

to address “upstream” issues, a focus on short-term national targets appeared to have constrained the adoption of population-level prevention initiatives in favour of “downstream” service development approaches. Furthermore, participants anticipated increased rationing of health care in the near future. Reliable research evidence was considered essential to inform rationing decisions. However, most academic research was perceived to be aimed at clinicians. Guidelines, particularly those produced by the National Institute for Health and Clinical Excellence (NICE), as well as local data (such as hospital statistics), were currently the main sources of evidence used by policy-makers and planners. In order to facilitate future decision-making, participants requested that researchers provide unequivocal evidence on the best approaches to service delivery.

Conclusions Most policy-makers and planners rely on NICE guidance and local data rather than directly accessing research evidence. Furthermore, public health decision-making in the NHS is constrained by organisational rigidity imposed by historic budgets and short-term national targets. Recent NHS cuts have led to increased systematisation and an emphasis on the evidence base. However, these cuts have also led to a focus on downstream interventions. In future, more effective health care rationing may require additional research on models of service delivery.

P55 THE IMPACT OF NEO-LIBERAL “POLITICAL ATTACK” ON HEALTH: THE CASE OF THE “SCOTTISH EFFECT”

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Objective There is a prevalent, but as yet untested, view in Scottish society that the “Scottish Effect” (the excess mortality in Scotland after taking account of deprivation) is linked to the neo-liberal “political attack” against the organised working class implemented by the post-1979 UK Conservative governments. The objective is to develop and begin to test such a “political attack hypothesis”.

Design Development of a “political attack hypothesis” underpinned by social science literature on UK and Scotland, and by a theory of change connecting neo-liberal “political attack” and mortality. Identification of key respects in which the West of Scotland in particular would seem to have been more susceptible to negative impacts of “political attack” on key upstream determinants of mortality. Testing with relevant data.

Setting West of Scotland and comparison areas consisting of other UK and European de-industrialised areas.

Results The links between such neo-liberal “political attack” and adverse health outcomes are plausible and have been examined in other contexts, including the former USSR. Evidence from the Fraser Institute and Luxembourg Income Study indicates that a neo-liberal policy agenda was implemented in the UK to an extent not seen elsewhere in Europe. Authoritative historical accounts indicate that the West of Scotland became a particular target for the UK political attack planned by the Conservative Party prior to its election in 1979. They also suggest that Scotland was disproportionately vulnerable to its adverse effects. This is confirmed by data on industrial employment, on housing tenure and on voting trends (taken as an indication of an intensifying sense of disempowerment and loss of control within Scotland during the period in which the “Scottish Effect” is known to have emerged).

Conclusion There is some evidence to support a “political attack” hypothesis in relation to the Scottish Effect. The hypothesis offers an important avenue for further investigation. Similarly elaborated hypotheses may also have broader relevance to other contexts where a radical neo-liberal agenda has been implemented.

Area effects

P56 DOES AREA REGENERATION IMPROVE RESIDENTS’ HEALTH AND WELL-BEING?

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Background Despite £12 billion of UK government investment in the last 20 years, the impact(s) of regeneration initiatives on health remain unclear. The literature shows that some regeneration initiatives appear to have had positive effects on health, whilst others have had no, or even a detrimental effect. This however may be down to difficulties in designing appropriate evaluation studies rather than the effects of regeneration per se. Evaluations in this field have often lacked rigour and have thus rarely been able to explore the dynamic nature of area change that often accompanies the regeneration process.

This poster reports on the progress of the quantitative phase of a mixed-methods PhD study that employs a mixed-methods design to investigate the little understood effects of area regeneration on health in Scotland.

Objective To address limitations seen in previous evaluations such as: Use of small case studies to make assumptions about the successes and/or failings of regeneration programmes.

Inability to follow individuals through time so that individuals’ changing circumstances can be more securely related to the regeneration processes that they experience.

Use of unsatisfactory cross-sectional approaches that compare population characteristics before and after regeneration processes, which ignores the fact that resident population may have changed substantially during the regeneration period.

Methods This phase of the research will conduct a quantitative secondary analysis of data from the Scottish Longitudinal Study to explore the health and socio-economic effects of area regeneration on people’s health and well-being in Scotland. We will compare outcomes for individuals who experienced regeneration between 1991 and 2001 with individuals living in similarly deprived areas throughout the same period that did not.

Conclusion Area-based regeneration is seen in the UK as a strategy for tackling the poor health and health inequalities that many of the poorest members of society experience simply by virtue of their socio-economic status. Thus, unlike many past evaluations, this longitudinal study will allow us to determine how regeneration has influenced those who actually experienced it by following individuals through time. This will benefit the wider public by helping to improve the rigour of the (currently limited) evidence base, which in turn may assist in the development of more effective policy aimed at tackling socio-economic deprivation through area-based initiatives.

P57 PERSISTENT REGIONAL VARIATION IN TREATMENT OF HYPERTENSION

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Objective To investigate risk factors for treatment for hypertension in people with survey-defined hypertension in England.

Design Cross-sectional health examination surveys.

Setting Three, nationally representative random samples of the general population living in private households in England—the Health Survey for England (HSE) in 2005, 2006, and 2007.

Participants A new, nationally representative sample is selected each year. A random sample of the free-living general population (HSE

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 2.02), $p=0.002$). 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 Condgon, 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 knoll 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.

P59 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.