1. Welcome: EUPHA and ASHPER

2. Plenary Presentations: abstracts
   - Plenary Session 1: Thursday 14 November 2013, 13:00-14:00
   - Plenary Session 2: Thursday 14 November 2013, 17:40-18:40
   - Plenary Session 3: Friday 15 November 2013, 09:00-10:00
   - Plenary Session 4: Friday 15 November 2013, 16:40-17:50
   - Plenary Session 5: Saturday 16 November 2013, 14:00-15:00

3. Oral presentations: abstracts
   - Parallel Session 1: Thursday 14 November, 14:00-15:30
     B.1. Skills building seminar: Everything you always wanted to know about EU health policy but were afraid to ask
     C.1. Round table: Health (Impact) Assessments – enriching the policy cycle
     D.1. Workshop: Context matters: social and cultural factors in health behaviour research
     E.1. Round table: The silent revolution towards sustainable health care systems in Europe
     F.1. Austerity
     G.1. Child health
     H.1. Skills building seminar: A scenario building exercise for the future burden of disease in Europe
     J.1. Round table: Europe’s role in combatting non-communicable diseases in a globalized world
   - Parallel Session 2: Thursday 14 November, 16:00-17:30
     A.2. Workshop: The EU health programme 2014-2020
     B.2. Capacity building in public health
     C.2. Health determinants
     D.2. Workshop: From repair to prepare – The contribution of health to social cohesion
     E.2. Health services

4. G.2. Public health miscellaneous
   - Plenary Session 3: Friday 15 November, 10:30-12:00
     A.3. Round Table: Bridging the gap between policy and practice in Roma health: from common European goals to local achievements
     B.3. Ferenc Bojan Young Investigator Award
     C.3. Workshop: Road Traffic Accidents & Drugs and Alcohol – A public health concern
     D.3. Tobacco control
     E.3. Workshop: Quality and equity in primary care in European countries, Canada, Australia and New Zealand
     J.3. Disability
     K.3. Obesity and diabetes
   - Parallel Session 3: Friday 15 November, 13:30-15:00
     A.4. Workshop: How can public health research respond to new trends and lead to sustainable societies?
     B.4. Skills building seminar: Grant proposal writing
C.4. Environmental threats to health
D.4. Workshop: Coordinating public health: comparing innovative approaches and practices across health systems
E.4. Round table: Measuring and optimizing the impact of European health care research on policy and practice
F.4. Round table: Access to medical innovation in times of austerity: a right for all or a privilege for the wealthy?
G.4. Workshop: Children and adolescents with neurodevelopmental disorders: challenges and opportunities
H.4. Workshop: Using Health Claims Data in Health Services Research – a Blessing or a Curse?
J.4. Workshop: An Optimal European Chronic Care Framework: Towards Implementation and Benchmarking
K.4. Nutrition and eating disorders
L.4. Information and quality
M.4. Round table: Risk communication for the prevention of communicable diseases – Introducing a new risk communication paradigm
N.4. Mental disorders
O.4. Workshop: Loneliness – a public health issue?
P.4. Skills building seminar: The Miniature City concept: a new approach to making urban health comparisons

Parallel Session 6: Saturday 16 November, 09:00-10:30

A.6. Workshop: Austerity, social exclusion and health in Europe
B.6. Skills building seminar: Public Health competencies for young professionals: a 90 minute work-out to face future challenges in public health communication
C.6. Violence and sex
D.6. Tobacco and substance abuse
E.6. Assuring quality in primary care
F.6. Migrant health
G.6. Workshop: Effective public health action – examples from childhood injury prevention
H.6. Skills building seminar: Understanding, interpreting and calculating Disability-Adjusted Life Years (DALYs)
J.6. Risk factors in sickness absence
K.6. Physical activity
M.6. Prevention of infectious diseases
N.6. Workshop: Men's Mental Health
O.6. Workshop: Implementation and evaluation of integrated chronic care management in various European countries
P.6. Health inequalities 2

Moderated Poster Session: Friday 15 November, 15:00-16:00

A.5. European public health: where do we go from here?
B.5. This will build your capacity (miscellaneous)

C.5. Health determinants of children and adolescents
D.5. Evidence-based decisionmaking
E.5. Hospital care
E.5. Who is at risk?
G.5. Adolescent health and lifestyle
H.5. Health data and policy
J.5. Chronic diseases
K.5. Physical activity and nutrition
L.5. Health systems reviews and policy
M.5. Infectious diseases 1
N.5. Mental health 2
O.5. Ageing and chronic diseases
P.5. Health inequalities 1

Saturday 16 November, 11:00-12:00

A.7. European comparative studies in public health
B.7. Public health training for all
C.7. Health determinants and the environment
D.7. Methodology
E.7. Quality in health services
F.7. Consequences of austerity and equity
G.7. Perinatal and neonatal health
H.7. More health data and policy
J.7. Disability and the labour market
K.7. Lifestyles and substance abuse
L.7. Primary care
M.7. Infectious diseases 2
N.7. Mental health 3
O.7. Influencing the healthy part of ageing
P.7. Inequalities and migrants

Poster Walks: Thursday 14 November 2013, 14:00-15:30

W.1. Health promotion walk
W.2. Health services walk

Thursday 14 November 2013, 16:00-17:30

W.3. Child and adolescent public health walk
W.4. Prevalence, treatment and control of chronic diseases walk

Friday 15 November 2013, 10:30-12:00

W.5. Environmental health walk
W.6. The ASPHER president’s public health walk

Friday 15 November 2013, 13:30-15:00

W.7. Health inequalities walk
W.8. Target populations of chronic diseases walk

Saturday 16 November, 09:00-10:30

W.9. Lifestyles walk
W.10. The EUPHA president’s public health walk

6. List of authors
SUPPLEMENT

6TH EUROPEAN PUBLIC HEALTH CONFERENCE

Health in Europe: are we there yet?
Learning from the past, building the future

Brussels, 13–16 November 2013

ABSTRACT SUPPLEMENT

Guest editors: Martin McKee, Walter Ricciardi, Dineke Zeegers Paget

CONTENTS

1. Introduction
2. Plenary presentations: abstracts
3. Oral presentations: abstracts
4. Moderated poster presentations: abstracts
5. Poster walks: abstracts
6. List of authors

This publication arises from the conference “6th European public health conference” which has received funding from the European Union in the framework of the Health Programme.
1. INTRODUCTION

We are delighted to introduce this supplement to the European Journal of Public Health which contains the abstracts of papers to be presented at the 6th European Public Health Conference. It includes abstracts for the main part of the conference: plenary sessions; oral sessions (including workshops); moderated poster sessions; and poster walks.

Once again, we were delighted by the response from Europe’s public health community. We received a remarkable total of 796 abstracts for single presentations and 67 workshop abstracts, with submissions from over 50 countries. These were reviewed by the members of the International Scientific Committee, which consists of experts from all of Europe nominated by EUPHA members, EUPHA, ASPHER, the Belgian Association for Public Health, EuroHealthNet and EHMA. We are extremely grateful to them for the hard work this involved. The members of the International Scientific Committee scoring in 2013 are listed in the Box.

The review process was rigorous. Single abstracts were scored by an average of 6.76 scorers. The average score was 3.352, the highest score was 4.833, the lowest 1.000. Abstracts were accepted according to the following criteria:

- For oral presentation with a score higher or equal to 3.667 (st.dev. 0.707);
- For moderated poster with a score higher or equal to 3.200 (st.dev. 1.304); and
- For poster with a score higher or equal to 3.000 (st. dev. 0.707).

Workshop abstracts were scored by an average of 6.09 scorers. The average score was 3.509 (highest score 4.500, lowest score 2.000). Workshops with an average score of 3.500 or higher were accepted for the programme.

All of these scores were reviewed by a smaller group of Committee members at a meeting in Brussels in June. We spend several hours arranging and rearranging pieces of paper containing the titles of all of the abstracts accepted to generate piles of what we hope are coherent themes (itself a valuable exercise as we learnt much from the task of resolving many of our own differences in understanding of some key public health issues). We ended up with 15 reasonably distinct tracks:

A. European Public Health
B. Capacity building
C. Health Determinants
D. Health Determinants and Policy
E. Health Services Research
F. Austerity and Equity
G. Child and Adolescent Public Health
H. Data for Policy
J. Disability and Chronic Diseases
K. Health and Lifestyles
L. Health Systems Information and Policy
M. Infectious Diseases and Cross Border Care
N. Mental Health
O. The Ageing Population
P. Inequalities

We greatly enjoyed reading the submissions, and learned much from them. We hope that you will find this volume equally interesting, and even moreso the actual presentations, which promise to be of very high quality yet again.

Walter Ricciardi, chair of Brussels 2013
Martin McKee, chair of the International Scientific Committee
Dineke Zeegers Paget, head of the EPH Conference Office

Box: 2013 International Scientific Committee

- Martin McKee, United Kingdom (chair)
- Genc Burazeri, Albania
- Antoon de Schryver, Belgium
- Elke van Hoof, Belgium
- Johan Bilsen, Belgium
- Viviane van Casteren, Belgium
- Danijela Stimac, Croatia
- Anders Foldspang, Denmark
- Allan Krasnik, Denmark
- Gabriel Gulis, Denmark
- Christiane Stock, Denmark
- Ossi Rahkonen, Finland
- Reima Suomi, Finland
- Jutta Lindert, Germany
- Guido Nöcker, Germany
- Ulrich Laaser, Germany
- Beatrice Casini, Italy
- Fausto Felli, Italy
- Ramune Kaletiene, Lithuania
- John M Cachia, Malta
- Julian Mamo, Malta
- Natasha Azzopardi Muscat, Malta
- Aurora Timen, Netherlands
- Els Maceckelbergh, Netherlands
- Judith de Jong, Netherlands
- Jantine Schuit, Netherlands
- Marieke Verschuren, Netherlands
- Auke Wiegersma, Netherlands
- Peter van den Hazel, Netherlands
- Camilla Ihlebaek, Norway
- Johan Lund, Norway
- Stan Tarkowski, Poland
- Silvia Florescu, Romania
- Iveta Rajnicova-Nagyova, Slovakia
- Tit Albreht, Slovenia
- M. Luisa Vazquez, Spain
- Maria Rosvall, Sweden
- Ilona Koupiil, Sweden
- Kristina Alexanderson, Sweden
- Arpana Verma, United Kingdom
- Christopher Birt, United Kingdom
PARALLEL SESSION 3
Friday 15 November, 10:30–12:00
A.3. Round Table: Bridging the gap between policy and practice in Roma health: from common European goals to local achievements

Organized by: Open Society Foundations, Public Health Program
Contact: acovaci@osieurope.org

Chairpersons: Kieran O’Reilly and Alina Covaci, European Roma Rights Centre
Contact: acovaci@osieurope.org

The panel will bring together national and regional perspectives in order to explore how national challenges can be addressed through regional frameworks and how European Union tools and responses can become more relevant to local problems. It will also look at community level strategies to bring practice in line with policy, including community and civil society monitoring and legal empowerment.

The format of the workshop is a moderated interactive panel. The participants will be responding to questions from the moderator rather than making individual presentations. They will also be afforded opportunities to comment on each other’s interventions. The panels bring different backgrounds and perspectives to the panel, representing both local/national and regional viewpoints. Simona Bardu (Romani CRiSS, Romania) will reflect on the role that national level law and policy advocacy, as well as community empowerment to pursue such advocacy, play in fighting discrimination in access to health, and thereby realizing regional nondiscrimination standards at national level. Deyan Kolev (Amilpe, Bulgaria) will discuss the organization’s experiences with community monitoring in health care and how it has shaped local practices and improved accountability. A representative from the Directorate General for Justice (TBD) will address the regional legal framework on nondiscrimination in health care and the opportunities and challenges for both the EU and Roma civil society in enforcing these standards locally. A representative from the Directorate General for Health and Consumers (TBD) will discuss opportunities for involvement of civil society in strengthening the national strategies on Roma inclusion in health and improving the health outcomes for Roma across Europe.

B.3. Ferenc Bojan Young Investigator Award

Evolutions in both co-payment and generic market share for common medication in the Belgian reference pricing system
Jessica Fraeyman
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2Interuniversity Institute for Bioeconomics and statistical Bioinformatics, Hasselt University, Hasselt, Belgium
3Centre for Health Economics Research & Modeling Infectious Diseases (CHERMID), Vaccine & Infectious Disease Institute (VAXINFECTIO), University of Antwerp, Antwerp, Belgium
4Pharmacology, University of Antwerp, Antwerp, Belgium
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Background
In Belgium, a co-insurance system is applied where patients pay a part of the cost for medicines, called co-payment. The general rationale behind the use of co-payment is to make pharmaceutical consumers more responsible, increase solidarity and to avoid or reduce moral hazards.

Objectives: To study the possible influence of co-payment on sales volume and generic market share in two commonly used medicine groups: cholesterol lowering medication (statins and fibrates) and acid blocking agents (proton pump inhibitors (PPI’s) and H2 receptor antagonists (H2RA)).

Methods and data
The data were extracted from the Pharmanet database, which covers pharmaceutical consumption in all Belgian ambulatory pharmacies. First, the proportion of sales volume and costs of generic products is modelled over time for the two medicine groups. Second, we investigate the relation between co-payment and NIHDI contribution using change point linear mixed models.

Results
The change point analysis suggested several influential events. First, the generic market share in total sales volume was associated to a negative influence by the abolishment of the distinction in maximum co-payment level for brands and generics in 2001. Second, a change in reimbursement conditions for generic omeprazole (from more to less strict) stimulated generic sales volume in 2004. And third, an increase in co-payment for generic omeprazole was associated to a significant decrease in the sales volume of omeprazole in 2005. The observational analysis showed several evolutions over time. First, the amounts of co-payment for brand and generic drugs converged in the observed time period for both medicine groups under study. Second, the proportion of co-payment in total cost for simvastatin and omeprazole increased for small packages, and more so for generic than for brand products. Specifically in omeprazole, not only the proportion, but also the amount of co-payment increased over time. And third, there is a shift from prescribing small packages to larger packages over time.

Conclusions
As maximum co-payment levels decreased, over time they seem to have overruled the reference pricing system in Belgium. Also, the changes in co-payment share significantly impacted sales volume, however it is unclear who is the decisive actor on the demand-side in pharmaceutical consumption, physician or patient.

Key message
Co-payment may have a considerable influence on pharmaceutical consumption, it is however unclear who is the decisive actor here, the physician or patient.

The prospective association between obesity and major depression: a longitudinal cohort study in the general population
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Background
Obesity and major depression are important public health problems which often co-occur. However, the direction of the
association between obesity and major depression remains unclear. The objective was to examine the direction of the association between obesity and major depression, single or recurrent episode, in a longitudinal cohort study in the general population.

**Methods**

The study was performed in a cohort of 1094 participants of the Prevention of Renal and Vascular End stage Diseases (PREVEND) study in the northern Netherlands. Data were collected at baseline and at an average 2-year follow-up. Major depressive disorder as single (MDD-S) and recurrent (MDD-R) episodes were assessed by the Composite International Diagnostic Interview (CIDI 2.1). Obesity was defined as Body Mass Index ≥ 30 kg/m². Binary logistic regression was used to examine whether obesity predicted MDD-S/MDD-R or vice versa.

**Results**

The incidence of obesity was 19.8 per 1000 person-years. The incidence rates of MDD-S and MDD-R were 24.5 and 1.9 per 1000 person-years, respectively. Prospective analyses showed that obesity was associated with the onset of MDD-R (OR = 11.01, 95%CI (1.08, 112.09)) during 2-year follow-up, but not with the onset of MDD-S (OR = 0.75, 95%CI (0.24, 2.30)). Neither MDD-S nor MDD-R were associated with the development of obesity during 2-year follow-up (OR = 1.64, 95%CI: 0.64, 4.22) and (OR = 2.26, 95%CI: 0.84, 6.22), respectively.

**Conclusions**

Obesity was associated with the onset of MDD-R, but not MDD-S. The diagnosis of MDD-S or MDD-R was not associated with the development of obesity over a 2-year period. The findings add to the understanding of the association between obesity and major depression—single or recurrent, and need replication in a large sample. This finding has important implications for public health. It in particular calls for monitoring of mood among obese individuals, and early treatment of mood disorders where needed. This could ultimately reduce the burden of depression.

**Key messages**

- Obesity was associated with the onset of major depressive disorder—recurrent (MDD-R), but not major depressive disorder—single (MDD-S) episode.
- Neither MDD-S nor MDD-R were associated with the subsequent development of obesity.

**The organigraph method to map responsibility in implementing child safety policies and interventions**

Katharina Förster

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**Issue/problem**

Effective advocacy for change in healthy policies and interventions requires knowledge of which actors are involved in the adoption, implementation and monitoring phase. This is often not transparent, particularly in the area of child safety where multiple sectors are often involved. Advocacy efforts could be facilitated by a tool that provides a way to explore and describe existing relationships between actors involved in a given intervention. The mapping of responsibilities through the organigraph method is tested for its usefulness in this research.

**Description of the problem**

Mintzberg and van der Heyden developed organigraphs as a method to better show how organisations really work. This method was developed further by the authors to illustrate how policies in child safety are developed and implemented across the EU, national and regional/local levels including the mandated responsibilities of actors involved in the process and their relationships. Over the course of a year, professionals working in child safety in 25 European countries were instructed to draw organigraphs of a chosen intervention or policy in one of the four domains: road, water or home safety or intentional injury prevention. In addition, a Brussels based NGO mapped EU governance of child safety.

**Results (effects/changes)**

The resulting organigraphs show a variety of approaches to child safety governance. Authors of the organigraphs report that the process of drawing improved their understanding of their own work and made them engage with other stakeholders in the field. The results show that most interventions cause local level action, even if an intervention is established at the national or regional level. Interestingly there was limited acknowledgement of EU-level action on child safety governance in many organigraphs.

**Lessons**

The organigraphs identify how action on child safety works in practice, the many sectors involved in prevention and at what level relevant action takes place. The organigraph method provides a useful tool for professionals to assess their own activities and networks, and to foster collaborations among relevant stakeholders in the field.

**Key message**

- The organigraph method provides a method to gain in-depth insight into the varying approaches of child safety governance. It can also be applied to other health policy fields.

**Elderly from lower socioeconomic groups are more vulnerable to mental health problems, but area deprivation does not contribute: a comparison between Slovak and Dutch cities**

Martina Behanova

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¹Graduate School Kosice, Institute for Society and Health, Safarik University, Kosice, Slovak Republic
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³Slovak Public Health Association – SAVEZ, Kosice, Slovak Republic
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**Background**

Little is known about factors associated with mental health problems (MHP) of the elderly in socioeconomically deprived neighbourhoods, and comparisons between Central European and Western European countries on this topic are lacking. We examined whether MHP occurred more frequently in deprived neighbourhoods and among deprived people. Next, we examined whether the association of MHP with area deprivation differed by country and whether this could be explained by the socioeconomic characteristics of the residents.

**Methods**

We obtained data on non-institutionalised residents aged 65 and above from the EU-FFP: EURO-URHS 2 project from Slovak (N = 665, response rate 44.0%) and Dutch cities (N = 795, response rate 50.2%). An elevated score on GHQ-12 ≥ 2 indicated MHP. Education and household income with financial strain were used as measures of individual socioeconomic status. We employed multilevel logistic regression.

**Results**

Overall rates of MHP were significantly higher in Slovakia (40.6%) than in The Netherlands (30.6%). The neighbourhood-unemployment rate was not associated with the mental health of elderly in either country. Rates of MHP were significantly higher among elderly with low and medium income (odds ratio, OR = 1.75, 95%-confidence interval, CI = 1.16-2.62; OR = 1.64, 95%-CI = 1.12-2.41, respectively)
and financial strain (OR = 2.26, 95%-CI = 1.56-3.28) when compared with those with high income and no strain, respectively. Individual-level socioeconomic characteristics explained a part of the between-country differences.

Conclusions
The risk of MHP among the elderly is associated with their individual-level socioeconomic position, but not with neighbourhood deprivation in both Slovakia and The Netherlands. Policies targeted at poverty prevention and economic deprivation can help in prevention of mental health problems.

Key messages
- Neighbourhood SE indicators were not associated with mental health of the elderly.
- MHP of the elderly are explained by their individual-level SE position and not by the area they live in.

Does the type of welfare regime influence associations between life course socioeconomic position and the quality of life of older Europeans?
Claire Niedzwiedz

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Background
Studies comparing socioeconomic inequalities in health in different welfare regimes have demonstrated they may not be narrower in more egalitarian types. A key aim of the welfare state is to maintain a reasonable level of quality of life for its citizens, but few studies have examined quality of life as an outcome. Most studies have used one indicator of socioeconomic position (SEP) from a single time-point. We examine the magnitude of social inequality in the quality of life of Europeans aged 50 to 75 years, using different measures of SEP from across the life course, and the role of the welfare state in influencing these associations.

Methods
Data from 13 countries (N = 15,649) were derived from Waves 2 and 3 of the Survey of Health, Ageing and Retirement in Europe, collected during 2006-07 and 2008-09. Slope indices of inequality (SIIs) were calculated for the association between indicators of SEP and CASP-12, a measure of positive quality of life. Multilevel linear regression was used to assess the overall relationship between SEP and quality of life, using interaction terms to investigate the influence of the type of welfare regime (Southern, Scandinavian, Post-communist or Bismarckian).

Results
Socioeconomic inequalities in quality of life were present in all welfare regimes and across different dimensions of SEP from both childhood and adulthood. More proximal measures of SEP were associated with larger inequalities, wealth displayed the strongest association among both men (SII = 3.85, 95% CI: 3.45 to 4.26) and women (SII = 3.97, 95% CI: 3.57 to 4.37). Effect modification by welfare regime was apparent. Compared to the Scandinavian welfare regime, where narrow inequalities in quality of life by education level were found in both men (SII = 0.15, 95% CI: -0.97 to 1.27) and women (SII = 0.97, 95% CI: -0.10 to 2.05), the gap in quality of life was particularly wide in Southern and Post-communist regimes.

Conclusions
Scandinavian and Bismarckian welfare regimes experienced higher overall quality of life and narrowest socioeconomic inequalities. In some regimes the impact on quality of life of being poorly educated is worse than experiencing a limiting illness.

Key messages
- Our study is the first to examine the effect of welfare regimes on social inequalities in the quality of life of older people, using measures of socioeconomic position from across the life course.
- Results suggest social policies providing comprehensive welfare benefits and wealth redistribution may help cut the quality of life gap between socioeconomic groups in older people across Europe.

Austerity’s health effects: a comparative analysis of European budgetary changes
Aaron Reeves

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2Department of Medicine, Stanford University, Palo Alto, United States
3Department of Public Health and Policy, LSHTM, London, United Kingdom
4Department of Epidemiology and Public Health, University College London, London, United Kingdom
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One aspect of the austerity-debate that has received far less attention in the political arena is the impact of reduced spending on health. To examine this, we first examine what has actually happened to different types of government spending across Europe. We use comparable budgetary data between 2009 and 2011 from 25 EU countries taken from EuroStat’s Government Expenditure Dataset, 2013 edition. First, we compared spending cuts across Europe. Monetary units were adjusted for inflation and purchasing-power-parity to facilitate valid cross-national comparisons. From this perspective, the UK’s austerity package was the third largest in Europe, behind Greece and Luxembourg. By contrast, Sweden, Poland, and Germany substantially increased social spending. Second, to assess which groups were most adversely affected by austerity measures, we disaggregated government budgets into types of spending. Across Europe, health budgets have seen the largest cuts between 2009 and 2011, followed by reductions to housing and community funds. Regarding social protection, cuts to sickness and disability benefit contributed most to overall budget cuts, followed by family support (including early childhood development programmes) and unemployment benefits. We show how austerity might be expected to affect health in Europe. Here we describe the two economic mechanisms that are likely to have significant health effects: i) exacerbating the socioeconomic consequences of recession (including rising unemployment, debt, poverty, and homelessness), and ii) worsening the health effects of these socio-economic risk factors. Using the United Kingdom as a case study we show, first, that reductions in public-sector unemployment can be expected to increase depression and suicide rates. Second, 30,000 adults are now at risk of poverty due to the abolition of the Disability Living Allowance and its replacement with Personal Independence Payments. Finally, there has been a 40% rise in those newly defined as homeless concurrent with cuts to the social housing budget. In the United Kingdom, as with most of Europe, the burden of budget cuts are falling most greatly on disabled, low-income, and unemployed persons. These cuts are expected to exacerbate health inequalities.

Key messages
- Across Europe, health budgets have seen the largest cuts between 2009 and 2011, followed by reductions to housing and community funds.
- In the United Kingdom, as with most of Europe, the burden of budget cuts are falling most greatly on disabled, low-income, and unemployed persons. These cuts are expected to exacerbate health inequalities.
Could birth weight predict feeding behaviours in early life? Cross-cultural comparisons within three European population-based cohorts
Andrea Oliveira
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4School of Social and Community Medicine, University of Bristol, Bristol, United Kingdom
5Faculty of Food and Nutrition Sciences, University of Porto, Porto, Portugal
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Background
Biological plausibility supports that birth weight, as a surrogate of intrauterine environment, could influence child’s feeding behaviours, but there is a lack of population-based evidence. We aim to prospectively relate birth weight (standardized for gestational age) with feeding behaviours at different ages in three European population-based cohorts: Generation XXI (Portugal), ALSPAC (UK) and EDEN (France).

Methods
Analyses were conducted within the HabEat project (http://www.habeat.eu/). Caregiver’s perceptions on feeding behaviours were assessed at 4-6, 12-15, 24 and 48-54 months. Children born small (SGA), appropriate (AGA) or large (LGA) for gestational age were defined based on sex-specific Kramer standards. Associations were estimated by odds ratio and 95% confidence intervals (OR, 95%CI), obtained from logistic regression (maternal age, education, pre-pregnancy body mass index (BMI), smoking, breastfeeding duration, number of older siblings, birth type, child’s z-score BMI as confounders).

Results
Children born SGA presented higher odds of eating small quantities at each meal at 4-6 months in the Portuguese (OR = 1.97, 95%CI = 1.35-2.86) and UK cohorts (OR = 1.26, 95%CI = 1.05-1.51) compared to AGA children. These associations did not remain at older ages. A model without adjustment for child’s current BMI, showed these associations in all three cohorts at 4-6 months, and in at least one cohort associations were found at older ages as well. Conversely, children born LGA were less likely to refuse foods after 12 and 48-54 months in the UK cohort (OR = 0.81, 95%CI = 0.63-1.05, OR = 0.80, 95%CI = 0.61-1.06, respectively).

Conclusions
The results suggest that compared to AGA children, feeding behaviours differ between SGA and LGA children. The effects were weakened after adjustment for child’s BMI, suggesting that caregiver’s perception of child’s poor eating could be influenced by child’s weight. As feeding problems are persistent throughout childhood and increase the risk of other behavioural and psychosocial problems, their early identification, followed by parents’ advice and support may reduce feeding difficulties, and potentially improve childhood growth and future health.

Funding from FP7/ 2007-2013 under the grant agreement n° FP7-245012-HabEat.

Key messages
- Birth weight could predict different feeding behaviors during early childhood, which may influence childhood growth and future health.
- Caregiver’s perception of child’s poor eating could be influenced by child’s weight.

Do children with disabilities in Kazakhstan live in different families than healthy children?
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Background
According to UNICEF, there are about 150 million children with disabilities worldwide. In Kazakhstan, 62081 or 1.2% of all children are disabled. However, there have been no publications about families with children with disabilities in Kazakhstan.

Objective
To study the main problems in families with children with cerebral palsy and to assess whether these families differ from other families by socio-demographic characteristics in Kazakhstan.

Methods
A cross-sectional study. All 192 families residing in a town of Semey (former Semipalatinsk) were invited and 175 of them participated. Their socio-demographic characteristics were compared to those of 180 families selected at random in the same town. Moreover, both types of families were asked about the main problems (they could select 0-3 out of 9). Categorical data were compared using chi-squared tests. Continuous data were analyzed using Mann-Whitney tests.

Results
The main problems reported by the families with a child with cerebral palsy were child disability (71.4%) followed by material deprivation (38.8%) and hopelessness (12.6%) while in families with children without disabilities the three most common answers were ‘we do not have problems’ (58.9%), material deprivation (21.1%) and lack of free time (19.4%). Differences between groups were significant (p < 0.001). Families with a child with cerebral palsy were more likely to be single-parent families (20.6% vs. 5.6%, p < 0.001). Mothers in families with disabled child were less likely to have higher education (30.3% vs. 40.0%, p = 0.007) and be a housewife (68.0% vs. 36.1%, p < 0.001). Fathers in these families were also less likely to have higher education (31.7% vs. 45.9%, p = 0.026) and be a white-collar worker (36.0% vs. 55.3%, p = 0.006). No differences in parental age, ethnic background and the number of children in the family between the groups were observed.

Conclusions
We observed significant social differences between families with children with and without disabilities. Given that many families with children with disabilities report poverty and hopelessness as main problems, better support should be provided to these families should be improved. Further research is needed on the effectiveness of the services provided to these families.

Key message
- We observed significant differences between families with children with and without disabilities by marital status, education and occupation of both parents.