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 the world
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 inequities

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

G.2. Public health miscellaneous
H.2. Workshop: Health expectancy: an overarching population health outcome indicator for health policy
J.2. 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
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
G.3. Workshop: The changing face of European school meal culture – implications for public health
H.3. Workshop: Assessing and addressing non-response in population health studies
J.3. Disability
K.3. Obesity and diabetes
L.3. Workshop: Towards an integrative European perspective on health human resources policy: how and why?
M.3. Public health and infectious diseases
N.3. Skills building seminar: Well-being concepts and measurement
O.3. Workshop: Pampers or pamper? Should we celebrate an ageing population or fear it?
P.3. Inequalities

Parallel Session 4: 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)
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

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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.
0.5 km were reported by 38% of women in 2000, but only 29% in year 2011. The trend was similar in men. Poor vision was 50% less common in year 2011 than in 2000, but hearing difficulties were equally common at both time points. A larger proportion of older persons performed well in cognitive tests in 2011 than in 2000. The proportion of those reporting difficulties in basic activities in daily living declined. Most of the changes in social functioning were positive, but some negative trends were also noted: a smaller proportion of older adults reported not having a close relationship or not getting practical help and participation in various activities increased whereas meeting friends decreased.

Conclusions
Functioning of Finnish older population has markedly improved from 2000 to 2011. This has partly balanced the growing need for treatment and care induced by the aging of the population. The favorable development implies that an increasing proportion of the elderly is able to live at home independently and participate in various activities and voluntary work, and take care of relatives. Maintaining the positive development will require intensive efforts to improve the determinants of good functioning, including good living conditions, adequate treatment and care as well as healthy behavior.

Key message
- The functioning of Finnish older population has markedly improved from 2000 to 2011.

Alcohol use disorders and risk of Parkinson's disease: findings from a Swedish national cohort study 1972-2008
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Background
Little is known about the aetiology of Parkinson's disease (PD). Alcohol has been suggested to either be protective of, or not associated with PD. However, experimental studies indicate that chronic heavy alcohol consumption may have dopamine neurotoxic effects relevant for PD. The aim of the present study was to study the association between diagnosed alcohol use disorders and PD.

Methods
All men and women in Sweden that had been admitted with either a diagnosis of an alcohol use disorder or appendicitis (serving as comparison group) between January 1, 1972 and December 31, 2008 were identified through the Swedish National Inpatient Register, and followed for up to 37 years for a diagnosis of PD. Diagnostic codes according to the Swedish version of the WHO International Classification of Diseases (ICD-8, 9 and 10) were used. Information about deaths was obtained from the National Cause of Death Register. We estimated hazard ratios (HR) with 95% confidence intervals (CI), for development of PD among men and women hospitalized for an alcohol use disorder and adjusted for age and sex.

Results
We identified 1,761 (0.3%) cases of PD in the total cohort of 602,930 individuals, 1,101 (0.4%) among those admitted with an alcohol use disorder and 660 (0.2%) of the individuals admitted with appendicitis. The mean follow-up time was 13.6 and 17.1 years, respectively. The risk for PD was increased by 40% in the individuals with an alcohol use disorder compared to the group with appendicitis, HR 1.40 (1.27-1.55) when adjusted for age and sex. When the risk was estimated in age groups for first hospital admission with PD the highest risk was observed in the lowest age group, ≤44, HR 2.58 (1.05-6.31), adjusted for age at exposure and sex. In the age group 45-59 the HR was 1.85 (1.31-2.60), in age group 60-74, 1.89 (1.61-2.21), and ≥75 years 0.92 (0.79-1.10).

Conclusions
We found an increased risk of admission with a diagnosis of PD for both women and men with a history of an alcohol use disorder. In particular, the risk of PD was higher at lower ages of first admission with PD.

Key messages
- Heavy alcohol consumption may increase the risk of PD which is the second most common neurodegenerative disease following Alzheimer's disease.
- Given the high level of excessive alcohol use in the population, an increased risk of a serious neurodegenerative disease like PD is of public health importance.

Quality of life profiles across five chronic diseases: implications for chronic condition management
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Background
Chronic disease puts a huge burden on both the individual and society through increased health care utilisation and loss of productivity. It is well-known that chronic disease negatively impacts quality of life (QoL) but the comparative impact across diseases is under-studied. This has implications for chronic disease care. The objective of this study, therefore, is to compare QoL among five chronic diseases in Slovakia.

Methods
Data was collated from five patients' databases: rheumatoid arthritis (n = 296), end-stage renal disease (n = 220), Parkinson’s disease (n = 175), multiple sclerosis (n = 165), and coronary heart disease (n = 710). QoL was measured using the SF-36 which has proven to be a valid and reliable tool across diseases. QoL profiles were developed to visualise similarities across diseases while Kruskal-Wallis tests and General Linear Modelling (GLM) were used to statistically compare the diseases, controlling for socio-demographic factors.

Results
Mental quality of life (MCS) is much more similar across the five diseases than physical quality of life (PCS). Although emotional role limitation is the only dimension of the SF-36 that is similar across all diseases (p = 0.074, Kruskal–Wallis), similarities occur in every dimension and component summary of quality of life. Scores that are similar across three or more diseases include mental component summary, general health, physical role limitation, mental health, social functioning and vitality.

Conclusions
The results of this study show that QoL, particularly mental QoL, is similar across chronic diseases. This supports the idea that patients with different conditions may benefit from similar care and provides further support for introducing mixed self-management programs to chronic disease care.

Key messages
- Mental quality of life is much more similar across the chronic diseases than physical quality of life.
- Patients with different conditions may benefit from similar care and in particular introduction of the mixed self-management programs to chronic disease care.
Socioeconomic differences in work disability due to depression

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Background
In addition to decreased quality of life, depression causes substantial work impairment. In the Global Burden of Diseases, Injuries, and Risk Factors Study 2010, major depressive disorder ranked 2nd in terms of years lost due to disability. Previous studies have found a socioeconomic gradient in depression, but there have been controversial results regarding socioeconomic status (SES) and return to work (RTW) after depression.

Methods
We examined socioeconomic differences with four indicators of SES: occupational position, educational level, residence size, and residence ownership. Work disability due to depressive disorder (≥9 days) according to the International Classification of Diseases 10th revision, codes F32-F34 and RTW after a depressive disorder were the outcome variables. The study was a prospective cohort study among Finnish public sector employees (n = 125,355) during 2005-2011.

Results
We found a consistent inverse socioeconomic gradient in work disability due to depression. In the model adjusted for confounders and other SES indicators, manual workers had a 1.35-fold (95% CI = 1.13-1.61), and lower-grade non-manual workers had a 1.32-fold (95% CI = 1.17-1.50) increased risk compared to upper-grade non-manual workers. Employees with basic education had a 1.52-fold (95% CI = 1.25-1.85), and employees with secondary education had a 1.32-fold (95% CI = 1.17-1.50) increased risk when compared to employees with higher education. Employees with residence size less than 70 m2 had a 1.23-fold (95% CI = 1.08-1.41) increased risk when compared to those with residence size of more than 100 m2. Finally, those living in a rented residence had a 1.30-fold (95% CI = 1.16-1.45) increased risk for work disability due to depressive disorder when compared to home-owners. Of the disability episodes due to depressive disorder (>9 days), 62% ended in less than two months, and 90% ended during the follow-up. In the adjusted model, depression had a 1.30-fold (95% CI = 1.16-1.45) increased risk when compared to those with residence size less than 70 m2, and employees with basic education had a 1.23-fold (95% CI = 1.08-1.41) increased risk when compared to employees with higher education.

Conclusions
SES should be taken into account in the attempts to reduce social inequalities in work disability due to depression and in the promotion of returning to work after depression.

Key messages
- There is a consistent inverse socioeconomic gradient in work disability due to depression as measured by occupational position, education, residence size, and residence ownership.
- Returning to work after work disability episode due to depressive disorder is slower for employees with basic education when compared to employees with higher education.

Risk factors for suicidal behaviour in people on disability pension due to common mental disorder in Sweden (2005-2010)

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Background
This study aimed to examine the association of different socioeconomic factors and health care consumption with subsequent suicidal behaviour (suicide attempt and suicide) among individuals on disability pension (DP) due to common mental disorders (CMD).

Methods
This is a population-based prospective cohort study based on register linkage. All individuals aged 16-64 years, living in Sweden on 31-Dec-2004 who in 2005 were on DP due to CMD (N = 46,745) were followed with respect to suicide attempt and suicide (2006 - 2010). Univariate and multivariate hazard ratios (HR) and 95% Confidence Intervals (CI) with regard to suicidal behaviour were estimated by Cox regression.

Results
In total, 1046 and 210 individuals attempted and committed suicide, respectively, during the follow-up. Preliminary analyses suggest that young age (16-24 years) and not obtaining upper-secondary education were associated with an increased risk of suicide attempt (HR 2.1; 95% CI: 1.5-2.8 and HR 1.6; 95% CI: 1.3-1.9), respectively. Being single without children living at home was associated with a 20% and 90% increased risk for suicide attempt and suicide, respectively. Prescription of antidepressants during 2005 as well as inpatient care due to mental disorders and suicide attempt (2001-2005) were strong predictors for suicidal behaviour (range of HR 1.4-3.2), while inpatient care due to somatic disorders (2001-2005) was only predictive of suicide attempt.

Conclusions
Young age, low education, living alone, as well as health care consumption due to mental and somatic disorders were predictive of suicidal attempt, while low education, living alone and mental health care consumption increased the risk of suicide in individuals on DP due to CMD. From a public health perspective it is important to be aware of these risk factors when designing strategies to prevent suicidal behaviour in this group.

Key messages
- When designing public health measures to prevent suicidal behaviour in disability pensioners due to CMD, individuals with young age, low education, and living alone should be particularly considered.
- Special attention should also be given to individuals with health care consumption due to mental and somatic disorders as well as suicide attempt.

A life-course study on effects of parental risk factors on suicide attempt in individuals born in Sweden 1973-1983

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Background
Research on the temporal relationship of parental risk factors with offspring’s suicide attempt is scarce and a life course approach has not been applied to date. We investigated the temporal relationship of parental morbidity and mortality with offspring’s suicide attempt and whether any such association was modified by offspring’s age at attempt.

Methods
We designed a case-control study through linkage of Swedish registers. Cases comprised all individuals in Sweden born 1973-1983 with inpatient care due to suicide attempt (15-31 years of age) and with information on both biological parents (N = 15,193). Ten controls were matched to each case. Conditioned logistic and spline regressions were applied.