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

Guest editors:
Martin McKee
Walter Ricciardi
Dineke Zeegers Paget
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
I.1. Round table: Europe’s role in combating non-communicable diseases in a globalized world
J.1. Noncommunicable diseases
K.1. Noncommunicable diseases
L.1. Round table: European Health Information System: Steps from idea to reality
M.1. Cross border care
N.1. Preventing alcohol related harm
O.1. Health for older adults
P.1. Workshop: Tools for addressing regional health inequalities

Parallel Session 2: Thursday 14 November, 16:00-17:30
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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
G.2. Public health miscellaneous
H.2. Workshop: Health expectancy: an overarching population health outcome indicator for health policy
J.2. Workshop: Risk factors for disability
K.2. Workshop: Fact or fiction: ‘European physical activity policies are evidence-informed’
L.2. Workshop: Improving public health information systems across Europe: which contribution of syndromic surveillance?
M.2. Workshop: Measles in Europe: Challenges in the field
N.2. Mental health
O.2. Workshop: Age-related changes in health in European populations
P.2. Inequalities

Parallel Session 3: Friday 15 November, 10:30-12:00
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B.3. Ferenc Bojan Young Investigator Award
C.3. Workshop: Road Traffic Accidents & Drugs and Alcohol – A public health concern
D.1. Tobacco control
E.1. Workshop: Quality and equity in primary care in European countries, Canada, Australia and New Zealand
G.1. Workshop: The changing face of European school meal culture – implications for public health
H.1. Workshop: Assessing and addressing non-response in population health studies
J.1. Disability
K.1. Obesity and diabetes
L.1. Workshop: Towards an integrative European perspective on health human resources policy: how and why?
M.1. Public health and infectious diseases
N.1. Skills building seminar: Well-being concepts and measurement
O.1. Workshop: Pampers or pamper? Should we celebrate an ageing population or fear it?
P.1. Inequalities

Parallel Session 4: Friday 15 November, 13:30-15:00
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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
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P.4. Skills building seminar: The Miniature City concept: a new approach to making urban health comparisons

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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

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B.5. This will build your capacity (miscellaneous)
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ABSTRACT SUPPLEMENT

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

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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 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
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
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- Christiane Stock, Denmark
- Ossi Rahkonen, Finland
- Reima Suomi, Finland
- Jutta Lindert, Germany
- Guido Nöcker, Germany
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- Julian Mamo, Malta
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- Peter van den Hazel, Netherlands
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- Johan Lund, Norway
- Stan Tarkowski, Poland
- Silvia Florescu, Romania
- Iveta Rajnicova-Nagyova, Slovakia
- Tit Albreht, Slovenia
- M. Luisa Vazquez, Spain
- Maria Rosvall, Sweden
- Ilona Koupil, Sweden
- Kristina Alexanderson, Sweden
- Arpana Verma, United Kingdom
- Christopher Birt, United Kingdom
J.5. Chronic diseases

A UK feasibility study on the value of singing for people with Chronic Obstructive Pulmonary Disease (COPD) September 2011 to June 2012

Ian Morrison

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Background
COPD is an umbrella term for a number of specific conditions (primarily bronchitis and emphysema) leading to irreversible airflow obstruction. COPD is characterised by a ‘spiral of decline’: ‘As COPD progresses, patients fail to exercise, feel depressed, and experience low self-esteem.’ In England, approximately 835,000 people have been diagnosed with COPD, but the true prevalence is likely to be over 3 million. Exacerbation of COPD is the second most common cause of emergency admissions to hospitals in the United Kingdom and one of the most expensive conditions treated by the NHS with direct costs of £810-930 million per year, which are expected to rise. COPD mainly affects people beyond retirement age, but 24 million lost working days a year are due to COPD. The Department of Health consultation on a strategy for COPD in England 2010 highlighted the need to improve prevention efforts, support early identification, ensure accurate diagnosis and ensure high quality care of people with the disease and at the end of life. The strategy lays particular emphasis on the third sector taking responsibility for contributing to service change and improvement.

Aim
To explore the feasibility of weekly community singing for people with COPD and to assess impact on lung function, functional capacity, breathlessness, and quality of life.

Methods
An uncontrolled observational study of a weekly group singing programme was undertaken over the period September 2011 to June 2012. The St. Georges Respiratory Questionnaire (SQRQ), MRC breathlessness scale, EQ-5D and York SF-12 were administered at baseline, mid-point and end of study, and spirometry to assess lung function at baseline and study end.

Results
Health-related quality of life assessed by SQRQ showed a 3.29 point change in the direction of health improvement \([-3.29 (-6.14; -0.45); p=0.024]\). Improvements were also found in FEV1 %, FVC and FVC%.

Conclusions
Health improvements are encouraging as COPD is a progressive illness and a decline in health would be expected over ten months. The study provides a good foundation for designing a more robust controlled community trial.

Key messages
- Regular group singing is an innovative, cost-effective initiative to help people with COPD engage in physical and social activity to support independence and quality of life.
- The success of this study indicates the need for a larger-scale controlled study on singing and COPD, and to build an evidence base.

The economics of chronic kidney disease stage 5 (CKD5) on renal replacement therapy (RRT) in Romania: is a cost-effectiveness analysis (CEA) sufficient to assist with planning for treatment requirement?

Andreea Steriu

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Background
Chronic kidney disease stage 5 (CKD5) with end-stage renal failure (ESRF) is uncommon but expensive to treat, despite advances in technology. Appropriate and equitable service provision requires good quality information on the population served: how many people require treatment, how much does it cost, what are the benefits? In Romania this information is in limited supply.

Methods
Costs were estimated in 3 Romanian centres for: annual average cost of haemodialysis (HD) based on the number of dialysis sessions per patient-year; annual average cost of continuous ambulatory peritoneal dialysis (CAPD) based on the initiation session and the variable component of this cost; and transplant costs based on the maintenance medication documented in all centres as well as from the National Renal Register. Shared costs (overheads) were also estimated. Life-years gained (LYG) were computed as the sum of months alive for each type of RRT. The final cost/LYG ratio was calculated as the total cost of treatment for new patients (proportionate centre’s total cost) divided by total LYG, for each centre.

Results
All 3 centres provided HD, 2 centres provided CAPD and there were small numbers of transplants in 2 of the 3 centres. The marginal cost of HD per LYG over no RRT varied between centres by up to 41%. The marginal cost of CAPD per LYG varied by 47%. The marginal cost of HD/LYG over CAPD varied between centres by 11 to 15%. Annual maintenance costs for transplants were the lowest of the three modalities, but with no Romanian data on costs of transplantation during the first post-transplant year, estimates had to be based on the international literature.

Conclusions
Haemodialysis was more expensive than CAPD in the two centres where both modalities were provided, by 11% and 15%. Kidney transplantation is the most cost-effective RRT method in studies elsewhere, and in this study transplant maintenance costs were lowest. However neither this study nor other Romanian sources could provide reliable costs for the first post-transplant year, as so the evidence base for efficient RRT services is incomplete in Romania.

Key messages
- Cost effectiveness analyses are useful planning health economics tools.
- Incomplete information weakens the evidence base for efficient services.

The mediating effect of coping on the association between fatigue and quality of life in patients with multiple sclerosis

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Background
Fatigue, as one of the most common symptoms in patients with MS, has various adverse effects on patients’ physical and...
mental health-related quality of life (PCS, MCS). The aim of this study is to explore whether coping mediates the relationship between fatigue and PCS and MCS.

**Methods**

We collected 197 consecutive MS patients (response rate: 71%; 76.3% women, mean age 40.2 ± 9.7). Patients completed the Short-Form Health Survey (SF-36) for measuring PCS and MCS, the Multidimensional Fatigue Inventory (MFI-20) for measuring fatigue and the Coping Self-Efficacy Scale (CSE) for measuring coping. The mediating effect of coping was analysed using multiple linear regressions and the Sobel test.

**Results**

In PCS coping strategies were significantly associated only with the ‘general fatigue’ dimension. The indirect effect of coping strategies on relationship of fatigue and quality of life varied from 6.6% to 16.9%. In MCS, the significant indirect effect of coping strategies was found in all fatigue dimensions. The values of indirect effect in MCS varied from 20.1% to 32.2%.

**Conclusions**

Coping is a significant mediator of the association between fatigue and MCS in all fatigue dimensions, while the association between fatigue and PCS coping seems to be much less important. These results should be taken into account when planning educational programs for patients, their caregivers or physicians and can also be helpful in the therapeutic process, especially based on Cognitive Behavioural Therapy.

**Key messages**

- Coping strategies are significant mediators in the relationships between all dimensions of fatigue and MCS.
- Regarding PCS, they mediate the relationships between general fatigue and PCS.

**Cervical cancer in the Semey region, Kazakhstan: incidence and mortality in 2008-2012**

Andrej Grjibovski

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**Background**

Cancer cervix is the second most common cancer among women. Association between radiation and cancerogenesis is well-established. Semey (former Semipalatinsk) is a town adjacent to the Soviet nuclear tests site in Kazakhstan. However, little is known about epidemiology of cancer in this region.

**Objective:** To study the incidence of and mortality from cervical cancer in Semey, Kazakhsan in 2008-2012.

**Methods**

Data on all cases of cervical cancer that occurred in the town of Semey during the study period were obtained from the Semey Regional Cancer Registry.

Population size was obtained from the Regional Bureau of Statistics. Standard World Population was used for calculation of the age standardized mortality and incidence rates.

**Results**

Altogether, 365 primary cases of cervical cancer were registered during the study period. The incidence increased from 10.0 per 100,000 in 2008 to 13.2 per 100,000 in 2012. Most cases occurred in age-group 40-44 years (19.5%) followed by 35-39 years (16.2%) and 50-54 years old (13.2%). Mortality rate increased from 4.7 in 2008 to 7.2 in 2012. Most women who died from cervical cancer belonged to age-group 70-74 years (12.4%) followed by age-groups 40-44 years (11.1%) and 50-54 years (11.1%).

**Conclusions**

Both incidence of and mortality from cervical cancer in Semey, East Kazakhstan increased in recent years. Both indicators exceed the average for Eastern Kazakhstan region and the whole country. This might be partly explained by either delayed effects of nuclear tests performed at Semipalatinsk test site or by other factors, which will be discussed.

**Key message**

- Both incidence of and mortality from cervical cancer in Semey, East Kazakhstan increased in recent years.

**Regional distinctions regarding standardised mortality and prevalence of chronic respiratory diseases in Russian Arctic: results of National population study**

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**Background**

Both chronic respiratory diseases (CRDs) and cardiovascular diseases (CVDs) are well-established. Semey (former Semipalatinsk) is a town located in the Russian Arctic.
Russian Arctic with 5% of national population seems to face bigger burden of chronic respiratory diseases (CRD) in Russia, which is neglected despite the economic importance of the region.

The aim of the study is to analyse regional distinctions regarding age-standardised CRD mortality and prevalence in Russian Arctic.

Methods

The CRD death rates from National statistics 2010 data for population aged 25-64 from selected Arctic regions were standardized and analyzed according to European standards. Data from National multi-centre population based study with randomly selected subjects aged 35-64 (N = 3771; RR = 81%) in selected regions with different environmental conditions and comparable regarding CRD mortality. Yakutsk (Russian Arctic), Chelyabinsk (industrial) and Vologda (midland Russia) were analysed. Chi-squared tests and odds ratios (OR) were utilized; multiple logistic regression was employed to analyse association between CRD, smoking patterns and regional distinctions.

Results

Results showed CRD mortality rates from twice higher to national average with contribution to overall mortality up to 7.4%. Men had significantly higher CRD mortality rates. CRD together with CVD and Cancer resulted as cause of death of 57-64% population of Russian Arctic and of 91% male population of Arkhangelsk Oblast aged 25-64.

The prevalence of CRD in National sample was 21.9%: 23.1% in men, 21.1% in women; while half did not have CRD diagnosis (p < .001). Yakutsk had highest rates of COPD: 28.9% - 28.6% in men, 29.1% in women compared to the other regions (p < .001). Chances of CRD were significantly higher among heavy smokers–10.5 times in men (OR 5 = 10.5; 95%CI 5.4-19) and 5 times in women (OR 95%CI 2.8-8.8). The odds of CRD in Yakut people were significantly higher–2.2 times in men (OR = 2.2, 95%CI 1.6–3) (p < .001) and 3.5 times in women (OR = 3.5, 95%CI 2.7-4.6) (p < .001) compared to Vologda. The status of hyperborean had the highest significant contribution to chances of CRD, comparable only with heavy smoking status.

Conclusions

Russian Arctic population faces high premature CRD mortality, higher prevalence of CRD, with biggest contribution of smoking and environmental factors. Findings allow to set priorities in developing integrated preventive programs to address the regional inequalities.

Key messages

- Working-age population in Russian Arctic regions face higher prevalence of CRD and CRD mortality compared with National average with significantly bigger contribution to overall mortality.
- Environmental factors together with smoking make biggest contribution to chances for CRD that has to be considered when developing integrated preventive programs to address the regional inequalities.

Health related quality of life assessment amongst people with cystic fibrosis in Belgium

Simeon Situma Wanyama

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K.5. Physical activity and nutrition

Transition in Romania: not only a matter of politics

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The nutritional transition is a modern notion, referring to the shift of diets in developing nations from a traditional, wholesome diet, to one with energy dense items. It is generally accompanied by a shift in the morbidity profile, the “abundance illnesses”, like diabetes and cardiac diseases, dethroning the infectious ones. Emerging ex communist countries are confronted, after the change of regime, with complex peculiar patterns of transition, explaining partially the