Is there anything in the text that suggests that local leaders have been given the responsibility, but without the power to enact change? (see https://pubmed.ncbi.nlm.nih.gov/37131506/) Or is there a fatalism about inequalities and local leaders do not want to be held accountable for something they don't feel it is within their gift to change?	objectives are helpful. The text already points to a mix of reasons why local leaders found translating national policy objectives into local priorities challenging—including the broad and vague nature of the policy 'ask' on health inequalities, the fact that ICSs were in the early stages of planning and developing governance structures, and weaknesses in national policy guidance. We also include analysis on roles and responsibilities for tackling health inequalities, which links to the reviewer's question about whether local leaders have power and resources for addressing them. Following the reviewer's suggestion, we have added additional text to the discussion section to expand on these questions further (focusing on the potential risk of local leaders being held accountable for things they can't control) (lines 373-374), as well as an additional reference to the paper mentioned by the reviewer that provides additional analysis on this topic (reference 68).
4 *There is an assumption in the paper that health inequalities is the right conceptualisation of the problem of unequal health across different groups. Perhaps the findings suggest that the current approach to inequalities is not working because the conceptualisation is wrong. Would a national policy approach which targeted patients with greatest need, disadvantaged groups and conditions/risk factors intrinsically associated with poverty be a more effective approach, rather than asking local systems to explore the rather nebulous concept of unfair and avoidable differences.*	This is an interesting comment and we agree that there are challenges with the national policy approach to health inequalities. The findings of our analysis support this—and we point to the need for greater conceptual clarity in national policy in the discussion section of the paper. However, the analysis in our paper focuses on local interpretations of existing national policy objectivs on health inequalities in England. A different research question and analysis would be needed to provide a critical assessment of the content of the national policy approach and make recommendations about alternative approaches. Other studies (including the reviewer's paper linked to in comment 3, which we now reference in the discussion) focus on this question. We have therefore chosen not to revise the paper in response to this comment.
5 *I wonder if a diagram or figure would be useful in trying to pull together the findings in a more coherent manner. Such as the barriers or forces that local systems face to make progress on health inequalities.*	This is a helpful suggestion. We reviewed the manuscript and think the narrative summary of findings under three clear headings makes sense as a way to present the data. The paper focuses on local interpretations of policy on health inequalities rather than providing a comprehensive analysis of barriers to addressing these inequalities, so we have not incorporated the suggestion to include a table on these.

6 *The manuscript as written ties the findings to the English NHS landscape. I think there is a risk that the manuscript will go out of date quickly when there is a change in NHS organisations or policy. I would encourage the authors to where possible focus on the science and theory of the problem, rather than trying it too closely to the here and now. For example, I'd suggest not using terms like "ICS leaders" in the conclusion of the abstract, but rather something like local health decision makers (i.e. a term that is likely to have more longevity).*	We have revised the conclusion of the abstract to broaden the terms used for local health leaders (switching 'ICS leaders' for 'local health leaders') (line 24). We have also revised the conclusion of the manuscript to broaden the focus of the policy implications (lines 450-451). This should help illustrate the relevance of the manuscript to broader debates about the theory and practice of cross-sector collaboration to reduce health inequalities. (We have also emphasized links between the phenomenon studied and broader international and historical policy developments in the introduction and discussion.) But we have retained more specific language linked to current national NHS reforms throughout the paper, given the specificity of the study to the English context and direct relevance of the findings to current policy debates about integrated care systems in England. We think this is a strength of the study.
7 *The references in presented in an unusual way – rather than having a single number for each reference, the same reference has several numbers. For example, Oliveria 2022 is both reference number 30 and 34*	Thanks to the reviewer for spotting this. There were several duplicate references, which we have removed. We have updated the reference numbers to account for this.
Reviewer 2	
8 *Thank you for a very interesting and well-written study. You raise highly relevant issues around 1) the interpretations of national objectives pertaining to health inequalities, 2) resource availability and prioritization at local level, and 3) the extend of organizational powers, scope, mandate etc. in addressing health inequalities at local level.* *You rightly highlight the central choice (for local leaders) between narrow action to reduce inequalities in health care outcomes and broader efforts to tackle underlying social and economic conditions, or rather the prioritization of these. Your study also refers to other (non-equality) organizational decisions relating to e.g., the balancing of objectives pertaining to reduced inequality and other issues, such as reduced waiting times, budgetary constraints, adoption of new and costly technologies etc., which I*	We are pleased the reviewer found the findings interesting and relevant. The reviewer notes our findings about health inequalities being 'crowded out' by other objectives (such as pressures on hospitals) and wonders whether this sometimes involves a 'trade-off' between health inequalities and other objectives. We are not entirely clear how this differs from the 'crowding out' effect described in the paper. But the manuscript gives various examples of what this meant in practice for our interviewees at a local level. This includes senior leaders spending more time on short-term issues over longer-term objectives on health inequalities, and clinicians being unable to spend time on new initiatives to tackle underlying causes of health inequalities because they are busy working on core services. We think these concrete examples are the best way to describe the experience of local leaders. The manuscript also sets out some of the potential reasons for this crowding out effect—and we return to this point in the final

think are highly important. As you find, concern for these other issues can 'crowd out' concerns for health inequality but I sense the relationship can even more complex, also involving tradeoff. Including more of this discussion would be helpful.	section of the discussion. We therefore think that this issue is given sufficient attention in the paper.
9 *You conclude that local leaders have contrasting—sometimes conflicting—perceptions of the boundaries of ICS action and interpretations of needed actions to reduce inequalities. This is probably not surprising since disagreement on the fundamental issues such as those relating to health equality is widespread. The question for me is what are the solutions to this fundamental problem (over and above local leaders muddling through)? One important finding in this study is that some local decision-makers and interviewees found vague language in national documents provided flexibility to interpret local needs. I don't find it evidently true when you argue that "progress on reducing health inequalities will not happen unless national and local agencies take a coherent and systematic approach—including clarity on the 'problem'o be addressed, priorities and principles for action, and potential interventions at different levels." A key question for me is if we should expect local leaders to make these kinds of decisions (i.e., prioritizing action on health inequalities) in the first place, or whether decision-making on such issues will have to have broader foundations – for examples in some form of a process to ascertain procedural fairness. For such a process to be legitimate, it would arguably have to involve engagement of a range of stakeholders – and possibly beyond the narrow group of organizational leaders interviewed for this study. You could mention the prospective benefits of local processes for priority decision-making on health inequalities rather than ruling out such an approach in favor of a more centralized approach dictated by national policymakers.*	This is an interesting comment, and the reviewer makes good points about procedural fairness and the policy process to set priorities on health inequalities. But it is important to stress that our analysis focuses primarily on local interpretations of national policy on health inequalities, rather than critically assessing the national policy approach on health inequalities and suggesting alternatives (see response to reviewer comment 4). The existing NHS policy context in England is highly centralized and hierarchical, with policy objectives and measures for integrated care systems coming from the 'top down'. More broadly, the UK is a highly centralized state, with much of the power and resources for reducing health inequalities held at a national level (for example, most public spending, including social security, is managed by central government). Our analysis focuses on the experiences of local leaders in this context—and our discussion section expands on what could support progress in this context too. Our comment in the discussion that a more systematic approach is needed (quoted by the reviewer) reflects this, given our findings about lack of clarity from national policymakers and conflicting interpretations of policy objectives among local leaders. A more detailed analysis of priority setting processes on health inequalities in England—while interesting and important—is out of scope for this paper.
10 *It would be helpful to have more details on ICSs' policy objectives pertaining to health*	This is a helpful comment. We have added detail on other ICS policy objectives in the introduction

inequalities, as well as other objectives on which they are expected to deliver (you hint that there may be tradeoffs between these different objectives, which could also be further explored). And I also miss in the introduction the historical background to the English NHS focus on health and health care inequities, which is provided in the discussion. Having this perspective, potentially expanded, early on would provide a framework to better understand the findings.	(lines 76-78), including explicitly mentioning objectives linked to improving the performance of hospital care in the NHS (linked to the trade-off mentioned by the reviewer). Paragraph three of the introduction already provides historical context on past partnership policies on health inequalities in England. We think this is sufficient to put the latest NHS reforms in context—and the discussion section reflects in more detail on how our findings fit in the context of these policies.
11 *Why did the study select ICSs with similar socioeconomic profile (higher level of social deprivation) for inclusion? Would it be helpful to compare these ICSs with areas with less socioeconomic deprivation? Arguably, a different interpretation of equality objectives in less deprived areas lends further support to a decentralized and inclusive process for decision-making.*	We selected three ICSs experiencing a relatively high concentration of socioeconomic deprivation for a mix of reasons—and think this sampling approach is a strength of the study. We briefly summarize these reasons below, then set out how we have revised the text in response. The national NHS approach to reducing health inequalities in England involves targeting efforts at the top 20% most deprived of the population. We therefore selected sites with a high concentration of local areas (LSOAs) in the most deprived 20% of areas nationally. Leaders in these ICSs are also likely to be particularly aware of their role in reducing health inequalities and may pursue some common approaches. At the same time, we wanted to ensure heterogeneity in our sample in relation to other characteristics shaping how ICSs collaborate to reduce health inequalities. We therefore selected three ICSs (from the larger sub-set of ICSs experiencing a high concentration of socioeconomic deprivation) with varying characteristics in other domains shaping collaboration functioning—including size, rurality, and other factors identified in the literature. This means that there is still substantial variation between the ICSs we selected for inclusion (as well as variation within them, given they cover large geographical areas). This approach left us with a final sample of three ICSs with varied characteristics all experiencing high levels of socioeconomic deprivation. The rationale for this approach is set out in the methods. We also note strengths and limitations of these methods in the manuscript. The reviewer is right that alternative sampling approaches could have been used—for instance, by selecting three sites with varied or limited concentration of socioeconomic deprivation. But we think that this would have provided findings

	with less depth and relevance to the policy being studied. In response to the reviewer's comment (and reviewer 3's similar comment 12, below), we have added additional text in the methods (lines 109-110) and limitations sections (lines 425-426) to describe the rational and implications of our sampling approach more clearly.
Reviewer 3	
12 *Methodology:* *• The process is sound. It is well described and consistent with other similar studies. It is worthy of publication in BMJ Open.* *• Interviews with key stakeholders are the obvious method and 32 interviews across 3 case-studies seems reasonable. But there is little corroboration with documentary or observational evidence.* *• A stronger justification and statement of the implications of choosing 3 ICSs with high levels of deprivation should be included. There are arguments and counter-arguments about choosing a homogeneous or a heterogeneous sample. This is complicated by the geographical and population size of ICSs which comprise many different neighbourhoods and communities. Might tackling health inequalities be `harder' in areas with mixed levels of deprivation? Crowding out of policy (in favour of other "priorities") might be harder in these places. Likewise, little information of the socio-demographic characteristics is given of the 3 ICSs; eg. rural/urban/coastal community, previous collaborative maturity. While it is understandable that they are not named, some further contextual evidence is merited.*	We are glad the reviewer thinks the methods are sound. We have revised the methods and limitations sections of the paper to articulate the rationale and implications of our sampling approach more clearly (see response to comment 11). We have also added some additional information about the characteristics of the three ICSs we selected in the methods section (lines 117-118). As the reviewer notes, the data for the study are 32 interviews with senior health leaders (rather than analysis of other documentary evidence). We think these methods are appropriate to answer the study's research question—and we draw on wider evidence in the introduction and discussion using different methods (such as documentary analysis) to interpret our findings and put them in context.
13 *Findings:* *Generally, there is a good balance between direct evidence (through quotes) and interpretation of the findings. However, some quotes are presented sometimes with little/no interpretation, one after the other. In most cases, the (multiple) quotes are drawn from contrasting case-studies but the differences and similarities could be*	We are pleased that the reviewer thinks we've generally got the balance right between direct evidence and interpretation of the findings. Where we have included multiple quotes from different ICSs together (such as lines 282-296), this is to emphasize the commonality of a major theme from our analysis across our case study sites. We think this helps emphasize the strength and consistency of the theme from our analysis for readers, backed up by direct

drawn more clearly. More contrast between / within ICSs could be presented notwithstanding the word limit of the journal.	evidence from our interviewees. We note consistency and variation between interviewees throughout the findings section—and we often found as much variation within ICSs as we did between them.
14 *The findings tend to focus on whether or not health inequalities are being `tackled' and possibly how they are being tackled. They are more reticent about the types of inequality that ICSs are pursuing. For example, access and outcomes are mentioned in the findings section but mostly briefly as part of a quote. Since the types of equity are effectively choices to be made, the process by which they do so would be insightful.*	The reviewer is right that our interviewees (whose views we reflect and analyse in the findings section) were vague on the types of inequalities that ICSs are pursuing. This likely reflects a mix of factors reported in the paper—including lack of clarity on policy objectives, the early stage of planning for most ICSs, and the challenges prioritizing action on health inequalities. As a result, the reviewer's comment accurately reflects what we found in the study.
15 *In the section "threaded throughout…", the argument fails to draw on a reasonably extensive body of evidence regarding `mainstreaming.' Whilst much of this knowledge is ostensibly found in social policy (including gender and environment), there are numerous applications in terms of health inequalities. Examples of the mainstream research include the following: Evans and Killoran; Cairney et al; Popay.*	The findings of the paper focus on reporting and analysing the perspectives of the senior health leaders in the three ICSs included in our research. These are the data for our study (as set out in the methods). As a result, the findings section of the paper (a) does not include our analysis of other literature (eg on mainstreaming) or (b) seek to correct the interpretations of our interviewees (eg if they fail to draw on a particular theory). This means it would not be appropriate to add information or data to our findings that do not reflect the perspectives of our interviewees (see similar response to reviewer comment 19, below). However, the reviewer is right to point out that the findings link to broader literature on 'mainstreaming' (which describes a process through which something, like a focus on addressing health inequalities, becomes the norm at all levels in an organization or system). The literature on mainstreaming identifies the need for clarity on the issue being addressed to make progress on mainstreaming (among other factors, such as capabilities and enabling structures). We focus on this issue in detail in the discussion, given our findings about the lack of clarity on ICS roles and responsibilities on health inequalities (lines 367-380). In response to the reviewer's suggestion, we have added a reference to the mainstreaming literature in the relevant part of the discussion (reference 67).
16 *Implications:*	The reviewer makes good points about the need for greater collaboration in central government to reduce

The authors set a legitimate remit to focus on ICSs, but there could be some mention of the need for better collaboration centrally between government departments and agencies. To date, such coordination has been patchy but may be essential for better local coordination. Equally, the most appropriate geographical / organisational scale for tackling health inequalities (within ICSs (place or neighbourhood or entire ICS) could also have been broached.	health inequalities, as well as debates about the right geographical unit for interventions on health inequalities. However, given these are not a core focus of the analysis or findings, we have decided not to expand on them in the discussion (though have made other additions to the discussion in response to other reviewer comments, including 3, 15, and 17).
17 *It is reasonable to focus on ICSs but it is equally legitimate to ask whether the ICS approach is the only or most effective mechanism to reduce health inequalities? ICS are the primary vehicle for planning and organising NHS efforts to do so, but other actors and agents (such as general practice) might also deliver. Likewise, what has been learnt other (previous) `vehicles'? These might include, for example, public health (now a local government function); the evidence of (current and planned) local government cutbacks does not augur well for public health's contribution to tackling health inequalities. Overview and Scrutiny Committees, Health and Wellbeing Boards as well as the VCSE sector might also be addressed here.*	This is an interesting and reasonable question, and we agree with the reviewer that there are limits on what ICSs can achieve to reduce health inequalities (as we have discussed elsewhere https://www.bmj.com/content/378/bmj-2022-070910). However—whether we like it or not—ICSs have been given responsibility for reducing health inequalities by national policymakers. And the focus of this study is on understanding and analysing local perspectives on this policy objective among senior health leaders involved in ICSs. The paper includes some discussion of roles and responsibilities for reducing health inequalities—particularly the tension between the roles of the NHS and local government (lines 263-278 in the findings, and lines 391-406 in the discussion). We have also added additional text to the discussion on this question in response to reviewer comment 3 (lines 373-374). But a broader discussion on whether ICSs are the right vehicle for reducing health inequalities is beyond the scope for this analysis.
18 *Many of the findings and much of the Discussion is substantively similar to what studies found in recent policy `waves' tackling health inequalities. The article acknowledges this (eg line 60 onwards) but why did policy-makers fail to learn from this substantial body of evidence? This is not simply describing the causes and manifestations of health inequalities but more crucially for this article, how to tackle them. This lack of policy learning (or repeating similar issues such as vagueness) would appear to be an important implication for evidence-based policy-making.*	This is a helpful comment, and we agree with the reviewer. We have added text to the discussion (line 417) to emphasize this lack of policy learning more strongly. As the reviewer notes, we already put the findings and our interpretation in the context of past policy waves on health inequalities.
19	

The article does not distinguish clearly enough between health inequalities and the social determinants of health (SDH). For example, the quote (line 243) cites Michael Marmot's emphasis on SDH without acknowledging that such SDH are inequitably distributed. Policy could address "housing and jobs and things" without necessarily addressing the equity dimension. The article fails to mention the "social gradient", an emblematic feature of Marmot's overall thesis. This relates to a distinction which is implicit in the title, viz. between poverty and health. Similarly, the work of Hilary Graham is instructive in this regard.	The findings of the paper focus on reporting and analysing the perspectives of the senior health leaders in the three ICSs included in our research. These are the data for our study (as set out in the methods). As a result, the findings section of the paper (a) does not include our analysis of other literature (eg an overview of Marmot's work on social determinants) or (b) seek to correct the interpretations of our interviewees (eg if the interviewee quoted by the reviewer has not given a full account of Marmot's thesis). The reviewer is right to point out that social determinants are not equally distributed and the social gradient is a core part of Marmot's thesis. We note that social determinants, such as housing conditions, shape health inequalities when introducing the 'health care versus health inequalities' theme of our analysis (lines 214-218). But we can not add information or data to our findings that do not reflect the perspectives of our interviewees.

VERSION 2 – REVIEW

REVIEWER	Ford, John University of Cambridge, Public Health
REVIEW RETURNED	12-Feb-2024

GENERAL COMMENTS	I'm happy with the corrections in the revised manuscript.

REVIEWER	Hasman, Andreas UNICEF, Programme Group
REVIEW RETURNED	06-Mar-2024

GENERAL COMMENTS	Thank you for your responses to comments on the first submission, which I found satisfactory.

REVIEWER	Exworthy, Mark University of Birmingham, HSMC
REVIEW RETURNED	13-Mar-2024

GENERAL COMMENTS	The authors have responded well to the 3 reviewers' comments, enhancing the quality of the research presented. Whilst there remain some concerns about the responses to each set of comments, these are minor and should not delay publication. I would therefore recommend that this paper be published.