Conclusions
Education, occupational status, and income are all independent determinants of long sickness absence. Part of the effect of education is mediated by occupational status and income. Further research is needed to explore these pathways in more detail.

Disparities in the participation rate and the results of mass screenings of national health insurance between the disabled and the non-disabled

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Background
Because the disabled have high prevalence rates and early onsets on chronic diseases than the non-disabled, participation in mass screening is important for health promotion and maintenance of chronic diseases with the disabled. The purpose of the study is to analyse the different participation rates in the NHI mass screening and prevalence of chronic diseases based on the results of NHI mass screening between the disabled and the non-disabled.

Methods
The disabled were identified using the National Disability Registry (2003). From 2000 to 2003, the participation rates and prevalence of chronic disease were compared between the disabled and the non-disabled based on the result of NHI mass screening, which are provided by the National Health Insurance of Korea for 12 million people every year.

Results
The difference in the participation rates between the disabled and the non-disabled was 6.3–8.8%: the participation rates of mass screenings were 37.1 and 43.4% (disabled versus non-disabled) in 2000; 33.5 and 41.7% in 2001; 34.7 and 43.5% in 2002; and 40.9 and 48.3% in 2003. The prevalence rates of diseases per 10 000 participants were higher in the disabled: 49 versus 19 (disabled versus non-disabled) in lung diseases; 189 versus 126 in hypertensions; 103 versus 83 in hyperlipidemia; 204 versus 150 in liver diseases; 80 versus 59 in renal diseases; and 39 versus 33 in anaemia.

Conclusions
Significant disparities in the participation rates of mass screening services were found between the disabled and the non-disabled although the prevalence rates of chronic diseases were higher in the disabled than in the non-disabled.

Employees long-term sickness listed due to psychiatric diagnoses: a prospective cohort study in Sweden with regard to sick leave and disability pension over three years

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Background
In recent years there has been a dramatic increase in sickness absence owing to psychiatric diagnoses in Sweden. Such sickness absence is anticipated to be extremely long; however, the knowledge regarding this is limited. The aim of this study was to describe the magnitude of sickness absence and disability pension (DP) in a cohort of employees long-term sick listed with psychiatric diagnoses.

Methods
A prospective cohort study of 5014 employees in Sweden who in 1996 were aged 20–65 and had a new sick-leave spell >90 days owing to psychiatric diagnosis. Register data of sickness absence and disability pension for 1996–2002 were obtained. Logistic regressions were performed to calculate odds ratios (ORs) of sick leave and DP according to socio-demographic attributes with 95% CIs.

Results
The year before including the mean number of absence days/person was low: 17 days/person/year whereas in 2000 it was 211 days/person/year. Twenty-six per cent had been granted DP in 2002 with a significant over-representation of men. However, a higher proportion of women than men had long-term sickness absence. Of all the 5014 subjects, 1764, that is 35%, had <17 sick-leave days in 2002. The OR of having short (<17 sick-leave days), moderate (17–90 days), and long sick-leave (91–365 days) decreased with age. The reverse was found for obtaining DP. Low socio-economic status was an independent predictor for an increased risk of obtaining DP (OR = 3.43, 95% CI 2.30–5.12).

Conclusions
As many as 35% had very low rates of sickness absence 3 years after inclusion. Gender differences disappeared when controlling for age and socio-economic status. This cohort of long-term sickness absence with psychiatric diagnoses did not have a previous history of long-term sickness absence, which is in contrast to persons regarding long-term sickness absence with back pain.

Track 4: Workshop: Positioning health promotion and prevention within public health—challenges and pitfalls

Chairpersons: Ursel Broesskamp-Stone, Petra Plunger*
Organiser: Joint session of the Health Promotion Foundations in Austria and Switzerland

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This session will be opened by a 'round table discussion'. The *aim* is to jointly identify key challenges and pitfalls with respect to the positioning of health promotion and prevention in national and European fields or systems of Public Health. The results of the session will be carried forward to the next EUHPA Conference 2006 in Montreux, Switzerland. The session will have two parts: the first part starts with different perspectives with key persons in European Public Health, with an orientation towards health promotion and disease prevention, who will provide short opening statements. This will lead into a round table discussion with high-level representatives of the two national health promotion foundations in Austria and Switzerland. It is expected that, in the second part of the session and sparked by the statements and round table discussion, session participants will actively step into the debate and search for answers.

Part 1: Round Table Discussion (50 min). Three statements addressing the questions and core theses will open this part.

Dr Bertino Somaini, Director of Health Promotion Switzerland, and Mr Dennis Beck, Director of the Austrian Health Promotion Foundation (tbc) will have a discussion with

international colleagues and particularly emphasise the questions put forward.

Part 2: Moderated discussion with all participants (40 min). This discussion will be centred around the questions and theses, and other selected key issues that may have emerged during the round table discussion.

The role of health promotion in improving population health—experiences from Swedish public health policy

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What does/what can health promotion contribute to the goal achievement of the field of Public Health and of (national) Public Health systems, particularly with respect to the goal of improving population health? Lessons learned from the Swedish public health policy.

- What is the potential of guiding principles, such as empowerment, advocacy, fostering participation, and building partnerships?
- How have the action areas put forward in the Ottawa Charter for Health Promotion (1986) contributed to a broad public health perspective, e.g. in Sweden?

Core theses:

- Through advocacy for health, health promotion fosters and emphasizes a broad perspective on health, with specific emphasis on social determinants and root causes of health/disease. In doing so, it strives for equity-oriented strategies to improve population health.
- Health promotion carries forward the settings-based approach and working in networks. In doing so, it fosters participation and cooperation on the personal and organizational levels as one important prerequisite for improving health.
- Prerequisites for health, core principles, and action areas as stated in the Ottawa Charter for Health Promotion (1986) are mirrored in the 11 general objectives of the Swedish national public health policy, aiming at creating societal conditions that ensure good health for the entire population. Through addressing determinants of health on the societal level, the Swedish policy focuses on changes by political decisions. In doing so, it places the main public health and health promotion work outside health care, advocating for empowerment, participation, equality, and social security via multi-sector interventions, mostly at the community level.

Exploring the position of health promotion in the field of public health

Ilona Kickbusch

Within the field of Public Health, what is the position of health promotion and primary prevention? How can these 'essential pillars' of Public Health be strengthened? What are the obstacles to get health promotion and prevention higher on the Public Health agenda? How can they be overcome?

- In the light of this, what are the roles, positions, benefits, and challenges of specific structures such as Health Promotion Foundations? How can they contribute best to the achievement of the Public Health goals?

Core theses:

- Three seminal social trends will shape the future of public health and health promotion: the epidemiological shift, new economic forces in the health arena, and developments in the life sciences. These trends contribute to a change in our understanding of health and in the strategies we apply to ensure and improve the health of individuals and populations.
- A key challenge to the future of health promotion will lie in devising strategies for harnessing the private sector for population health without increasing inequalities.
- The strength of health promotion lies in the fact that it has always maintained that health is a social concept, a process towards empowerment, not an ultimate goal in itself. Via the involvement of civil society in health or through public–private partnerships, health promotion has been at the cutting edge of public health thinking.
- Future action in public health and health promotion should be based on an ecological model and a societal environmental approach to health, applying the settings approach, addressing health effects of policies in areas other than health, and emphasizing health literacy and social capital.
- Health promotion foundations have the potential to act as advocates for health promotion, building up the knowledge base for health promotion, lobbying for core principles, and ensuring funding for health promotion action.

Strengthening the effectiveness of health promotion

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What are key issues for actors in health promotion and prevention and other public health actors, if strengthening the effectiveness of health promotion and prevention interventions, programmes, and policies is the goal?

- What can health promotion and prevention actors learn from other Public Health actors—and vice versa?
- What are specific roles, strengths, and challenges of (national) health promotion and prevention foundations?

Core theses:

- Public health and health promotion have to orient themselves at a complex frame of reference: primarily the function systems of (health) policy/politics, health care, (health) sciences are relevant, but others also have to be taken into account. Answers on the questions—what is successful and what should foundations do in support—can differ.
- It will be important to understand specific determinants of success in each of the relevant systems/arenas; it will also be important to understand how synergies can be created/counter-productive interaction effects be avoided.
- National Foundations are challenged to balance an 'evidence based' approach (favouring rather individualistic, lifestyle-oriented interventions) with a settings approach targeting broader social, politically relevant determinants, even if evidence for effectiveness of settings-oriented interventions does not comply with the gold-standard of evidence-based health interventions.
- National Foundations will have to lobby/invest for this balanced approach concerning regulatory political frameworks, programmes, and specific interventions, concerning programmes and institutions for knowledge development and distribution, and for a balanced approach among public health professionals and their associations.
- Given the ongoing pressure towards a good evidence base for all decisions on scarce resources, investment in improving the level of knowledge ('best available evidence') also for complex interventions should be among the top priorities of National Foundations.