

2005 (n=5321), 2006 (n=10 213), 2007 (n=4848) were visited by an interviewer then a nurse; the interview was supplemented by physical measurements using standardised protocols. Blood pressure was measured three times with an Omron HEM207 after a 5-min rest. Mean of second and third readings in participants who had not eaten, drunk alcohol, smoked, or exercised in the preceding 30 min were used.

Main Outcome Measures Hypertension was defined as systolic blood pressure ≥ 140 mm Hg, diastolic blood pressure ≥ 90 mm Hg, and/or taking prescribed medication to lower blood pressure.

Results A higher proportion of participants in London than elsewhere in England with survey-defined hypertension were on treatment (2005–2007 average: 61% men, 66% women in London; 43% men, 55% women in England, (p for London vs rest of England <0.001 for each sex). Regression analysis showed this regional effect for odds of treatment persisted after adjustment for demographic, socio-economic, and health behaviours (OR 1.48, 95% CI 1.04 to 2.10, p=0.029) and was strengthened (OR 1.87 (1.25 to 2.81), p=0.003) by including self-reported health, long-standing illness, diabetes, and cardiovascular disease in the model. Apart from the regional differences, treatment for hypertension increased with age and was more likely among women (OR 1.59 (1.29 to 1.97), p=0.001); former smokers (OR 1.44 (1.05 to 1.99), p=0.026); and people who were married; were overweight (OR 1.40 (1.03 to 1.89), p=0.033) or obese (OR 1.80 (1.32 to 2.42), p<0.001); reported limiting (OR 2.49 (1.93 to 3.20), p<0.001) or non-limiting (OR 3.25 (2.48 to 4.24), p<0.001) long-term illness; or reported diabetes (OR 2.36 (1.60 to 3.47), p<0.001) or cardiovascular disease (OR 1.54 (1.18 to 22.02), p=0.002). Treatment was 39% and 61% less likely in widowed (p=0.004) and co-habiting participants (p<0.001), respectively, and 40% less likely in binge-drinkers (p=0.014).

Conclusion The proportion of people in London being treated for hypertension is above the national average even after adjustment for sociodemographic and health-related factors. This may be due to greater population mobility in London with more people having new Patient Health checks. Education and financial incentives for improvements in detection, treatment and control of hypertension in primary care in England have been beneficial but remain inadequate.

P58 THE DEATH OF SOCIAL FRAGMENTATION: A SECONDARY ANALYSIS OF HEALTH SURVEY DATA

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Background Social Fragmentation is the idea that isolation and disorganisation within an area influences individual health. Some, but not all, studies have shown it to be related to suicide and parasuicide risk, higher GHQ12 scores and higher admission rates for psychoses. The aim of this study is to determine if fragmentation per se affects mental health or if the association is due to other factors relating to fragmented areas.

Methods A measure of social fragmentation was constructed from four census variables (as per Condon, 1996) for each of the 890 super-output areas in Northern Ireland (avg pop. 1900). These were divided into quintiles and added to the 2005 Health and Social Wellbeing Survey (HSWB) as a contextual variable. Respondent characteristics known to be associated with mental health were included such as age and sex, marital status, living alone, perceived social support, socio-economic status (based on car availability and housing tenure) and health status (based on limiting long-standing illness (LLTI)). A GHQ-12 score of 4 or more was taken as indicative of significant psychological ill health. Logistic regression analysis was restricted to 3306 individuals aged 25–74 years.

Results As expected, people in the most fragmented quintile were more likely to be unmarried and living in single person households, much more likely to be deprived, and were more likely to have a significant psychological disorder (OR 1.70, 95% CI 1.30 to 2.24), after adjusting for age and sex. Although level of perceived social support was strongly associated with GHQ12 score, adjustment for this did not significantly explain the likelihood of poor mental health across fragmentation quintiles (OR 1.44, 95% CI 1.08 to 1.91). However, adjustment for SES and LLTI completely eliminated the association between social fragmentation and psychological ill health.

Conclusions Social Fragmentation is associated with poor mental health, but only because these areas tend to be more deprived. After adjustments are made for SES, social fragmentation has no association with the likelihood of psychological disorder. It's who you are not where you live that determines mental health. However, before we completely sound the death knell for social fragmentation we should take into consideration the recognised imperfections of the construct and modify it. Until then, policies to improve mental health should focus on reducing individual poverty and material disadvantage rather than changing the character of areas.

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RESIDENTIAL HISTORIES AND CONTEMPORARY MORTALITY GEOGRAPHY: USING DATA LINKAGE TO DEVELOP A DATA SET DESCRIBING MOBILITY BETWEEN BIRTH AND DEATH

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Background and Objectives There are marked inequalities in mortality rates between areas of Britain. These inequalities have been persistent over long time periods and evaluation of recent area-based social policies in deprived areas has found that mortality rates have proven more resistance to change than other social indicators. Migration has been considered as one process that may underlie the persistence of health inequalities between areas. The geography of contemporary mortality rates is the product of movements across the life course however analysis of mobility over long time periods has been hampered by the limited availability of the necessary data in censuses, surveys and other secondary sources. The aim of this study was to assess if new detailed data sets describing residential histories between birth and death could be created through linkage of historical and contemporary data sources and used to illuminate current mortality geography.

Methods An age- and sex-structured random sample of 250 people dying in York was selected from death registrations in 2000/2001. The addresses of the deceased were traced in birth, marriage and electoral registers, BT phone books, street and trade directories and other sources. The distance between place of birth and death, time at last residence and how migration patterns varied with individual and neighbourhood characteristics were assessed within the context of data describing the health and socio-demographic history of the case study area.

Results Key residential data were successfully traced including place of birth and number of years resident at last address, collected for over 80% of cases. Only a third of those dying within York had been born in York but the majority were born in Yorkshire. Residential histories were shaped by a sub-regional network of movements linked to the development of the local economy, slum clearance and public housing policies. While the majority of the deceased in York were in-migrants half had been at their place of death for over 10 years and some for several decades. An exception to this pattern was those dying in nursing homes who often had moved shortly before death.

Conclusion The data set of life course residential histories created demonstrates that residential movements determining place of death often took place long before death. Recent mobility is concentrated among the young but most deaths are among the least mobile, elderly population. Analyses that consider only recent mobility cannot fully capture the selection processes that underlie contemporary mortality geography.

Health inequalities

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"IT'S LIKE THE SERVICE THAT WAS NEVER THERE": A QUALITATIVE LONGITUDINAL STUDY OF LAY HEALTH TRAINER SERVICES IN THE NORTH EAST OF ENGLAND

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Background Despite considerable improvements in the overall health of the UK population, the gap between the richest and poorest groups in society continues to widen. Health trainers are a new workforce introduced in the 2004 "Choosing Health" White Paper to address these inequalities by targeting individuals from the poorest groups and supporting them to make healthy lifestyle choices. The largely grass-roots development of health trainers has resulted in a diversity of local service models that lack sound theoretical or empirical basis. However, the role provides an opportunity to enhance our understanding of the needs of typically "hard-to-reach" communities and develop tailored behaviour change interventions.

Objectives To conduct an in-depth exploratory study of the ways in which contrasting health trainer models influence behaviour change.

Design Qualitative longitudinal study, involving serial interviews conducted over a 12-month period. The interviews have been audio-recorded, transcribed verbatim and analysed using the constant comparative method associated with grounded theory.

Setting and Participants 26 clients, 13 health trainers and 5 managers theoretically sampled from 3 local health trainer services in the North East of England.

Results The health trainer services are characterised by diversity in terms of the main target groups, modes of client engagement and degree of emphasis on individual behaviour change. This has implications for the extent to which they are integrated (or not) into local public health systems, and also for the experiences of staff and service users. An emerging theme is the perception that these services are more flexible and holistic than similar lifestyle interventions, and that they address multiple priorities for clients. The importance of delivering interventions in appropriate settings was emphasised, particularly where clients have limited or negative experience of accessing other forms of support. The fact that health trainers tend to be members of the local community was often perceived to act as a facilitator of clients' ongoing engagement with the service.

Conclusions These preliminary findings highlight the potential role for health trainers in engaging with individuals from disadvantaged areas and attempting to facilitate their access into the health care system. Health Trainers are being embedded as an integral part of regional and local work on tackling health inequalities, as well as addressing a cross-government agenda. The findings of this study will be used to inform the development and evaluation of the role, as well as generating new evidence to assist practitioners in overcoming the barriers to successfully working with local communities.

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COULD DISAGREEMENT BETWEEN DOCTORS AND PATIENTS ON EVALUATING PATIENT'S HEALTH CONTRIBUTE TO WORSENING HEALTH INEQUALITIES? THE INTERMEDE STUDY

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Objective To determine whether disagreement between doctors and patients may be linked to the production of health inequalities.

Methods INTERMEDE is a multidisciplinary study of doctor/patient interaction. These results are from the quantitative cross-sectional phase. 27 GPs located in Paris, Nantes and Toulouse volunteered to participate in the study. 585 eligible patients were included after being approached in the GP's waiting room. Pre-consultation questionnaires were used to collect information on patients and doctors. Post-consultation mirrored-questionnaires were used to collect information from the GPs and patients, respectively, about what happened during the consultation. The outcome of interest is the difference between patient's perception of their own health status and patient's health status as evaluated by their doctor. Health status is categorised into three groups: very good/good; average; bad/very bad. The difference between the two health status variables provides an outcome variable indicating whether or not the patient and doctor agree on the patient's health status. Social position was measured using education level categorised into three groups: low; medium and high.

Results Patients with the highest level of education were most likely to agree with their doctors about their health status (75.4%) compared to those with a medium (74.8%) or a low (50.4%) education level. Among patients with a low education level who disagree with their doctors, 75.4% evaluate their health as being worse than their doctor's evaluation compared to 59.2% and 55.5% of those with a medium and high education level, respectively ($p<0.001$). The association was then tested in a multivariate multilevel logistic regression to adjust for a doctor-level effect as well as doctor's sex, patient's sex, age smoking, alcohol, BMI, duration of the relationship between patient and doctor in years, and frequency of consultation. Patients with the lowest education level were 4.1 times (95% CI 1.9 to 8.6, $p<0.001$) more likely to disagree with their doctor about their health status, evaluating their health as being worse than their doctor's evaluation, compared to patients with a high education level. No doctor-level effect was observed.

Conclusion Disagreement between patients and doctors on patient's health status was related to the patient's social position. Doctors underestimated their patient's health relative to the patient's own evaluation when patients had a low education level. This could potentially lead to differences in diagnosis and follow-up and consequently to exacerbating health inequalities.

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IMPROVING HEALTH EQUITY VIA THE SOCIAL DETERMINANTS OF HEALTH IN THE EU

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Objective Health inequalities between different socioeconomic groups persist throughout Europe. DETERMINE is a 3-year project supported by the European Commission which brings together a high level Consortium from 26 countries. Its objective is to support and enable policy makers and practitioners in all policy sectors to place a higher priority on health and health inequalities when developing policy. A frequent criticism of policy or action to address