

in which positions are presented, and their efforts to build coalitions in order to achieve specific policy outcomes. It finds that, while commercial stakeholders support e-cigarette regulation in general (e.g. age restrictions); there are efforts to influence regulation in a way that fits within their economic interests. This project shows that commercial stakeholders seek endorsement from public health organisations, in order to make health claims that can support the 'harm reduction argument'. The presentation will also discuss non-commercial stakeholders' arguments about whether commercial stakeholders should be included in e-cigarette policy debates or not.

P18 NEWLY AT RISK? USING HEALTH SURVEY FOR ENGLAND DATA TO RETROSPECTIVELY EXPLORE THE CHARACTERISTICS OF NEWLY DEFINED AT-RISK DRINKERS FOLLOWING THE CHANGE TO THE UK LOWER RISK DRINKING GUIDELINES

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Background Alcohol guidelines enable individuals to make informed choices about their alcohol consumption and assist healthcare practitioners to identify and offer support to at-risk drinkers. The UK lower risk drinking guidelines were revised in 2016 and the weekly guideline for men was reduced. This study sought to retrospectively establish 1) the number of additional men in England who have been drinking at increasing risk levels in the past 5 years, and 2) whether this group of newly defined increasing risk male drinkers shared any specific characteristics.

Methods Average weekly alcohol consumption data for men aged 16+ from the cross-sectional nationally representative Health Survey for England were used and regrouped into: non-drinkers; lower risk drinkers (≤ 14 units per week); newly defined increasing risk drinkers (> 14 to ≤ 21 units pw) and increasing/higher risk drinkers (> 21 units pw) in order to 1) calculate annual population prevalence estimates for newly defined increasing risk adult male drinkers from 2011–2015 ($n=3487$ – 3790) and 2) conduct a multinomial logistic regression analysis to assess which characteristics were significantly associated with men being newly defined increasing risk drinkers (reference category) versus lower risk and increasing/higher risk drinkers ($n=2982$). Models were fully-adjusted and included age-group, social class, region, smoking status, marital status, ethnicity and limiting-longstanding illness. Analyses were conducted in Stata 15.

Results Population prevalence estimates of newly defined increasing risk drinkers ranged from 10.2% of the adult male population in England (2,182,401 men) in 2014 to 11.2% (2,322,896 men) in 2011. Lower risk drinkers were significantly less likely ($p<0.05$) than newly defined increasing risk drinkers to be aged 55–64 (RRR 0.43, 95% CI 0.21 to 0.87); working in professional or managerial occupations (RRR 0.61, 95% CI 0.45 to 0.83); living in the North East (RRR 0.47, 95% CI 0.29 to 0.77), North West (RRR 0.56, 95% CI 0.38 to 0.82), West Midlands (RRR 0.52, 95% CI 0.32 to 0.83) or South West (RRR 0.57, 95% CI 0.36 to 0.91); and to be ex-regular (RRR 0.62, 95% CI 0.46 to 0.83) or current (RRR

0.56, 95% CI 0.39 to 0.81) cigarette smokers. Increasing/higher risk drinkers were significantly more likely than newly defined increasing risk drinkers to be ex-regular smokers (RRR 1.42, 95% CI 1.01 to 1.99).

Conclusion Approximately 11% of adult men would have been reclassified from lower risk to increasing risk drinkers according to the 2016 drinking guidelines. Such an increase in at-risk drinkers could impact clinical services. Newly defined increasing risk drinkers differ from lower risk drinkers on several characteristics but are largely similar to increasing/higher risk drinkers, therefore targeting this group specifically may not be feasible.

P19 DEVELOPING A FRAMEWORK FOR PRIORITY SETTING IN AN INTEGRATED HEALTH AND SOCIAL CARE SETTING

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Background There is a move, internationally, towards greater integration of health and social care. Integration, it is argued, should reduce budgetary boundaries and facilitate sharing of resources across health and social care. At local levels, delivery organisations need to alter the balance of care from acute settings to people's own home or similar community environments against a background of increasing austerity. To facilitate this shift, there is a need to use robust processes for allocating resources to make difficult decisions and to create interdisciplinary priority setting frameworks involving economists, ethicists, lawyers and decision scientists. In 2014, the Scottish Government established Health and Social Care Partnerships (HSCPs) to deliver this agenda, creating single commissioners and unifying budgets. This paper presents the early stages of a research project funded by the Chief Scientist Office, part of the Scottish Government Health Directorates with the aim to develop and implement an enhanced, multi-disciplinary framework for priority setting, for use by 4 HSCPs, and assess its impact on decision-making and resource allocation.

Methods To develop the framework, a literature review was conducted and the combined framework presented to a multi-disciplinary workshop involving academic colleagues, local and national-level stakeholders to gain feedback to develop it further. Participatory Action Research is being undertaken to explore how the framework functioned within complex settings, and how HSCP participants engaged with the framework, and consider how the framework can be adapted to the institutional setting as well as vice versa. Before and after interviews will be conducted.

Results The framework is underpinned by principles from economics (opportunity cost), decision-analysis (good decisions), ethics (justice) and law (fair procedures). It includes key stages for those undertaking priority setting to follow, including: framing the question, looking at current use of resources, defining options and criteria, evaluating the options and

criteria and a review stage. Each of these has further sub-stages and it includes a focus on how the content of the process and the framework interacts with the consultation and involvement of patients, public and the wider staff.

Discussion To assess its impact, the four sites using the framework will be compared with the remaining 27 HSCP sites. The aim of the comparison is to establish: the extent to which the remaining sites use elements of the framework; the principles and processes used for decision-making, and whether decisions have resulted in evidence-based resource shifts.

P20

ARE POLITICAL FEATURES ASSOCIATED WITH POPULATION HEALTH OUTCOMES? A SYSTEMATIC REVIEW OF INTERNATIONALLY COMPARATIVE STUDIES

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Background There are strong structural and theoretical reasons to expect politics to be an important determinant of population health outcomes. However, the most recently available systematic review of the evidence linking key political features (welfare state generosity, political tradition along the left-right axis, democracy, and globalisation) and population health outcomes contains searches only up to April 2010. Considering only internationally comparative studies, it found preliminary evidence that pro-social political features predicted better population health, but more up to date evidence synthesis is required. Therefore, the aim of this study was to present an updated systematic review on the political determinants of population health.

Methods Ten academic bibliographical databases, including MEDLINE, EMBASE, and Sociological Abstracts, were searched using search terms based on ((democracy OR autocracy OR welfare regime OR welfare state OR welfare capitalism OR politics OR political tradition OR internationality OR globalization) AND (health OR health services OR population health OR public health OR health economics OR health expenditure)). Supplementary searches were also conducted on Google Scholar and in relevant bibliographies. The final search was conducted in November 2017. We considered full-text scholarly articles or book chapters assessing the relationship between at least one of our eligible political features (welfare state generosity, political tradition along the left-right axis, democracy, and globalisation) and any population health outcome in human populations, except healthcare spending. Standardised data extraction, risk of bias assessment and narrative synthesis were conducted. Proportionate second review was conducted.

Results 73 articles were identified from the previous 2010 review. Updated database searches yielded 43 356 records (35 207 unique) and supplementary searches yielded 55. Full-text screening was conducted on 255 publications, and 176 publications (176 studies) were included, of which 106 were newly identified by our 7-year update. 79/102 studies found that increased welfare state generosity predicted greater population health. 15/17 studies found this effect for left-of-centre political tradition, as did 34/44 for democracy. Half of

identified studies suggested that globalisation may be detrimental for health. 85 studies were at low risk of bias, 89 moderate, none high, and two could not be assessed.

Conclusion The evidence shows politics to be an important determinant of population health outcomes. The public health community should engage more with the political determinants of health in research and advocacy. Further research on globalisation is required. While we provide a rigorous and timely update, resources prevented us from conducting a new systematic review from inception.

P21

THE HEALTH OF ADULTS WHO HAD BEEN IN CARE UP TO 40 YEARS EARLIER: ARE THERE DIFFERENCES BY TYPE OF CARE? FINDINGS FROM THE ONS LONGITUDINAL STUDY

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Background The adverse life-long consequences of being looked after as a child are well recognised. However, systematic evidence on outcomes for looked-after children beyond the early adult years is currently very limited.

Methods Data were used from >1 20 000 dependent children (aged <18 and never-married) in the ONS Longitudinal Study (LS) in each of the census years 1971, 1981, 1991 and 2001 (total n=495,165). Separately for each census, logistic regression was used to compare odds of long-term limiting illness and self-rated health 10, 20 and 30 years later for LS members with different care experiences in childhood (parental household, relative household, non-relative household and residential care).

Results In this nationally-representative sample of children in England and Wales, approximately 1.4% of dependent children were looked after in non-parental households, 3664 children in relative households, 2351 in unrelated households and 1007 in residential care. From 1971 to 2001, there was a general trend of an increasing percentage of dependent children residing in relative households (0.4% to 1.2%) and decreasing percentage in residential care (0.3% to 0.1%) (p-values<0.001). At 10, 20 and 30-year follow-up, LS members who had resided outside the parental home in childhood, had higher odds of a long-term limiting illness and rating their health as 'not good' vs 'good'; with the highest odds for residential care. For example, for LS members who were dependent children in 1991, odds of a long-term limiting illness 10 years later were 7.8 (95% confidence interval: 5.3, 11.4) higher for those who had resided in residential care, 1.9 (1.4, 2.7) higher in relative households and 2.4 (1.9, 3.1) higher in non-relative households, compared to residence in a parental household. For non-relative and residential care, odds ratios increased with each successive census year. The longer the follow-up period the weaker the strength of association, but with all associations remaining significant. Weaker associations were seen for self-rated health compared to long-term limiting illness.

Additional analysis to be presented will make step-wise adjustments for childhood demographics and social circumstances.