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2005 (n=5521), 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; 45% 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 1.57 (1.25 to 2.51), p=0.005) 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 (1.05 to 1.89), p=0.033) or obese (OR 1.50 (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.

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.