EVALUATING THE HEALTH IMPACTS OF RESTRICTIONS TO INCOME SUPPORT FOR LONE PARENTS: A NATURAL EXPERIMENT STUDY USING UNDERSTANDING SOCIETY

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Background Lone parents experience poorer health and socioeconomic disadvantage compared to coupled parents. The UK Government has restricted access to Income Support, the primary income replacement benefit for lone parents, Under Lone Parent Obligations (LPO), lone parents are transferred from Income Support to Jobseeker’s Allowance once their youngest child reaches an age threshold (which has been reduced incrementally), and they must prove they are actively seeking work or face sanctions. We investigated the effects of introducing LPO on the health of lone mothers in the UK.

Methods We analysed 2009–2013 data from Understanding Society, a panel study representative of the UK general population. Our primary outcome was the mental health component of SF-12, with the physical health component and self-rated health assessed as secondary outcomes. We identified two intervention groups: lone parents newly exposed following the cut-off change from seven to five years and from ten to seven years. Each of these intervention groups were compared to two control groups: remaining unexposed (since the youngest child was older than the existing age cut-off), and already exposed (since the youngest child was older than the existing age cut-off). We estimated a pooled LPO effect to increase the cut-off change from seven to five years and from ten to seven years.

Results Our primary analysis included a total of 2257 participants. Mental health of lone parents consistently declined in intervention groups compared to control groups, whereas physical health and self-rated health showed little change. For lone parents with children aged 5–7 years who were newly exposed, the mental health score of SF-12 changed by −1.39 (95% CI −4.08,1.29) compared to those unexposed and −2.29 (95% CI −4.57,0.00) compared to those remaining exposed. Equivalent figures for the cut-off change from 10–7 years were −2.45 (95% CI −5.48,0.57) and −1.28 (95% CI −4.00,1.45), while for the pooled effect were −2.13 (95% CI −4.17,−0.10) and −2.21 (95% CI −4.13,−0.30). A complete case analysis and inclusion of males within the analytical sample led to similar results.

Discussion Increasing conditionality attached to the receipt of welfare benefits adversely impacted mental health of lone mothers but had no short-term impacts on physical health. Our study had limited statistical power and was only able to investigate short-term effects, but the pattern of findings was consistent across comparison groups. Planned extensions to LPO should be reconsidered.
Conclusion The review provides an overview of research strategies and measures with application and purpose described. Producing a map of how asset-based approaches are evaluated and articulating key methodological differences helps researchers and practitioners select appropriate evaluation methods. There are a number of limitations, including the use of rapid review methods which may have missed other relevant evaluation approaches. Further methodological development is needed in this field and we welcome debate about ways to evaluate asset-based approaches.

NEIGHBOURHOOD SOCIAL COHESION, ETHNICITY AND PHYSICAL ACTIVITY IN ADOLESCENTS: LONGITUDINAL EVIDENCE FROM THE ORIEL STUDY

Background Most adolescents do not achieve the recommended level of physical activity (PA) in the UK. Cultural norms – captured by ethnic identity – and social cohesion are aspects of the social environment that have the potential to influence health (behaviours). This study examines the relationships between social cohesion, ethnicity and three common types of PA in adolescents. The objectives are to test whether different types of PA have similar patterns of associations with social cohesion and ethnicity and to investigate confounding and interaction effects.

Methods We used longitudinal data from the Olympic Generation in East London (ORIEL) study. In 2012, 3088 adolescents aged 11–12 were recruited from 25 schools in four deprived and ethnically diverse boroughs of East London. Adolescents were followed-up in 2013 and 2014. Social cohesion was operationalised as trust in people living in the neighbourhood, measured on a four-point scale at wave 2. We grouped ethnic identities into eight categories. The outcomes were self-reported binary variables: walking to school, walking for leisure, and outdoor PA in the neighbourhood. We identified potential confounders. We fitted Generalised Estimated Equation models for each outcome, with a time trend and interaction effects.

Results During the follow-up of 14 years, there were 289 incident cases of T2DM (7.1 per 1000 person-years). Diabetes risk increased from higher to lower social class groups and from IMD quintile 1 (least deprived) to quintile 5 (most deprived) (P for trend=0.001). Compared with non-manual social class groups, age-adjusted HR for manual groups was 1.58 (95% CI 1.24–2.01) – this was largely attenuated (1.38; 95% CI 1.08–1.76) on adjustment for body mass index (BMI); adjustment for blood pressure, smoking, alcohol, physical activity, diet, medication and family history resulted in little attenuation while further adjustment for triglyceride levels attenuated the association. Compared with IMD quintile 1, the risk of incident T2DM was highest in IMD quintile 4 (HR=1.79; 95% CI 1.24–2.54). This largely attenuated on adjustment for BMI (HR=1.46; 95% CI 1.02–2.10), and became non-significant after adjustment for lifestyle factors (smoking, alcohol, physical activity and diet).

Conclusion Manual social class and neighbourhood-level socioeconomic deprivation was associated with an increased risk of T2DM in older British men. For social class this was mostly explained by BMI and triglycerides. For neighbourhood-level socioeconomic deprivation it was largely explained by BMI and lifestyle factors. Our results support the need for public health initiatives specifically targeting obesity as a means patterned by ethnic groups. Further analyses will jointly model the three PA outcomes to better capture the dependency and associations between the exposures and the outcomes.

Background Current evidence linking socioeconomic factors to incident Type 2 Diabetes Mellitus (T2DM) in older populations is conflicting. We investigated the prospective association of individual socioeconomic position and neighbourhood-level socioeconomic deprivation with incident T2DM in older British men, and examined possible underlying factors.

Methods A socially-representative cohort of 3487 men, aged 60–79 years in 1998–2000, from 24 British towns was followed-up for 14 years for incident cases of T2DM. Individual socioeconomic position was based on social class derived from the longest-held occupation in middle-age, and was categorised into non-manual and manual groups. Neighbourhood-level socioeconomic deprivation was based on national Index of Multiple Deprivation (IMD) quintiles; a composite score of neighbourhood-level factors (income, employment, education, disability, crime, housing and living environment), with a higher score indicating greater deprivation. Follow-up on type 2 diabetes was obtained from reviews of general practitioner records and self-reported from questionnaires. Cox proportional hazards models were used to obtain hazard ratios (HR) and 95% CI for incident diabetes according to social class and IMD quintiles. Prevalent cases of diabetes at baseline were excluded from the analyses.

Results During the follow-up of 14 years, there were 289 incident cases of T2DM (7.1 per 1000 person-years). Diabetes risk increased from higher to lower social class groups and from IMD quintile 1 (least deprived) to quintile 5 (most deprived) (P for trend=0.001). Compared with non-manual social class groups, age-adjusted HR for manual groups was 1.58 (95% CI 1.24–2.01) – this was largely attenuated (1.38; 95% CI 1.08–1.76) on adjustment for body mass index (BMI); adjustment for blood pressure, smoking, alcohol, physical activity, diet, medication and family history resulted in little attenuation while further adjustment for triglyceride levels attenuated the association. Compared with IMD quintile 1, the risk of incident T2DM was highest in IMD quintile 4 (HR=1.79; 95% CI 1.24–2.54). This largely attenuated on adjustment for BMI (HR=1.46; 95% CI 1.02–2.10), and became non-significant after adjustment for lifestyle factors (smoking, alcohol, physical activity and diet).

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