Integrated care systems and equity: prospects and plans

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Received 18 August 2022
Revised 19 October 2022
16 November 2022
Accepted 11 December 2022

Abstract

Purpose – Policies on integrated care have waxed and waned over time in the English health and care sectors, culminating in the creation of 42 integrated care systems (ICSs) which were confirmed in law in July 2022. One of the four fundamental purposes of ICSs is to tackle health inequalities. This paper reports on the content of the overarching ICS plans in order to explore how they focus on health inequalities and the strategies they intend to employ to make progress. It explores how the integrated approach of ICSs may help to facilitate progress on equity.

Design/methodology/approach – The analysis is based on a sample of 23 ICS strategic plans using a framework to extract relevant information on health inequalities.

Findings – The place-based nature of ICSs and the focus on working across traditional health and care boundaries with non-health partners gives the potential for them to tackle not only the inequalities in access to healthcare services, but also to address health behaviours and the wider social determinants of health inequalities. The plans reveal a commitment to addressing all three of these issues, although there is variation in their approach to tackling the wider social determinants of health and inequalities.

Originality/value – This study adds to our knowledge of the strategic importance assigned by the new ICSs to tackling health inequalities and illustrates the ways in which features of integrated care can facilitate progress in an area of prime importance to society.

Keywords Integrated care systems, Health inequalities, Place-based care, Organisational change

Paper type Research paper

Introduction

Many health and care systems have developed a focus on forging collaborations and partnerships across boundaries of different types in order to offer more integrated health and care to local populations. This can be *within* the healthcare structures (e.g. primary and secondary care), *between* health and social care systems; and also increasingly, between health, social care and *broader* partners in society such as voluntary services, education, welfare and criminal justice. In practice, the nature of integration varies enormously across a wide spectrum from loose partnerships to much more formal structures.

In England, policies on integration have been in place for many years, their priority waxing and waning over time in line with political interest. However, particularly since around 2014, various forms of partial integration have been encouraged (e.g. Vanguards, Sustainability and Transformation Partnerships, DevoManc), which have increasingly shifted the health and care systems towards the far end of the integration spectrum (Lewis *et al.*, 2021). This culminated in July 2022 with legislation (delayed from April 2022) that formally confirmed in law the 42 area-based integrated care systems (ICSs) in England (HM Government, 2022a). Although many of the partnerships represented in the ICSs have

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The author is very grateful to those members of staff from the integrated care systems who responded to requests for copies of their strategic plans.

Journal of Integrated Care
Vol. 31 No. 5, 2023
pp. 29-42
Emerald Publishing Limited
1476-9018
DOI 10.1108/JICA-08-2022-0044

been in place for some time, the Health and Care Act 2022 gives them statutory footing as entities responsible for planning and delivering local services for the population covered by the ICS, representing a major change in the organisation of the NHS and wider care systems. Note that different legislative and organisational arrangements on integrated care apply elsewhere in the UK (Kaehne *et al.*, 2017; Reed *et al.*, 2021).

ICSs draw together organisations and sectors to deliver on the health, public health and social care needs of the population within the ICS, taking a place-based approach (DHSC, 2022). The rationale for ICSs relates to the longstanding view that joined up, cohesive and collaborative approaches to providing care will deliver better outcomes for the population than fragmented systems that encourage duplication and overlap, with each having incentive structures that can militate against providing the best care. There is significant variation in the size, scope and nature of the 42 ICSs (NHS England, 2022), but essentially, the intention is to promote integration *within* the NHS by removing barriers to collaboration across primary, community, secondary and other care providers, as well as integration *between* the NHS and local government and non-healthcare organisations from the voluntary and independent sector such as faith groups, education, housing, leisure and transport.

The "fundamental purposes" of an ICS are defined by the government as follows: "improving population health and healthcare; *tackling unequal outcomes and access*; enhancing productivity and value for money; and helping the NHS to support broader social and economic development" (NHS England and Improvement, 2020). This paper focuses on the second of these – tackling health inequalities.

Health inequalities on the ICS agenda

The government has put addressing health inequalities at the heart of the responsibilities of ICS organisations. The focus is on the longstanding and in many respects increasingly entrenched inequalities, with deaths in the most deprived areas of the UK double the rate in the least deprived areas and significantly higher death rates in ethnic minority groups (Ford *et al.*, 2021). The failure to tackle these over many years (Taylor-Robinson *et al.*, 2019), the impact of austerity in slowing and even reversing some of the trends (Wickham *et al.*, 2019; Barr *et al.*, 2017) and the depth of the health inequalities revealed by coronavirus disease 2019 (COVID-19) (Bambra *et al.*, 2020), all reinforce the central importance to society of making progress on inequalities.

There are good reasons to expect that ICSs will be well-positioned to make progress in tackling health inequalities, not only will they have a population health perspective within a place-based geographical area, but they will be working across the boundaries of the NHS, which will enable them to address the wider determinants of health and well-being. There is a wealth of evidence – available for many years – that the economic and social conditions in which people live have a more significant impact than NHS and social care services on the health of individuals (Marmot *et al.*, 2010, 2020), with employment, housing, education, financial resources, access to transport, social capital and the physical environment, all influencing health and health inequalities. The "levelling up agenda" also reflects this approach (HM Government, 2022b) with a focus on tackling the regional economic and social disparities that underpin a wide range of geographical inequalities, including health and well-being. Place-based initiatives are widely seen as important to tackling health inequalities (Public Health England, 2017, 2021a; Local Government Association, 2021).

This paper reports on the content of the overarching ICS plans produced by a sample of ICSs in order to explore the way in which they focus on health inequalities and the strategies they intend to employ to make progress. In doing so, the main focus is on how the integrated approach of ICSs may help to facilitate progress on equity.

Data and methods

At an early stage in the research, it became clear that requesting “the ICS plan” would not be straightforward. Although all ICSs were meant to produce for NHS England, a very detailed “system plan” adhering to a format set out centrally, it was not possible to obtain these plans from NHS England. The response was that each ICS was the owner of their plan, and therefore it was necessary to approach each ICS individually to request the plan. On the contrary, many ICSs said they could not share the system plan as they were awaiting approval from NHS England, so there was a circularity in the perspectives on who owned the plan. In addition, the delay in legislation and the launch of the ICSs - which came in the middle of the research - meant that some were still updating their plans. Hence, the request was made for either their system plan (if available) or their most recent strategic ICS plan.

Initial requests were made to all 42 ICS organisations (in late 2021), using their websites as the first point of contact. Before the request was made, the websites were checked for anything that was in the public domain, but the request asked for confirmation that if so, this was the latest version. Intensive follow up was required because the contact details on ICS websites were often incorrect or not functioning, and automatic and personal replies often directed requests elsewhere. Four reminders were sent over a period of 4 months. Where no replies were received, the websites of the relevant clinical commissioning groups were trawled for alternative contact details. Where individual names of contacts were suggested, these were followed up, also with reminders when needed.

Seven ICSs either did not reply at all or suggested that they had asked someone to reply, but no further reply was forthcoming. Of the remaining 35 replies from ICSs, 12 either responded to say they were not able to share the plans as they had not been approved by NHSE or they were not in the public domain; or they sent a plan, but it was either out of date or very partial (e.g. just the people element of the ICS plan). Hence, 23 plans were included in the final sample. There did not appear to be any systematic geographical or population demographic differences between the non-responders or those who refused to send a plan, compared to the final sample.

Some ICSs had more than one element to their plan, e.g. an overview plus a more detailed plan or both a 5 -year and a 1 -year plan. Some had sets of appendices covering sub-sections of the plan in more detail. Where this was the case, all of the elements were considered. Where a plan was written earlier than 2021 or 2022, but had been updated or the ICS said they were still using an earlier plan, these were included as being the latest plan. ICSs have recently been given until the end of 2022 to produce new strategic plans but given the delays in getting plans into the public domain, it is likely to be late in 2023 before a complete new set is available for analysis, hence the plans included are likely to be in place for some time yet.

Whilst the use of software for qualitative analysis was explored, this did not offer any advantages over the use of a framework to guide the extraction of relevant information from the plans. There was limited insight to be gained from trying to quantify the use of particular words or phrases relating to equity, especially as the plans were not in a standard format. Although the key themes were set out in advance, a preliminary exploration of the plans was made in order to add any further relevant areas to include.

As some of the ICSs sent drafts of plans that were not in the public domain or sent them to the author in confidence, the analysis does not identify any of the ICSs by name.

There are numerous ways of considering inequalities but as the focus of the work was specifically on integration, this implied some key topics which formed the framework for the extraction of information from each plan. Three broad themes were identified: (1) How does equity feature in the plans? This is important because clear responsibility for tackling aspects of inequalities is, for the first time in integrated care policy in England, one of the fundamental roles of ICSs. How this role features in the ICS strategy, the perceived scope of their role and the way in which it is prioritised amongst competing demands can help determine the likely success in progressing this agenda. (2) Equity for whom? The degree to which interventions are targeted at specific disadvantaged groups or are population-wide is likely to impact on whether or not inequalities between population groups can be reduced. (3) Ways of reducing inequalities. This is the most important aspect of exploring the plans as it relates to how the ICSs believe they should approach inequalities in their local population. If they are focussed on the wider determinants of health inequalities, then their approach and the levers they have at their disposal will differ from those used to address only inequalities in access to healthcare services. The scope of these themes is expanded further below and revisited in the discussion.

Findings

How does equity feature in the plans?

All ICS plans give a high profile to reducing health inequalities, reflecting the overarching aims of the national integrated care policy, and most have this as one of a small number of strategic priorities. Indeed, tackling health inequalities is stated as *the* major priority for some ICSs, e.g. they will use the "lens of tackling inequalities" to assess all their priorities [ICS 9]; the "ultimate aim" of their strategy is to "reduce inequalities that our residents face" [ICS15] and tackling inequalities to be a "must do" foundation of every single plan [ICS11].

The majority of plans explicitly link partnership working and integration to their high level equity aims: "We will tackle health inequalities and improve the lives of the poorest fastest. We believe we can do this best by working in partnership" [ICS6]; we will "work together to drive health equality" [ICS17]; partnerships need to include a "broader church" of partners from the wider well-being and care system" [ICS13].

Ultimately, the ICSs are health and care organisations, so inequalities are usually expressed in terms of health and well-being outcomes, or in terms of process outcomes, such as access to health and care services. All plans cite mortality as a major outcome to be tackled by the ICS. Inequalities in life expectancy or healthy life expectancy are cited in all documents, either in comparison to national averages or in terms of variation within the ICS area (e.g. with gaps in life expectancy of up to 25 years across some ICSs), with a focus on increasing the average or closing the gaps within the ICS. Some plans cite inequalities in mortality linked to specific conditions, with many focussing on cancer, respiratory, diabetes and cardiovascular disease, and expressing the intention to address unequal access to services for prevention, diagnosis and treatment in these conditions. Access is measured in various ways, usually linked to utilisation or waiting times, and it is recognised that barriers to access can derive from a variety of sources, e.g. physical, language, attitudinal, distance, information [ICS16]. In particular, uptake of vaccinations and screening are highlighted in many plans as being variable across the ICS. Mental health is a central feature of many of the plans, with a focus, in particular, on reducing variations in access to services reflected in waiting times, out of area placements and also suicide rates.

As the ICSs have a primary focus on working across sector boundaries in order to address the wider social determinants of health, we would expect plans to consider the inequalities that arise *outside* of the health and care sectors, such as those in education and in the local labour market. All the plans acknowledge the importance of wider social determinants of health: e.g. "… 80% of a person's good health is influenced by social, behavioural and environmental factors …; 20% of health outcomes are determined by level of access and quality of care received" [ICS7]. Some plans document these inequalities, using information on overall deprivation, unemployment, workforce skills, pay, early childhood development, educational achievement, crime, homelessness, housing quality and air quality. Many analyse these factors by place – focussing on small areas or on parts of the ICS that have different experiences, such as those where economic success has brought good quality jobs (e.g. life sciences and bio-med) but only to a specific geographical area within the ICS [ICS5].

The role of health behaviours in causing ill health is widely acknowledged in the plans. Most plans focus on variations across their population in terms of rates of obesity, healthy eating, physical activity, alcohol and drug consumption, smoking, teenage conceptions. There is also a strong focus on health behaviours in terms of the *prevention* of ill-health as the ICSs need to manage increasing demand for health and care services and address financial challenges: “the NHS is brilliant at treating people when they are ill. But most of the things that influence whether or not we become ill are little or nothing to do with the NHS - such as where we live, our work, the air we breathe or what we eat or drink” [ICS16].

Equity for whom?

Inequalities in health can be analysed across a wide range of socio-demographic characteristics such as deprivation, gender, age and ethnicity, and this is reflected in all of the plans. The national approach to inequalities suggests that the most deprived 20% of the population (as measured by the index of multiple deprivation) should be the major focus of attention (NHS England, 2021). As outlined above, the social determinants of health have a central role for ICSs in tackling inequality, and hence, the plans present data that reflect the way these factors are associated, with a major emphasis on the geographical and place-based inequalities: e.g. “People in the most deprived 10% of the population have multiple morbidities equivalent to people 10 years older in the least deprived 10%” [ICS13]; “40% of [XX] residents and 12% in [YY] are living in most deprived areas in Britain” [ICS3]; “if the most deprived areas experienced the same rates as rest of [XX] then each year over 400 children would be healthy weight, there would be 1,000 fewer emergency admissions for older people and 60 fewer deaths from preventable causes” [ICS16]; “people living in most deprived areas experience the onset of multimorbidity 10–15 years earlier than those in the most affluent areas” [ICS21]. Some ICSs that span a varied geography also comment on inequalities related to rural or remote areas.

NHS policy also encourages ICSs to look at their local population for specific groups who may be affected outside of the “20%” most deprived, and most ICS plans highlight those which are most important in their area, which include those with severe mental ill health, disabilities, learning disabilities, autism and those with drug and alcohol problems. In addition, because of the wider remit of the ICSs for their whole population and to tackle inequalities wherever they arise, we would expect to see other vulnerable groups that face specific challenges (often in turn also linked to social deprivation) to be highlighted. Some plans indeed are explicit about their focus on some of these groups, including travellers, armed forces veterans, LGBTQ + community, unskilled workers, refugees, those in contact with the justice system, who experience violence and trauma or speak certain languages, or generally those with complex lives.

How will inequalities be reduced?

ICSs are of course expected to do more than just describe the nature and causes of the inequalities in their area – they must take action to tackle them, and this is the most important element of their approach. As a significant proportion of health inequalities is due to wider social factors which are not influenced greatly by the receipt of health and care, there is a challenge for ICSs in terms of how they will reduce inequalities. A key part of the rationale for the new organisations is to facilitate this by drawing in the partner organisations that can better influence some of the wider determinants of health and devising approaches that go beyond the health boundary. Although this is widely acknowledged (as outlined earlier), the focus of many of the priority *actions* outlined in the plans centre mainly on the health and care system or on health behaviours, which calls into question the impact these will have on the wider determinants of health. Indeed, this tendency is recognised by some of the ICSs – for example one notes that feedback from wider stakeholders and the public to earlier versions of the plans suggested the plan was still very NHS focussed and that the priorities reflected improvements in services rather than factors such as wealth, education and prevention and that partnership with the voluntary sector needed more attention [ICS7]. Another ICS noted that the integrated care partnerships tended to have strategies based on using a “clinical lens” and focussed efforts on delivery of clinical services [ICS13].

Actions falling into the health and health behaviour category tend to be more traditional approaches to tackle barriers to access to care and support, and where ICSs have identified priority clinical conditions where inequalities in outcomes are most prevalent – for instance, CVD, cancer, stroke, respiratory, diabetes – they aim to tackle the prevention, treatment and health behaviours that influence outcomes. Examples include: improving the uptake of a range of preventive and treatment services by minority and hard to reach groups by focussing on specific neighbourhoods where rates of utilisation are low; re-designing care pathways; bringing services closer to the community (e.g. mobile screening, community hubs to reach mothers and babies, risk assessment for diabetes undertaken in food banks); improving the continuity of maternal and neonatal care in deprived groups; improving physical health checks of those with serious mental health illness; increasing cultural awareness amongst staff; catering better for multiple languages; providing options for those without digital skills to access services. There are also plans in many areas to re-commission particular services in order to provide a more equitable service to those with low uptake and high risk, e.g. sexual and reproductive health services and alcohol support services. Where plans have been updated since the COVID epidemic, some ICSs stress the importance of tackling the waiting list backlog in an inclusive way that addresses inequalities in waiting times by ethnicity and deprivation. In some plans, working with partners outside of the health and care sector to tackle health inequalities arising from health behaviours is given more of a focus, for example, healthy eating strategies and messaging in schools and workplaces, place-based travel plans to enhance walking and cycling opportunities, extending social prescribing.

However, there are also many references throughout the plans to working more closely and with partners in order to try to tackle the wider determinants of health not just health services or health behaviours, although many of these are quite general and refer only to closer working with a wider group of partners: “Becoming an ICS will allow us to work together to address the factors that affect health - from jobs to housing from education to environment so it is much more than just access to health services” [ICS11]. That is not to say that nothing is happening, only that the strategic plans tend not to provide very much detail. But examples include: providing a pathway to help rough sleepers address financial and housing issues; providing digital skills training for particular groups; working with the voluntary sector to improve support for victims of violence and engaging with councils, housing associations and landlords to improve access to good quality, safe housing and fair rents. A major theme in relation to the wider determinants of health is the enhancement of economic opportunities, and this has two main strands. First, working with councils and local employers to enhance employment options, for example, trying to spread geographically located employment to wider communities, whether that be from urban settings to rural or ex-mining communities and investigating alternative career paths for people from deprived areas. Second, a core part of the plans relate to what the NHS organisations themselves can do directly as “anchor institutions” in their local communities. This concept recognises that NHS and care organisations as economic actors in their own right – they are large employers, contractors, purchasers and asset holders and have the potential to use their resources in a way that helps to address wider factors that can contribute to poor health and inequalities locally. Plans include targeting pockets of high unemployment and deprivation in recruitment strategies; seeking to make the health and care sectors more accessible for groups such as those with mental health problems; providing new pathways for working in health and social care settings, such as apprenticeships. Other partners such as the local authorities are also major anchor institutions and can act in a similar way to provide a joined-up approach to tackling inequalities in employment opportunities. Indirectly, their procurement and contracting practices can also help with employment, if they are targeted towards local business and the third sector and if they are designed to include social value considerations. There is also a focus on the role of anchor institutions in influencing other determinants of health in their communities, such as air quality and environmental sustainability, and this is reflected in many of the plans, for example, in terms of electrifying NHS transport, enhancing opportunities for digital and remote access to reduce travel, reducing plastic waste and using their land to the benefit of local populations.

Additional specific levers and facilitators for tackling health inequalities are detailed by some ICSs, and three themes emerge across the plans. First, the targeting of actions – as described above, national policy encourages the focus on the most deprived parts of the population, but some plans are more explicit than others about doing this, for example, the ICS that says they “. . . want to improve the lives of the poorest fastest” [ICS6] and those that wish to focus on groups with the biggest gap in mortality compared with the national average [ICS12]. Where an ICS covers populations with variable characteristics, they often refer to targeting, e.g. in one ICS, one of the four areas covered by the ICS is very affluent with only 3 small areas in the most deprived 20% in England, hence they will consider providing “enhanced” services and support to people in those 3 areas [ICS2]; similarly, another ICS which is overall relatively affluent will use neighbourhood teams to target those residents in the pockets of deprivation [ICS4]. Others mention that they want to achieve the biggest impact on behaviours and outcomes in these areas, e.g. greatest improvement in smoking reduction in areas where levels are currently high [ICS5]; targeting support for weight management in areas with highest obesity rates [ICS7], and similarly, support for alcohol services [ICS10], or in many plans, they wish to target areas where there are low levels of diagnosis or treatment for specific diseases. Second, and related to targeting, the use of financial levers and targeting of resources is reflected in some of the plans, for example, “ . . ..those with greatest need are the focus of investment . . .. rather than all receiving the same irrespective of need”[ICS8]; the use of “proportionate investment” across communities based on the relative needs of communities within the ICS [ICS18] and allocating resources where “they are most needed to improve health outcomes and address inequalities” [ICS20].

The third lever and facilitator relates to the use of data and evidence. ICSs are required to take a population health management approach in planning and delivery of health and care. So the analysis of local data and intelligence on health inequalities and the determinants of health is at the heart of the plans, e.g.: the desired “destination” of the ICS is to embed population health management and be informed by data and evidence [ICS20]. In some plans, details of inequalities work they have already undertaken is given, for example, analysis of waiting times, referrals and non-attenders by a range of socio-demographic characteristics underpins the development of a “waiting well” initiative for those on waiting lists [ICS22]; and the use of data segmentation techniques and risk profiles to help identify hard to reach groups. Another example is the pooling of apprenticeship levies across the ICS in order to employ population health analyst apprentices who will rotate across the ICS [ICS11]. Several of the plans note that they require better socio-economic data about their local population and also data on other factors such as learning disabilities and mental illness in order to tackle inequalities effectively. One notes that they will launch a large-scale communication exercise to gain the buy-in of the local communities to share this information by demonstrating how it will improve health [ICS8]. Undertaking equity audits and equality impact assessments more systematically is another strand within this theme. A number of the plans mention that they will use the data to develop metrics and set quantitative targets for reducing health inequalities across the ICS and some have already started that process.

Discussion

Tackling health inequalities is at the heart of the requirements for ICS organisations, and the plans indeed reflect the priority they are giving to this task, highlighting it as part of their strategic development and presenting the ICS as a means of moving on from "just managing health services" [ICS19] towards taking wider responsibility for the health of their communities, including addressing health inequalities. The partnerships with organisations beyond the healthcare system, which are an intrinsic feature of the ICS development, are recognised as being a key factor in helping the ICSs to address health inequalities as well as the wider social determinants of those inequalities. The place-based nature of the ICSs is also core to this approach, and this will also allow targeting of efforts and resources at the different geographical levels of the ICS, including lower level communities and neighbourhoods wherever inequalities exist. There is much potential in this approach given the widespread place-based inequalities that exist and the fact that these have recently become even more entrenched in areas of high deprivation. The gap in male life expectancy between the most and least deprived areas in England widened from 9.4 to 9.7 years between 2017 to 2019 and 2018 to 2020; and for females, the equivalent gap also significantly widened, rising by 0.3 years to reach 7.9 years. In both cases, the biggest decreases in life expectancy were seen in the most deprived areas (Office for Health Improvement and Disparities, 2022).

Although the content of the plans demonstrate that this is to the forefront of the ICS strategies, the ability to make headway in practice against such entrenched and worsening inequalities will depend on a wide range of factors. First, despite the intention to broaden the focus of the ICS beyond health, there may be a tendency for the organisations to revert to concentrating mainly on the delivery of healthcare services when under pressure, as indeed was noted in some of the plans themselves. In particular, the impact of the pandemic and the urgency to address some of the backlog in elective care and diagnostics may mean the focus on tackling inequalities gets side-tracked in the interests of expediency. The scale of the financial and workforce challenges may also divert attention. Keeping a long-term perspective on tackling the root causes of inequality and preventing ill-health will be key to the ultimate success of the ICSs.

A second and related point is the quality of the relationships and partnerships forged with non-health agencies and the effectiveness of these collaborations in maintaining a focus on inequalities. The governance arrangements are key because if non-NHS partners become "sidelined" by powerful NHS agencies, it will be easier for inequalities to fall off the agenda (Alderwick *et al.*, 2021a). Much has been written about whether integration, collaboration and closer working between health and non-health agencies can make an impact on health and other outcomes, and the evidence that they can is not yet overwhelming and is often said to be overstated by policymakers (Alderwick *et al.*, 2021b, 2022). The tendency for systems badged as integrated care to actually mean in practice a focus largely on health and hospital care has been noted as reflecting experience over the last decade of integrated care in England (Miller *et al.*, 2021).

Yet the commitment to collaboration and partnerships that is embedded in the ICS development does at least in principle facilitate the more joined-up approach to tackling health inequalities that has been widely called for. The plans reviewed in this study do indeed provide examples of what good partnerships have already and can in future achieve, in relation to progress in addressing some aspects of inequalities (and there will be more beyond those in the plans), so there are reasons to be perhaps more optimistic than some commentators have been. In addition, there is also a view that the pandemic demonstrated the value of closer working between the NHS, local authorities and the voluntary sector, which provides a good foundation for the ICSs partnerships (NHS Confederation, 2022).

Third, the scale of the challenge facing ICSs is very variable as the areas they cover have very different profiles in terms of health inequalities and the wider determinants of health. For example, rates of cancer mortality in the under 75 population vary from 60 to 146 per 100,000 population between ICSs; and the proportion of neighbourhoods in the most deprived fifth of neighbourhoods nationally range from less than 1% to almost 50% across ICS areas (Dunn *et al.*, 2022). Unless financial resources are geographically aligned with the scale of the challenges – and this does not appear likely to be the case (Dunn *et al.*, 2022) – then many ICSs may struggle to make headway on inequalities. Moreover, many plans noted their intentions to target efforts, services and resources on areas or groups most in need.

But if the ICSs facing the most severe gradients find themselves unable to reallocate resources locally to reflect this principle because of high demands on their overall budget, this will hinder their progress. In particular, reallocation of budgets away from the usual patterns of clinical and acute care may be very difficult without extra resources. The fact that some of the plans mention that they also have significant budget deficits to tackle, reinforces that it may be difficult to make big changes in allocations across the ICS and across different groups, especially where there may be no "quick returns" on such investments compared with other uses of resources. It has been noted that constrained funding has hindered the ability of previous integrated care schemes to achieve some of their goals and moreover has meant that cost-savings (through reduced utilisation) have become a major indicator of success *per se* (Lewis *et al.*, 2021).

Fourth, the headline attention given by most plans to the wider social determinants of health can be seen as a positive indicator that ICSs are taking seriously the need to play their role in addressing some of the social and structural barriers to addressing health inequalities. It has been suggested that earlier in the journey towards the ICS arrangements, organisations focussed largely on individual level programmes and behaviour change, rather than on population level initiatives which in turn can do more to address some of the causes of inequalities (Briggs *et al.*, 2020). It has been noted that this focus on the "downstream" effects rather than the "upstream" underlying social causes of health behaviours has also been reflected in many national level policies on inequalities, which goes some way towards explaining lack of progress over many years, despite the proliferation of policies targeted at addressing health inequalities (Mackenbach, 2010).

But although the role of social factors in health and health inequalities is headlined by all the plans, there is evidence that many ICSs are still focussing in a major way on individual health *behaviours* such as smoking, alcohol, activity and healthy eating, despite the fact the plans also acknowledge the importance of the social drivers of those health behaviours. It is interesting that some of the plans separate out the relative contributions of healthcare, health behaviours and wider social determinants of health on health outcomes, but often did not go further and link the behaviours themselves to the social context in which people live and work in their communities. Despite this, many of the plans do go further and set out ideas and ambitions that address the wider causes of ill health and inequalities, even if these are not always given in detail within these specific plans. Some promising examples include the role of the NHS and local authorities as anchor institutions trying to make progress on extending training and employment opportunities for unemployed and low paid workers; and the attempt to influence the quality and affordability of rental housing and reduction in homelessness. Tackling *both* the behavioural and the social drivers of inequalities together, rather than focussing only on one or the other approach, is necessary to deliver significant change (Marteau *et al.*, 2021), and this will also be influenced by central policy developments, rather than solely on what ICSs can do locally.

Last, if the ICSs can deliver on plans to gather more informative data on the health of their local population and relevant socio-demographic variables, and to join up and share that data effectively, this will be a major facilitator to address health inequalities. There are detailed requirements on data and digital standards set out for ICSs as part of a "digital transformation" (NHS England and NHS Improvement, 2021) and a wide range of sources of population data that can be used to understand, measure and monitor inequalities (Public Health England, 2021b). But there are also significant security, governance and cultural obstacles to overcome in this area.

This study has a number of shortcomings. The first is related to the sample. It is based on a sub-set of 23 out of 42 plans, and there is also some variation in the type of plan made available. The 23 plans covered similar ground so there was enough evidence of the general themes discussed in this paper to give a flavour of what ICSs strategic plans are in relation to health inequalities, and it is unlikely to be radically different in the remaining areas. The analysis is also based on what the ICS plans *say* rather than what they actually do/will do. Some of the detailed actions and plans for health inequalities will be contained in various other plans or reports, e.g. population health management plans. Nonetheless, this overview of the high level plans gives a useful indication of the *strategic* importance assigned to tackling health inequalities. It also illustrates the ways in which some of the main features of ICSs, such as the place-based focus and partnerships outside of health and care, can support them in their strategic aims on inequalities. Second, some of the plans had not yet been updated to reflect the recovery path from COVID. As indicated, although COVID has exacerbated health inequalities, making it even more important than ever to make progress, this could in principle also alter some of the relative priorities of ICSs if there is a drive to focus on healthcare delivery. This tendency would not have been picked up comprehensively in this study. Last, the study has not sought to detail all the features of ICSs (or integrated care more generally) that can influence the success of the new organisations, such as culture, leadership, resources, governance, budgeting arrangements, many of which have been explored by others (Cheng and Catallo, 2020; Bhat *et al.*, 2021). Instead, it has focussed only on those aspects of ICSs that are most *directly* linked with their ability to address health inequalities. Similarly, it has not sought to provide an in-depth account of health inequalities and the causes of health inequalities, focussing instead on the aspects that have particular relevance to the integrated care agenda.

Despite the shortcomings, the study adds to what we know about how ICSs may deliver on one of the core objectives given to them by the government. Given the stalling and even reversal of some of the previous improvements in reducing health inequalities, there is clearly an urgent need for ICSs to make progress. This paper has shown that there are not only good intentions, but also some more concrete promising signs that the ICSs may be able to move forward effectively with this agenda. But it is also clear that there are some significant challenges and barriers ahead, and this paper has provided some insights into what those are and how the ICS plans address them. It will be important for the ICSs to set out robust indicators to measure their success, and future research will need to focus on outcomes rather than only planned intentions.

Two final points are worth making. First, that ICS strategies and initiatives can be a key part of, but not the whole answer, to tackling health inequalities. This is because not only are there limits on the power of local place-based initiatives to have an impact (McGowen *et al.,* 2021), but also given the significance of socio-economic factors in influencing inequalities. Effective central government policies – not just in relation to health but right across government – are needed in a "whole of government" approach to tackling inequalities (Marmot *et al.,* 2020; Merrifield and Nightingale, 2021). Reviews of large bodies of evidence on the impact of integrated care initiatives in the UK and internationally suggest that improved access to some types of care is sometimes achieved

(Baxter *et al.*, 2018), but there is limited information on the resulting implications for equity of access. There is even less information on the impact on health inequalities more broadly, and results reported from integrated care in other parts of the UK have been mixed and somewhat inconsistent over time (Reed *et al.*, 2021). Individual studies of specific forms of integrated care have sometimes reported on the impact of changes in service utilisation with reference to socio-demographic factors (e.g. Piroddi *et al.*, 2022), but these do not shed light on the overall impact of large scale integration programmes on population health inequalities. A review of international examples of 15 integration "re-design" initiatives that had a specific focus on population health reported that the majority had a focus on improving equity for vulnerable populations, often via partnerships with non-healthcare partners and action to tackle the wider determinants of health (Farmanova *et al.*, 2019). Improvements in the utilisation of some types of care for some groups of people arising from the 15 initiatives was widespread, although again, due to the absence of population health measurement in most of the countries and schemes, the ultimate impact on the degree of health inequalities is not known. It is therefore important to acknowledge that integrated care by itself is not a panacea for addressing health inequalities.

Second, there needs to be enough longevity in both the structural re-organisation that accompanies the move to ICSs and the objectives and priorities with which they are tasked by governments, to give them enough time and space to make progress in the vital area of health inequalities. These are not easily influenced (or even measured) within a short period of time and indeed even less complex and potentially more immediate outcomes may not be apparent without adequate time for initiatives to run and be evaluated properly (Rocks *et al.*, 2020). In addition, the presence of competing, unclear or changing policy aims has been identified as a barrier to the success of integrated health and care initiatives (Auschra, 2018; Miller *et al.*, 2021). Hence, moving the goalposts too soon – as has often been the case in successive healthcare system reforms in England and elsewhere – will be detrimental to the ability of ICSs to play their role in improving the health and well-being of some of the most disadvantaged members of society.

References

Alderwick, H., Gardner, T. and Mays, N. (2021a), "England's new health and care bill", *British Medical Journal*, Vol. 374, p. n1767, doi: 10.1136/bmj.n1767.

Alderwick, H., Hutchings, A., Briggs, A. and Mays, N. (2021b), "The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews", *BMC Public Health*, Vol. 21 No. 1, p. 753, doi: 10.1186/s12889-021-10630-1.

Alderwick, H., Hutchings, A. and Mays, N. (2022), "A cure for everything and nothing? Local Partnerships for improving health in England", *British Medical Journal*, Vol. 378, e070910, doi: 10.1136/bmj-2022-070910.

Auschra, C. (2018), "Barriers to the integration of care in inter-organisational settings: a literature review", *International Journal of Integrated Care*, Vol. 18 No. 1, p. 5, doi: 10.5334/ijic.3068.

Bambra, C., Riordan, R., Ford, J. and Matthews, F. (2020), "The COVID-19 pandemic and health inequalities", *Journal of Epidemiology and Community Health*, Vol. 74 No. 11, pp. 964-968, doi: 10.1136/jech-2020-214401.

Barr, B., Higgerson, J. and Whitehead, M. (2017), "Investigating the impact of the English health inequalities strategy", *British Medical Journal*, Vol. 358, p. j3310, doi: 10.1136/bmj.j3310.

Baxter, S., Johnson, M., Chambers, D., Sutton, A., Goyder, E. and Booth, A. (2018), "The effects of integrated care : a systematic review of UK and international evidence", *BMC Health Services Research*, Vol. 18, p. 350, doi: 10.1186/s12913-018-3161-3.

Bhat, K., Eswarathasan, R., Jacob, M., Poole, W., Sapaetharan, V., Sidhu, M. and Thomas, A. (2021), "Identifying and understanding the factors that influence the functioning of integrated care systems in the NHS: a systematic review", *BMJ Open*, Vol. 12, e049296, doi: 10.1136/bmjopen-2021-049296.

Briggs, A., Gopfert, A., Thorlby, R., Allwood, D. and Alderwick, H. (2020), "Integrated health and care systems in England: can they help prevent disease?", *Integrated Healthcare Journal (BMJ)*, Vol. 2, e000013, doi: 10.1136/ihj-2019-000013.

Cheng, S.M. and Catallo, C. (2020), "Conceptual framework: factors enabling collaborative healthcare and social services integration", *Journal of Integrated Care*, Vol. 28 No. 3, pp. 215-229, doi: 10.1108/JICA-11-2019-0048.

Department of Health and Social Care (2022), "Joining up care for people, places and populations", CP 573, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1055688/joining-up-care-for-people-places-and-populations-print-version.pdf (accessed August 2022).

Dunn, P., Fraser, C., Williamson, S. and Alderwick, H. (2022), "Integrated care systems: what do they look like?", Health Foundation report, available at: https://www.health.org.uk/publications/long-reads/integrated-care-systems-what-do-they-look-like (accessed August 2022).

Farmanova, E., Baker, G. and Cohen, D. (2019), "Combining integration of care and a population health approach: a scoping review of redesign strategies and interventions and their impact", *Journal of Integrated Care*, Vol. 19 No. 2, pp. 1-25, doi: 10.5334/ijic.4197.

Ford, J., Sowden, S., Olivera, J., Bambra, C., Gimson, A., Aldridge, R. and Brayne, C. (2021), "Transforming health systems to reduce inequalities", *Future Healthcare Journal*, Vol. 8 No. 2, pp. 204-209, doi: 10.7861/fhj.2021-0018.

HM Government (2022a), "Health and care act chapter 31", available at: https://www.legislation.gov.uk/ukpga/2022/31/enacted (accessed August 2022).

HM Government (2022b), "Levelling up the United Kingdom CP 604 HM stationery office", available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1052708/Levelling_up_the_UK_white_paper.pdf (accessed August 2022).

Kaehne, A., Birrell, D., Miller, R. and Petch, A. (2017), "Bringing integration home. Policy on health and social care integration in the four nations of the UK", *Journal of Integrated Care*, Vol. 25 No. 2, pp. 84-98, available at: https://www.emerald.com/insight/content/doi/10.1108/JICA-12-2016-0049/full/html

Lewis, R., Checkland, K., Durand, M.A., Ling, T., Mays, N., Roland, M. and Smith, J. (2021), "Integrated care in England – what can we learn from a decade of national pilot programmes?", *International Journal of Integrated Care*, Vol. 21 No. 4, 5, pp. 1-10, doi: 10.5334/ijic.5631.

Local Government Association (2021), "Inclusive economies and healthy futures: supporting place-based action to reduce health inequalities", available at: https://www.local.gov.uk/publications/inclusive-economies-and-healthy-futures-supporting-place-based-action-reduce-health (accessed August 2022).

Mackenbach, J. (2010), "Has the English strategy to reduce health inequalities failed?", *Social Science and Medicine*, Vol. 71 No. 7, pp. 1249-1253, doi: 10.1016/j.socscimed.2010.07.014.

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeigh, D., Grady, M. and Geddes, I. (2010), "Fair society, healthy lives: the Marmot review. Strategic review of health inequalities in England post-2010", *The Marmot Review*, available at: https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf (accessed August 2022).

Marmot, M., Allen, J., Boyce, T., Goldblatt, P. and Morrison, J. (2020), "Health equity in england: the marmot review 10 Years on", *Institute of Health Equity, UCL, Health Foundation*, available at: https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on (accessed August 2022).

Marteau, T., Rutter, H. and Marmot, M. (2021), "Changing behaviour: an essential component of tackling health inequalities", *British Medical Journal*, Vol. 372, n:332, doi: 10.1136/bmj.n332.

McGowen, V.J., Buckner, S., McGill, E., Ronzi, S., Beyer, F. and Bambra, C. (2021), "Examining the effectiveness of place-based interventions to improve public health and reduce health inequalities: an umbrella review", *BMC Public Health*, Vol. 21, p. 1188, doi: 10.1186/s12889-021-11852-z.

Merrifield, K. and Nightingale, G. (2021), *A Whole-Government Approach to Improving Health*, The Health Foundation, London, doi: 10.37829/HF-2021-HL13.

Miller, R., Glasby, J. and Dickinson, H. (2021), "Integrated health and social care in England: ten years on", *Journal of Integrated Care*, Vol. 21 S2, pp. 1-9, 6, doi: 10.5334/ijic.5666.

NHS Confederation (2022), "The unequal impact of COVID-19: investigating the effect on people with certain protected characteristics", NHS Confederation, London, available at: https://www.nhsconfed.org/sites/default/files/2022-06/Unequal-impact-of-COVID-19-protected-characteristics.pdf (accessed August 2022).

NHS England (2021), "Core20PLUS5 - an approach to reducing health inequalities", available at: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/ (accessed August 2022).

NHS England (2022), "Integrated Care system leadership and websites", available at: https://www.england.nhs.uk/integratedcare/ics-leadership/ (accessed August 2022).

NHS England and NHS Improvement (2020), "Integrating care: next steps to building strong and effective integrated care systems across England", available at: https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf (accessed August 2022).

NHS England and NHS Improvement (2021), "Integrated care systems: design framework", available at: https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf (accessed August 2022).

Office for Health Improvement and Disparities (2022), "Health inequalities dashboard: statistical commentary", June 2022, available at: https://www.gov.uk/government/statistics/health-inequalities-dashboard-june-2022-data-update/health-inequalities-dashboard-statistical-commentary-june-2022 (accessed August 2022).

Piroddi, R., Downing, J., Duckworth, H. and Barr, B. (2022), "The impact of integrated care intervention on mortality and unplanned hospital admissions in a disadvantaged community in England: a difference-in- differences study", *Health Policy*, Vol. 126 No. 6, pp. 549-557, doi: 10.1016/j.healthpol.2022.03.009.

Public Health England (2017), "Reducing health inequalities:system, scale and sustainability", available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731682/Reducing_health_inequalities_system_scale_and_sustainability.pdf (accessed August 2022).

Public Health England (2021a), "Place-based approaches for reducing health inequalities: main report", PHE 2021, available at: https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report (accessed August 2022).

Public Health England (2021b), "Place-based approaches for reducing health inequalities: annex 1: data on health inequalities", PHE 2021, available at: https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-annexes#fnref:15 (accessed August 2022).

Reed, S., Oung, C., Davies, J., Dayan, M. and Scobie, S. (2021), "Integrating health and social care: a comparison of policy and progress across the four countries of the UK", available at: https://www.nuffieldtrust.org.uk/files/2021-12/integrated-care-web.pdf (accessed October 2022).

Rocks, S., Bernston, D., Gil-Salmeron, A., Kadu, M., Ehrenberg, N., Stein, V. and Tsiachristas, A. (2020), "Costs and effects of integrated care: a systematic review and meta-analysis", *European Journal of Health Economics*, Vol. 21, pp. 1211-1221, doi: 10.1007/s10198-020-01217-5.

Taylor-Robinson, D., Barr, B. and Whitehead, M. (2019), "Stalling life expectancy and rising inequalities in England", *The Lancet (Letter)*, Vol. 394, pp. 2238-2239, 10216, doi: 10.1016/S0140-6736(19)32610-8.

Wickham, S., Barr, B., Taylor-Robinson, D. and Whitehead, M. (2019), "Assessing the health impact of austerity and rising poverty in the UK", available at: https://publicmatters.org.uk/wp-content/uploads/2019/03/Liverpool_University_public_health_and_policy_response.pdf (accessed August 2022).

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