regions, especially in the North (91.2%) and Northeast (87.1%). Of the 1066842 deaths registered in 2008, almost 60% had causes related to the circulatory system, cancer and respiratory tract. The SMR for diseases of the circulatory system was 159.5 deaths per 100,000 inhabitants, highest in the Southeast (146.2) and lowest in the North (113.8). For neoplasms, the SMR was 75.5 deaths per 100,000 inhabitants, higher in the South (92.6) and lowest in the North (57.7).

**Conclusion** From 1980 to 2008, there was a change in the mortality profile, with increased proportion of deaths due to causes related to chronic diseases, to the detriment of infectious and parasitic diseases. The social and economic differences between Brazilian regions are reflected in differences in mortality rates.

### P2-94 TYPES OF SMOKERS, DEPRESSION AND DISABILITY IN TYPE 2 DIABETES: A LATENT CLASS ANALYSIS

**Methods** Weight and height were measured at baseline (32.0±7.0 y) and at follow-up in 510 women participants in the COCS study. BMI was calculated as weight/height², with cutoffs of ≤25 and ≥30 kg/m². BIP was used to classify women in normal (BMI ≤25), overweight (BMI >25–29.9), and obese (BMI ≥30) categories. BIP was assessed at baseline using the Stanford University Body Image Scale (SIBI). Multivariate linear regression was used to assess the influence of BIP on BMI changes stratifying by nutritional status and controlling for potential confounders (ie, parity, schooling, age).

**Results** At baseline, 61% had excess weight (57% overweight and 24% obese). In 3 years, this number increased to 70% (38% overweight and 31% obese). One out of 4 increased their BMI category, particularly normal women (28.9% from normal to overweight and 22.3% from overweight to obesity). At baseline, BIP-discrepancy was 86% and was associated to increased BMI only in obese (p<0.05; coefficient for BMI in the sample 1.29; 95% CI 0.75 to 1.83). BIP-discrepancy was unrelated to the 3-year changes in BMI (p=0.19; coefficient = 0.14; 95% CI 0.04 to 0.24).

**Conclusion** In 3 years we observe a large BMI increase among young women of a post-transitional country. Body size misperception does not explain this large increase. Population strategies are needed to stop this detrimental trend.

**Funding** Fondyce11090252.

### P2-95 OBESITY INCREASES 28% IN 3 YEARS IN PREMENOPAUSAL LOW-INCOME CHILEAN WOMEN INDEPENDENTLY OF BODY SIZE MISPERCEPTION

**Introduction** How body image perception (BIP) influences changes in Body Mass Index (BMI) in adult women has not been evaluated.

**Objective** To assess BMI-changes over a 3-year period and their relationship with BIP in a Chilean women population-based cohort.

**Methods** Weight and height were measured at baseline (32.0±7.0 y) and at follow-up in 510 women participants in the COCS study. BMI was calculated as weight/height², with cutoffs of ≤25 and ≥30 kg/m². BIP was used to classify women in normal (BMI ≤25), overweight (BMI >25–29.9), and obese (BMI ≥30) categories. BIP was assessed at baseline using the Stanford University Body Image Scale (SIBI). Multivariate linear regression was used to assess the influence of BIP on BMI changes stratifying by nutritional status and controlling for potential confounders (ie, parity, schooling, age).

**Results** At baseline, 61% had excess weight (57% overweight and 24% obese). In 3 years, this number increased to 70% (38% overweight and 31% obese). One out of 4 increased their BMI category, particularly normal women (28.9% from normal to overweight and 22.3% from overweight to obesity). At baseline, BIP-discrepancy was 86% and was associated to increased BMI only in obese (p<0.05; coefficient for BMI in the sample 1.29; 95% CI 0.75 to 1.83). BIP-discrepancy was unrelated to the 3-year changes in BMI (p=0.19; coefficient = 0.14; 95% CI 0.04 to 0.24).

**Conclusion** In 3 years we observe a large BMI increase among young women of a post-transitional country. Body size misperception does not explain this large increase. Population strategies are needed to stop this detrimental trend.

**Funding** Fondyce11090252.

### P2-96 CAN INCREASING PHYSICIAN FEE-FOR-SERVICE PAYMENTS IMPROVE SERVICE REGULARITY IN ELDERLY PATIENTS WITH CHRONIC DISEASE?

**Introduction** Developed nations are experiencing increased burden on their health systems from chronic diseases. One avenue Australia is seeking to reduce this burden is via primary care services with increased financial incentives for physicians to provide more continuous care to elderly patients, especially those suffering from chronic diseases. This study assessed the influence of increased fee-for-service values on regularity and frequency of primary care visits, and examined the independent effects of demographic factors (age and gender) and chronic disease history.

**Methods** We performed a retrospective, population-based, longitudinal cohort study, linking routinely collected primary care service claims and hospital separation data in people aged 65 or more years in Western Australia from 2001 to 2006. Multivariate logistic regressions evaluated changes in the likelihood of increased primary care service regularity and frequency in exposed and unexposed individuals, adjusting for age, gender and chronic disease status.

**Results** The higher value services significantly and substantially increased relative likelihood (up to 14 times) of higher regularity with no corresponding higher frequency of primary care services.

**Conclusion** The study suggests a potential for modification of physician and patient behaviour using incentives within the current fee-for-service system in Australia. This type of incentive could be adopted in systems, which are not based on fee-for-service, as an additional incentive or bonus payment.