Background Obesity is associated with diseases such as cardiovascular disease and diabetes as well as mental health. Previously it was shown that the socioeconomic inequalities in adult BMI stabilised in Scotland between 2008 and 2014. The aim of this study is to describe the change in socioeconomic inequalities in BMI between 2008 and 2018.

Methods Data from the annual cross-sectional Scottish Health Survey between 2008 and 2018 for those aged 16–64 years were analysed. Survey years were grouped into 2008–2011, 2012–2015, 2016–2018 and the data were modelled using logistic modelling for outcome ‘obese/less than obese’ and linear modelling for outcome BMI, for males and females, adjusting for 10 year age group, survey year groupings and SIMD quintile. An interaction term between year and SIMD and year and age were included. Slope Index of Inequality (SII) and Relative Index of Inequality (RII) were calculated. Data were also analysed by 10-year age group.

Results Average BMI and prevalence of obesity increased from 27.2 and 24.9% in 2008 to 27.5 and 25.9% in 2018 among males, and from 27.2 and 24.9% in 2008 to 27.6 and 25.9% in 2018 among females. When broken down by age group, the majority of this increase is observed among females aged 25–34 years and 45–54 years. When the data were modelled, socioeconomic inequalities in BMI were observed for both males (eg average BMI was 0.48 (0.23, 0.73) more in SIMD1, most deprived, compared with SIMD 5) and females (eg OR of being obese in SIMD1 was 1.45 (1.28, 1.63) of SIMD5). There was a significant rise in BMI and obesity prevalence over time. An interaction term between survey year and SIMD, however showed that this rise was not observed in the two most affluent SIMD quintiles and the increase for the three less affluent SIMD quintiles rose in an approximately stepwise fashion, suggesting a widening of inequalities, eg for outcome obese/not obese, adjusting for age, sex, year and SIMD, an interaction term between SIMD and survey year showed an OR of obesity in 2008 in SIMD1 of 1.62 (1.42, 1.85) that of SIMD5, but for each additional year, OR rose by 1.03 (1.003, 1.05) for SIMD1 relative to SIMD5. Both RII and SII saw a large increase between 2012–15 and 2016–18 for males and females.

Conclusion Socioeconomic inequalities in BMI have previously thought to have plateaued, however this study shows that inequalities are now increasing.
Abstracts

Thursday 10 September
Health Policy I

OP59 STAKEHOLDER NARRATIVES OF ‘PROBLEMS’ AND ‘SOLUTIONS’: ANALYSING THE 2018 HEALTH AND SOCIAL CARE COMMITTEE ANTIMICROBIAL RESISTANCE SUBMISSIONS IN THE UNITED KINGDOM

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Background Antimicrobial resistance (AMR) is an area of global policy attention. Antibiotic resistance is often characterised as a ‘wicked problem’, because it (i) affects, and requires simultaneous action by, public, private, and third sector stakeholders, (ii) requires local, regional, national, and supranational buy-in (and implementation of strategic change) across low, middle, and high-income countries, and (iii) spans human, animal, and environmental health. The corollary to AMR being described as a wicked problem is that ‘crisis’ narratives have been adopted by public health policymakers and practitioners to marshal resources, attention, and public engagement. This AMR narrative has been co-opted at times, in order to privilege solutions promoted by and involving the private sector; with the co-optation of these solutions comes the risk of sequestering public sector funds to subsidise private sector work – in particular, in the pharmaceutical and medical diagnostics industries.

Methods There were 72 written submissions made to the 2018 ‘Antimicrobial resistance’ House of Commons Health and Social Care Committee. The sectors represented in these submissions were industry, trade associations, non-governmental organisations, professional associations, academia, government, public private partnerships, and homeopathy proponents. We accessed these documents and extracted relevant data according to the theoretically-informed critical discourse analysis (CDA) framework that we developed. Once this was complete, two researchers collaboratively coded the findings. A third researcher randomly coded a sample of the documents in order to determine reliability.

We identified the dominant and biosecurity narratives that were used by the various actors who submitted evidence. We then compared the narratives, framing, and language used by the private sector with public and third sectors, and academia. We subsequently analysed the three main promoted ‘remedies’ to the AMR problem and categorised them within a ‘market paradox’ framework.

Discussion We found that, irrespective of sector, the submissions presented the problem of AMR similarly. The solutions, however, diverged dramatically. The relevant industries use particular discursive strategies to achieve their aims, including the development of market paradoxical positions; on the one hand, asking for subsidies and incentives, but on the other hand explaining that regulation would be detrimental to ‘innovation’. We expand on these paradoxes, and catalogue the tactics used to achieve them discursively, including: obfuscating funding sources, stake inoculation, and lobbying for influence. Learnings from the unhealthy commodities industry allowed us to critically appraise the framing of industries involved in AMR.

Conclusion Overall, our CDA demonstrates that commercial interests deploying the crisis narratives do so in order to lobby heavily for self-serving solutions, namely deregulation and public subsidies. Discursive choices shaped by a technocratic-industry complex are redefining the pathways to success, monitoring, and decision-making in the global AMR arena.