

**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

### P60 "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.

### P61 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.

### P62 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

health inequalities and one that is particularly relevant in a worsening macroeconomic climate is that there has been insufficient economic analysis or inadequate adoption of an economic perspective in these areas. The DETERMINE project sought to address this deficit in a discrete work package strand coordinated by the Institute of Public Health in Ireland.

**Design** Using a specifically designed data collection instrument, examples of economic evaluations conducted on relevant policies and actions were identified and the benefits and barriers to using economic arguments in this area were explored.

**Setting** Data were collected by partners representing Belgium, Czech Republic, England, Estonia, Finland, Iceland, Netherlands, Northern Ireland, Norway, Poland, Republic of Ireland, Scotland, Slovenia, Spain and Wales. In addition, one partner collected data at the EU level (EuroHealthNet).

**Main Outcome Measures** The rationale is that where such work has been undertaken, results should be disseminated to influence decision-making in favour of addressing health inequalities. If such work has not been undertaken it is important to understand why this is the case.

**Results** Findings show that much work is occurring and there are examples of good practice. Barriers and opportunities to progressing work were identified and described by project partners.

**Conclusions** Economic arguments are a useful approach to tackling health inequalities when used in conjunction with a range of mechanisms. Our research showed diversity across Europe regarding the desire to use such an approach as well as availability of data and tools.

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### MANDATED ATTENDANCE AT PARENTING WORKSHOPS IMPROVES WOMEN'S HEALTHCARE KNOWLEDGE BUT MAY WIDEN HEALTH INEQUITIES IN LOW AND MIDDLE INCOME COUNTRIES

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**Background** Conditional cash transfer schemes (CCTS) are relatively new policies in low and middle income countries which aim to improve the health and welfare of poor families by investing in their knowledge, skills and resources. Families are offered regular cash as long as they comply with certain conditions. One of these is that mothers/carers attend workshops where parenting and children's healthcare issues are discussed. We hypothesised that presence of a CCTS in Colombia would be associated with an increase in women's healthcare knowledge.

**Design and Setting** We analysed data from Familias en Acción, Colombia's national CCTS. Households from participating areas and control areas (matched on environmental and socioeconomic criteria) were prospectively surveyed in 2002 and 2006. Women were asked three questions on home-management of acute diarrhoeal illness (ADI), an important cause of childhood mortality for which cost-effective, home-based interventions are available. The sample comprises 5047 women from areas where Familias was operating and 3461 women from control areas.

**Outcome Measure and Analysis** A marker of healthcare knowledge was constructed from responses to survey items on home-management of ADI, using WHO guidelines to identify correct responses. The effect of Familias was estimated using an ordered probit model, controlling for individual, household and regional characteristics.

**Results** Familias was associated with nearly three-fold higher workshop attendance ( $\times 2.6$ ,  $p < 0.05$ ) and improved knowledge at follow-up (probit coefficient,  $\beta = 0.160$ ,  $p = 0.010$ ). Multivariate analysis indicated that women's age ( $\beta = -0.002$ ,  $p = 0.042$ ), literacy ( $\beta = 0.221$ ,  $p < 0.001$ ), level of completed formal education ( $\beta = 0.260$ ,

$p < 0.001$ ) and involvement in community activities ( $\beta = 0.057$ ,  $p = 0.033$ ) were independently associated with improved knowledge. Household wealth ( $\beta = 0.045$ ,  $p = 0.030$ ) and head-of-household literacy were also independently associated ( $\beta = 0.072$ ,  $p = 0.015$ ). Women's literacy (76%) did not improve.

**Conclusions** Familias is associated with increased healthcare knowledge amongst participating women. Women who are younger, literate, better educated, involved in their community and who live in better-off households with a literate head-of-household, however, show greater knowledge gain relative to other households. CCTS may widen health inequities by leaving behind women with lowest levels of completed formal education, household resources and community participation. Further thought must be given to the role these workshops play in relation to overall CCTS objectives. The most marginalised households may benefit from additional support to overcome illiteracy and strengthen community involvement.

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### SOCIAL DETERMINANTS OF DISABILITY AMONG THE IMMIGRANT POPULATION IN CHILE

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**Introduction** Chile is a middle-income country that has experienced progressive economic stability and improvement of its health status, however, one persistent and complex public health problem is disability. Social determinants of health have emerged as a significant aspect of current debates on this health problem. This analysis focuses on the international immigrants, who have not necessarily benefited from the country's economic development.

**Objective** To compare the social determinants of disability between the international immigrants and the Chilean-born population.

**Methods** Cross-sectional analysis of a Chilean population-based survey of 268 873 people. Independent variable: any disability (visual/hearing/speaking/learning/physical/psychiatric; dichotomous variable). Dependent variables: socio-demographics (age/sex/marital status/geographic location), socio-economics status (3 categories, low/medium/high, by combining income, occupation and education through complete-linkage hierarchical cluster analysis), and material living standards (overcrowding/sanitary conditions/quality of the housing). Descriptive, comparative and adjusted multiple logistic regression models were estimated using STATA 10.0.

**Results** 1% of the sample reported being an international immigrant and a further 0.67% did not respond to the question on migration status. International immigrants reported a lower prevalence of disability than the Chilean-born (3.55% vs 6.93%,  $p < 0.001$ ); and a clear inverse gradient of disability emerged by immigrants' socio-economic status. There was a significant association with single status, self-employed/public-sector employees, and being ill and retired ( $p < 0.001$ ). International immigrants living  $> 20$  years in Chile and those from Peru had a higher chance of disability (OR 2.95 and 7.85, respectively). A protective effect of living in rural areas (OR 0.99) and a negative association with adequate quality of material living standards (OR 0.96) was also found. Those who preferred not to report their migration status showed a higher prevalence of disability than the international immigrants (7.42%,  $p < 0.001$ ), particularly if they were in the poorest income quintile (OR 6.91).

**Discussion** Social determinants of disability varied between the international immigrants, those who did not respond to the migration status question and the Chilean-born population. Immigrants showed a clear inverse gradient of disability by socio-economic status. A possible healthy migrant effect was apparent among the international immigrants, but disappeared after 20 years living in Chile. Those who did not respond to the question on migration, potentially undocumented immigrants, showed some