the expense of higher numbers of deaths in both groups than in the actual scenario, and a lesser improvement in absolute inequality. The differences between the two scenarios raised ethical questions.
Conclusion When talking about health inequalities, defining desirable reductions in them, assessing trends and judging success and failure, it is important, on social justice and other grounds, to consider both absolute and relative inequality.

P1-353 CHILDHOOD CIRCUMSTANCES AND MODE OF DELIVERY

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[1,2]C Teixeira,* [1,2]S Correia, [1,2]H Barros. [1]*Department of Hygiene and Epidemiology, University of Porto Medical School, Porto, Portugal;* [2]*Institute of Public Health, University of Porto, Porto, Portugal*

Objective To assess the influence of social circumstances at 12 yrs on c-section delivery.
Methods Women (n=6827) were consecutively recruited during the assembling of a birth-cohort. Interviews were used to obtain data on social and demographic characteristics and current pregnancy events. Financial childhood circumstances were classified as low (LF) or high (HF) based on the number of amenities reported. Parents' education was defined as low (≤6 years, LPE) and high (HPE). The effect of participants' financial socioeconomic conditions on c-section risk was computed using logistic regression stratified by parents 'education.
Results Women with both high financial and educational childhood circumstances were significantly older, more educated and more frequently primiparous, with normal or underweight and reporting private antenatal care. The overall c-section rate was 35.6% varying from 32.2% (LF-LE) to 41.3% (HF-HE). After adjustment and considering women in LF-LPE as reference, we obtained OR=0.92; 95% CI 0.66 to 1.28 for LF-HPE group, OR=1.19; 95% CI 1.04 to 1.37 for HF-LPE group and OR=1.38; 95% CI 1.16 to 1.64) for HF-HPE group. Stratifying by parents' education and compared with women in LF group, those in HF group showed higher risk of c-section either in the LPE group (OR=1.19; 95% CI 1.04 to 1.37) or in the HPE group (OR=1.42; 95% CI 0.99 to 2.02).
Conclusions Our results suggest that, independently of the parents' education and the current socio-demographic conditions, the childhood financial environment may influence the mode of delivery.

P1-354 WCRF/AICR CONTINUOUS UPDATE PROJECT: KEEPING THE EVIDENCE ON FOOD, NUTRITION, PHYSICAL ACTIVITY, AND CANCER UP TO DATE

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[1]R Thompson,* [2]S Higginbotham, [1]M Wiseman, [2]D McGinley-Gieser, [1]K Allen. [1]*World Cancer Research Fund International, London, UK;* [2]*American Institute for Cancer Research, Washington DC, USA*

Introduction Understanding the causes of cancer depends on synthesising epidemiological, clinical and mechanistic evidence. Using this approach, the 2007 WCRF/AICR Expert Report defined the likely causal contributions of factors related to food, nutrition and physical activity to cancer risk, based on systematic literature reviews (SLRs) of evidence published up to 2005. For the Continuous Update Project (CUP) a team at Imperial College London (ICL) updates the previous databases as new studies are published.
Methods The CUP follows a similar process to the 2007 Expert Report. Having first combined the separate databases for the 17 cancers reviewed for the 2007 Expert Report into one database, the ICL team conducts SLRs of links between food, nutrition physical activity and specific cancer sites, and displays and analyses the evidence according to peer-reviewed protocols. An independent expert panel draws conclusions based on the updated evidence. The database is currently being updated with papers published since 2005 through a rolling programme. A complete, continuously updated database is expected by 2015.
Results An updated SLR for breast cancer was consistent with the conclusions of the 2007 Expert Report. Further reports of updated SLRs will be published on other cancers. Once the SLRs for all the cancer sites have been updated, the database will be made publicly available, and the 2007 Expert Report recommendations reviewed.
Conclusion The CUP will provide a unique resource synthesising epidemiological and other evidence on food, nutrition, physical activity and cancer, to facilitate related research, and underpin advice to public and policy-makers.

P1-355 LONG-TERM $PM_{2.5}$ AIR POLLUTION EXPOSURE AND MORTALITY AMONG CALIFORNIA RESIDENTS IN THE NIH-AARP COHORT

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[1]G D Thurston,* [1]R Lall, [1]Y Shao, [1]JiY Ahn, [2]Y Park, [1]R B Hayes. [1]*New York University, School of Medicine, New York, USA;* [2]*National Cancer Institute, NIH, Bethesda, Maryland, USA*

Introduction Epidemiological studies indicate that exposure to fine particulate matter air pollution mass ($PM_{2.5}$) is associated with an increased risk of premature mortality. Pope *et al* (2002, 2004) reported elevated mortality risks of long-term $PM_{2.5}$ exposure in the USA nationwide American Cancer Society (ACS) CP-II cohort, finding a total mortality risk of RR=1.04 per 10 ug/m^3 (95% CI 1.01 to 1.08), and a cardiovascular mortality RR=1.12 per 10 ug/m^3 (95% CI 1.08 to 1.15). We seek to evaluate the $PM_{2.5}$ association with these outcomes in another large US cohort.
Methods The NIH-AARP cohort is an ongoing prospective mortality study of more than a half million people from locations throughout the USA (Adams *et al*, 2006). Using available EPA data to interpolate exposures on a census tract level, we evaluated associations between $PM_{2.5}$ in California, the state with the largest number of cohort participants. The statistical approaches applied were similar to those used in the previously published ACS cohort research: standard Cox Proportional Hazards (CPH) modelling, including individual level covariates.
Results The CPH estimated long-term $PM_{2.5}$ risk in this NIH-AARP cohort in California was RR=1.09 per 10 ug/m^3 (95% CI 1.05 to 1.12) for total mortality. The risk found for cardiovascular mortality was RR=1.18 per 10 ug/m^3 (95% CI 1.11 to 1.24). These confirm excesses at least as great as observed in the ACS cohort.
Conclusion Analysis of mortality among California residents of the NIH-AARP cohort confirms excess total and cardiovascular risks from long-term exposure to $PM_{2.5}$.

P1-356 RELATIONSHIP BETWEEN PROPORTION OF BUDGET EXPENDITURE FOR HEALTH SERVICES FOR DISABILITY PREVENTION AND THAT FOR LONG-TERM CARE INSURANCE IN JAPAN

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Y Tomata,* M Kakizaki, I Tsuji. *Division of Epidemiology, Department of Public Health and Forensic Medicine, Tohoku University Graduate School of Medicine, Sendai, Japan*

Introduction The government of Japan encourages municipalities to promote Health Services for Disability Prevention (HSDP) to