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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