"We need to work closely with health care policy makers to make osteoporosis a global health priority."
Her Majesty Queen Rania of Jordan, Patron of the International Osteoporosis Foundation

Osteoporosis in Europe: Indicators of progress

and Outcomes from the European Parliament Osteoporosis Interest Group and European Union Osteoporosis Consultation Panel Meeting, Wednesday, November 10, 2004

Published by the International Osteoporosis Foundation on behalf of the European Parliament Osteoporosis Interest Group and EU Osteoporosis Consultation Panel

"The Commission will support the Council – as well as Member States – in any initiative aimed at preventing osteoporosis, which has a major impact on peoples' health and quality of life, and furthermore places a heavy burden on health care and social systems in Europe."
Markos Kyprianou, Commissioner of Health and Consumer Protection, December 2004

Contents

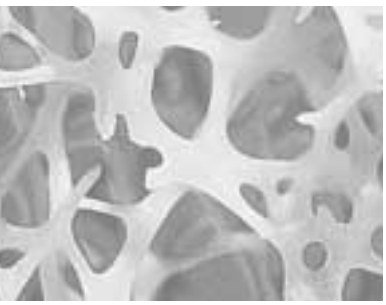
Why should policy makers be concerned about the prevention of osteoporotic fractures?

Osteoporosis

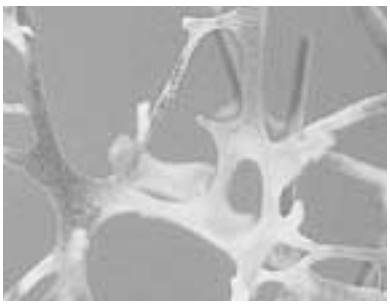
Osteoporosis, a disease in which the bones become porous and break easily, is one of the most common, debilitating, and costly chronic diseases in Europe. Wrongly often thought of as an "old woman's disease", osteoporosis affects not only one in three postmenopausal women, but also one in five men over the age of 50, younger women and even children.

Osteoporosis is known as the "silent epidemic" because there are often no symptoms until a fracture occurs. Once a fracture has occurred, the risk of a future fracture is at least doubled within one year.

Healthy bone



Osteoporotic bone



The human cost

People with broken bones suffer severe pain and disability, resulting in a loss of quality of life and independence. There is also an increased risk of death – 24% of women and 33% of men die within one year after a hip fracture. Yet the sad reality in Europe is that osteoporosis is usually not diagnosed in time. Despite the availability of approved diagnostic and therapeutic options, people continue to suffer fractures, many of which could have been prevented.

The social cost

As Europe's population ages and becomes more sedentary, the number of people affected by osteoporosis will increase significantly – hip fractures alone are expected to double in the next 50 years. Unless osteoporosis prevention and treatment becomes a priority for government and health care providers, this growing number of osteoporotic fractures will have a serious impact on society, not just in terms of people's quality of life, but also in regard to increased expenditure for health care, rehabilitation and nursing care.

Inese Ergle, osteoporosis patient and president of the Latvia Osteoporosis Patient and Invalid Association

After several years of extreme pain, Inese Ergle was diagnosed with osteoporosis at only 30 years of age. She had been to numerous doctors and had many X-rays before a diagnostic DXA scan finally revealed the cause of her pain and immobility. Inese was fortunate to find knowledgeable doctors and she received treatment, which quickly had beneficial effects. Although her back-pain still remains due to damage that is irreversible, she now enjoys freedom of movement and has regained much of her quality of life. But a constant source of worry has been the cost of medication, which eats up one-third of her income every month. With governmental promises to provide reimbursement for diagnosis and treatment being postponed several times, Inese and other concerned patients and doctors decided to take matters into their own hands. In 2002 they established the Latvia Osteoporosis Patient and Invalid Association, which is advocating reimbursement and is working to raise awareness of osteoporosis in Latvia. They have achieved much in a short time: patients are now looking forward to a positive decision on reimbursement policy at the end of this year. This important step will permit many sufferers who cannot afford medication to finally receive much-needed treatment for this chronic and debilitating disease.

Introduction

Worrying statistics gave rise to EC recommendations

In the 1990's new epidemiological research began to show the severe impact of osteoporosis. We now know that one in three women and one in five men over the age of 50 are suffering osteoporotic fractures, and osteoporosis accounts for more days spent in hospital than may other diseases, including diabetes, myocardial infarction and breast cancer for women over 45 years of age. As a result of these worrying statistics the European Parliament requested that the European Commission prepare recommendations aimed at making the prevention and management of osteoporosis and related fractures a health care priority in all Member States. These recommendations were published in 1998 .

In 2001 the International Osteoporosis Foundation (IOF) compiled an audit to see whether the recommendations were being implemented. The audit clearly showed that little progress had been made – governments were still not taking the steps necessary to prevent this growing epidemic of fractures.

Politicians and experts join forces to stimulate action

The disappointing results of the audit sparked the creation of an informal, all party group called the European Parliament Osteoporosis Interest Group. Founded by Mel Read MEP in December 2001, the EP Osteoporosis Interest Group – comprising some 30 MEPs from across Europe – issued a 'call to action' to help stimulate much needed policy developments at both national and European levels. Then Health and Consumer Protection Commissioner David Byrne stated his support for the 'call to action'.

"We must continue our work together with national governments who are responsible for the organisation and delivery of health services and medical care. The European Commission will take action in the short term to stimulate the necessary policy response at the national level." Health and Consumer Protection Commissioner David Byrne, December 2001

An important step forward was taken when the IOF received funding from the European Community to provide both a policy progress report and practical plan to outline the next policy steps required for implemention of the EC recommendations. In order to achieve these targets, the EU Osteoporosis Consultation Panel was initiated. This group of more than 50 experts and health policy makers has so far met three times to share information and discuss plans of action. In March 2004 the Consultation Panel submitted both a policy progress report and Action Plan, which outlines the key next policy steps required, to the health and consumer protection directorate general of the European Commission.

Collecting data to compare Member States's policies and performance

The third meeting of the Panel took place in November 2004 (see page 10). At that meeting – which saw the participation of representatives from the new Member States for the first time – panel members were asked to research and complete a questionnaire showing indicators of progress. The results of the questionnaires have been compiled and are presented on the following pages.

Recommendations from the 1998 European Commission "Report on Osteoporosis in the European Community – Action for Prevention"

Recommendation 1: Osteoporosis is to be adopted as a major healthcare target by the EU and governments of the Member States.

Recommendation 2: More information is required about the incidence and prevalence of osteoporotic fractures.

Recommendation 3: Co-ordinate national systems throughout the EU to plan effectively for an increase in demand for healthcare and to institute appropriate resource allocation.

Recommendation 4: Develop and implement policies to advise the general public and health professionals about calcium and vitamin D nutrition.

Recommendation 5: Access to bone densitometry systems should be universal for people with accepted clinical indications and reimbursement should be available for such individuals.

Recommendation 6: Member States to use an evidence-based approach to determine which treatment should be advised. Reimbursement should be available for all patients receiving treatment according to accepted indications.

Recommendation 7: Governments should actively promote national patient and scientific societies, providing financial support and helping to publicise their cause. Appropriate training of healthcare professionals involved in the management of osteoporosis should also be an important priority.

Recommendation 8: Further research is urgently required in a number of areas, including:

- Modifiable determinants (such as exercise and calcium intake) of peak bone mass and how these might be used to achieve higher peak bone mass in the population.
- Identification of risk factors for falling and the effects of fall prevention strategies on fracture.
- Assessment of the cost/utility ratio of screening in older women.
- The causes and treatment of osteoporosis in men.

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Hip fractures

Hip fractures are a serious result of osteoporosis. These fractures almost invariably result in chronic pain, reduced mobility, disability, and loss of independence. Hip fractures also result in mortality rates of up to 20-24% in the first year after a hip fracture. Various studies have shown that loss of function and independence among survivors is profound, with ca. 40% unable to walk independently and ca. 60% requiring assistance a year later. Because of these losses, around a third of the patients are totally dependent or in a nursing home in the year following a hip fracture.

The number and cost of hip fractures are commonly used to measure the burden of osteoporosis because, unlike other osteoporotic fractures, statistics for hip fracture are usually available through hospital records. Vertebral fractures and wrist fractures often go unrecorded and, in the case of vertebral fractures, often remain undiagnosed. The cost of hip fractures as indicated in the table opposite varies considerably from country to country. In every case, these figures do not reflect the total cost of hip fractures, only the direct hospital costs. The cost of rehabilitation, which can be considerable, is not included. In fact, where total care costs are available, these are as much as 2.5 times greater than the direct hospital costs provided in the graph.

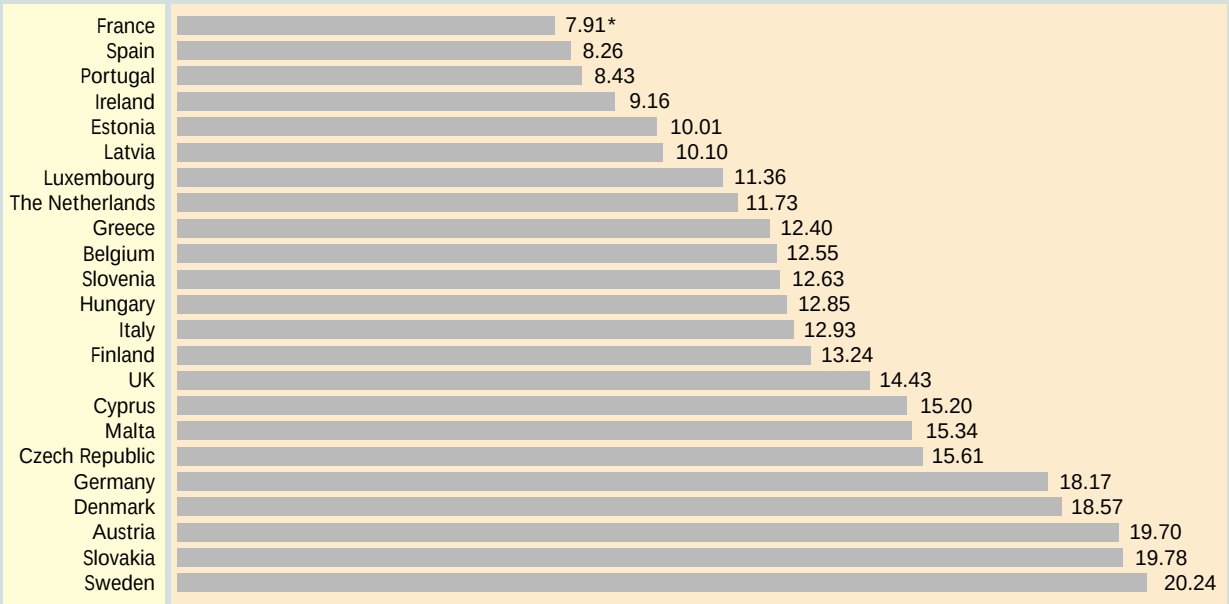
"Although most governments are developing plans to bring down waiting times for surgery, the expected epidemic of osteoporotic fractures will swamp facilities in the future."

Professor David Marsh, president, International Society of Fracture Repair

The risk of hip fracture generally follows a gradient from very high in Northern Europe to moderate in Southern Europe.

Number of hip fractures per year per 10,000 population

Based on latest available annual data, ranging from 2000 to 2003.



* INSERM 1996. The incidence of hip fractures / year in women and men over 65 years is 67.9/10,000 and 26.1/10,000 respectively (reference: Law on Public Health adopted by the French Parliament in 2004.)
Reliable data not available for Lithuania and Poland

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Acute Hospital Costs of a Hip Fracture

These figures do not reflect the total cost of a hip fracture as other costs such as rehabilitation are not included. In countries where total care costs are available the total is as much as 2.5 times greater than the costs provided in this analysis.

	euro
Austria	30,000
The Netherlands	28,250
Germany	20,300
UK	18,500
Denmark	14,800
Luxembourg	10,000 to 12,000
Ireland	10,600
Sweden	10,000
Belgium	8,700
Greece	7,920
Portugal	3,300 to 9,900
Italy	6,500
Finland	4,600 to 8,880 (mean 6,135)
Slovenia	4,600 to 6,300
Spain	5,000
Hungary	3,400
Poland	1,700 to 3,600
Czech Republic	2,500
Cyprus	1,200 to 2,000
Latvia	1,400
Slovakia	1,400
Lithuania	1,200
Estonia	1,000

France: data pending, Malta: data not available

Total care cost following a hip fracture can be as much as 2.5 times greater than the acute hospital costs shown in the table opposite.

Osteoporosis and the Ageing Population

Although young people are affected by osteoporosis, it remains a disease which mostly affects older people as the incidence of low bone mineral density increases with age after 50 years of age.

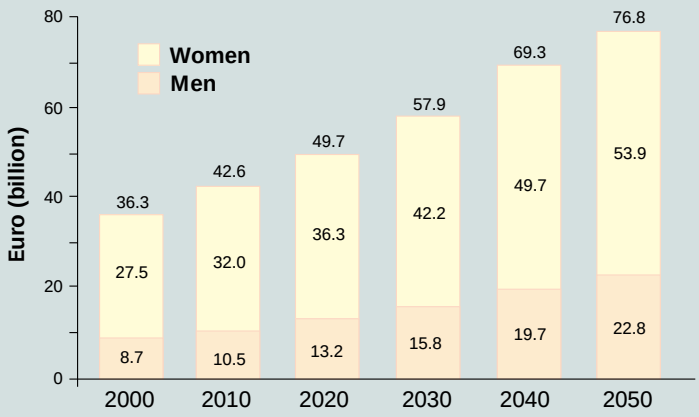
According to the 2002 UN World Population Prospects, by 2045-2050, people will live longer as average life expectancy in Europe is expected to rise to 80.5 years from the currently estimated 73.2 years. There will also be more elderly people as one-third of Europe's population will be at least 60 years old by 2050.

This has serious implications for the management of osteoporosis. If the rate of fractures is not reduced, the impact on health care services will be enormous – more hospital beds, more rehabilitation, greater demand on outpatient services and long-term nursing care.

"The current burden of osteoporotic fractures is enormous, in excess of euro 30 billion in the year 2000. This is expected to more than double in the year 2050."

Prof. John A. Kanis, WHO Collaborating Centre for Metabolic Bone Diseases, University of Sheffield Medical School, UK.

Projected costs of osteoporosis in Europe



Graph courtesy of Prof. John A. Kanis, WHO Collaborating Centre for Metabolic Bone Diseases

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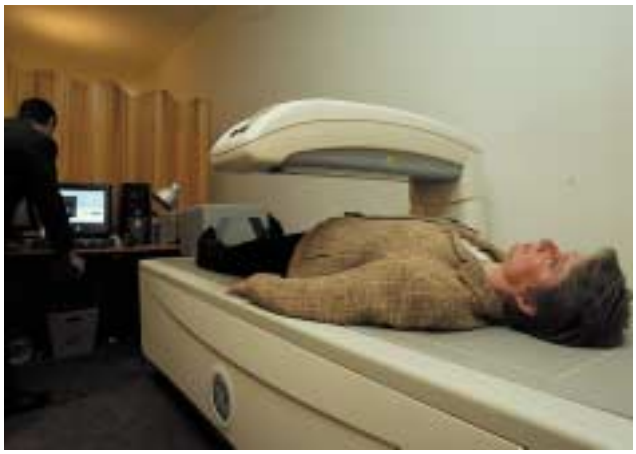
Diagnosis of osteoporosis

People with osteoporosis suffer from a reduction in their bone mass and bone quality- put simply, their bones become fragile, leading to an increased risk of fractures. Bone density loss is without noticeable symptoms. The most reliable way to determine loss of bone mass is to have a bone mineral density (BMD) test. DXA scans (Dual Energy X-Ray Absorptiometry) are the most accurate and most commonly used method of BMD measurement and are usually used to measure spine and hip bone densities.

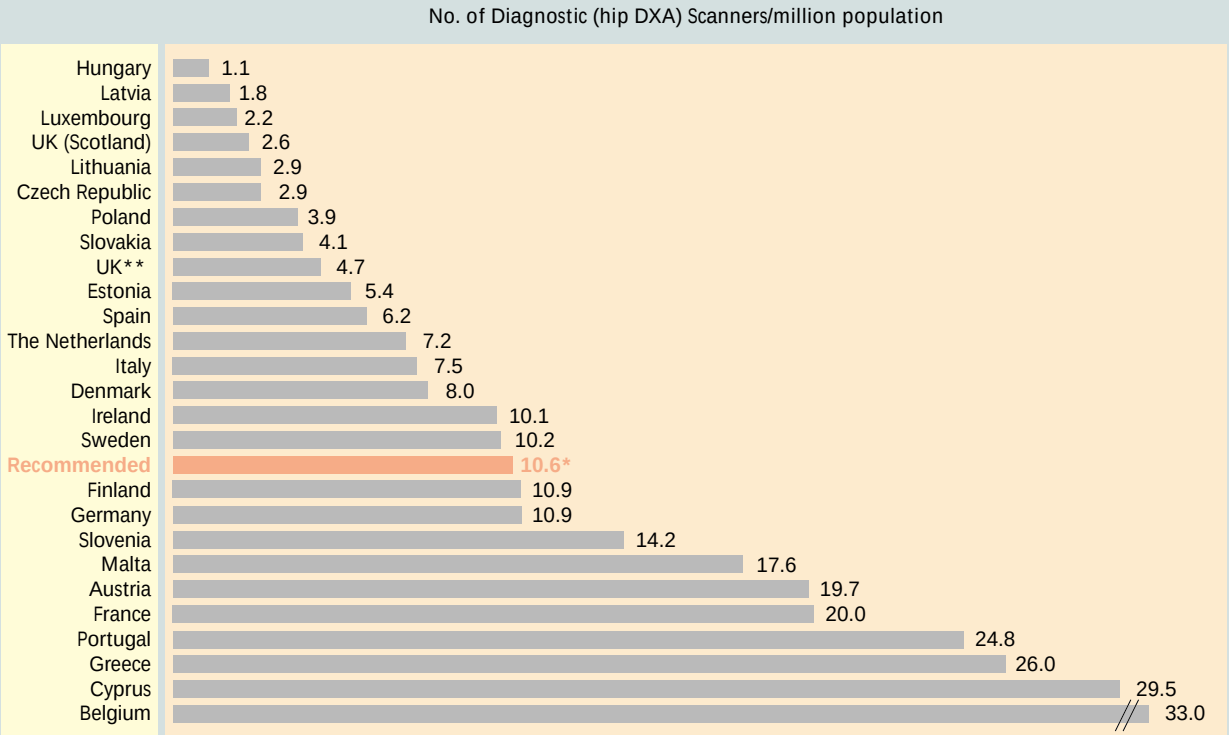
DXA scans are vital in order to properly diagnose and monitor osteoporosis. Yet access to bone mineral density measurement is sub-optimal in many European countries. Reasons include limited availability of densitometers, restrictions in personnel permitted to perform scans, low awareness of the usefulness of BMD testing, limited or non-existent reimbursement. Many of the DXA scanners are not available to the public health care system, or regional disparities mean that some parts of a country are under-serviced.



DXA scans are the most accurate method of bone mineral density measurement.

"Not all the scanners available in every country are for use in the public health care system. And, geographic distribution within a country is often patchy, resulting in poor access and long waiting times for some patients" Prof. Olof Johnell, Department of Orthopaedics, Malmö General Hospital, Sweden

Number of diagnostic scanners in the EU



*Recommended no. of DXA scanners put to optimal use within the public health care system from Kanis JA, Johnell O – Requirements for DXA for the management of osteoporosis in Europe. Osteoporos Int (2005) 16:229-238
**England, Wales, Northern Ireland

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Range of waiting time for a diagnostic (DXA) scan in the public health system

Latvia	No waiting time
Slovenia	No waiting time
Finland	0 to 7 days
France	A few days
Germany	A few days
Lithuania	2 to 3 days
Poland	2 to 4 days
Portugal	< 1 week
Belgium	≤ 1 week
Estonia	1 week
Hungary	1 to 4 weeks
Austria	3 weeks
Czech Republic	Approx. 3 weeks
Cyprus	Approx. 40 days
Greece	45 days
The Netherlands	1 week to 3 months
Ireland	1 week to 6 months
Luxembourg	3 to 90 days
Slovakia	2 to 6 weeks
Spain	3 to 6 months
Sweden	1 to 6 months
Denmark	0 to 9 months
Malta	8 months
Italy	1 week to 57 weeks
UK	1 week to 78 weeks

Karin Jöns MEP, Germany (left) and Frédérique Ries MEP, Belgium show the happy results of their bone test at the launch of the European Parliament Osteoporosis Interest Group, December 2001.

DXA scans to diagnose osteoporosis must be reimbursed for all Europeans with risk factors for osteoporosis.

Average charge for a diagnostic (DXA) scan of the hip and spine combined

	euro
Finland	Free of charge
Poland	10 to 15
Lithuania	10 to 25
Czech Republic	18
Latvia	25
Germany	30
Slovakia	30
Hungary	32
Slovenia	33
Estonia	35
Belgium	40
Austria	50
France	50
Luxembourg	50
UK	70-100 (when paid privately because of lack of access in the public health care system)
Italy	75
Cyprus	78 (for those not eligible for coverage)
Ireland	80
Spain	90
The Netherlands	100
Portugal	100
Greece	104
Denmark	188 (covered by health care. Patients cannot pay for examinations performed in a public hospital)
Malta	190
Sweden	335

Reimbursement policy in the public health care system for diagnostic (DXA) scan of the hip and spine

	Reimbursement	No reimbursement
Austria	YES*/**	
Belgium		NO
Cyprus	YES***	
Czech Republic	YES	
Denmark	YES*	
Estonia	YES*	
Finland	YES*	
France		NO
Germany	YES*	
Greece	YES*	
Hungary	YES*	
Ireland		NO
Italy	YES*	
Latvia		NO
Lithuania		NO
Luxembourg	YES*	
The Netherlands	YES	
Malta	YES	
Poland	YES****	
Portugal	YES	
Slovakia	YES	
Slovenia		NO
Spain	YES	
Sweden	YES	
UK – England, Wales, Northern Ireland	YES**	
UK – Scotland	YES*	

* With restrictions; ** Varies by region; *** Extent of reimbursement depends on the individual's income; ****Only as part of consultation

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Reimbursement in the public health care system of proven therapies

	Full reimbursement	Partial or restricted reimbursement	No reimbursement
Austria	YES		
Belgium	YES*		
Cyprus	YES***		
Czech Republic		YES	
Denmark		YES but only after individual application to the authorities	
Estonia		YES (50% of cost covered up to euro 25)	
Finland		YES	
France		YES (only after fracture)	
Germany		YES (only after fracture)	
Greece	YES****		
Hungary	YES*/****		
Ireland		YES	
Italy	YES*		
Latvia			NO
Lithuania		YES	
Luxembourg		YES	
The Netherlands	YES		
Malta			Generally NO
Poland			NO (for majority of treatments)
Portugal		YES	
Slovakia	YES**		
Slovenia	YES		
Spain	YES (> 60 years)	YES (60% for those < 60 years)	
Sweden	YES		
UK	YES**		

* Criteria limitations; ** Usually with a small prescription fee; *** Extent of reimbursement depends on the individual's income; ****90% reimbursed

Proven therapies for osteoporosis

The aim of treatment is to prevent the development of osteoporosis in order to decrease the risk of osteoporotic fracture. Fractures should be prevented before they occur – just as people with high blood pressure are treated to prevent stroke and people with high cholesterol levels are treated to prevent heart disease. Once a fracture occurs, the risk of further fracture is at least doubled within one year.

Today there is a wide range of therapeutic options which have been shown to be cost-effective and can reduce vertebral, hip and other osteoporotic fractures by 30 to 65%. Yet there are still many restrictions for reimbursement of osteoporosis therapies. In some health care systems medication is only reimbursed AFTER a fracture, in others there are age restrictions or only partial reimbursement is available.

Proven therapies must be reimbursed for all Europeans at risk of osteoporotic fracture.

Guidelines on Diagnosis, Treatment and Care

	Guideline availability
Estonia	YES, endorsed by government
Finland	YES, endorsed by government
France	YES, endorsed by government
Greece	YES, endorsed by government
Hungary	YES, accepted by government
Italy	YES, endorsed by government
The Netherlands	YES, endorsed by government
Portugal	YES, latest version in production. When produced will be presented to the health authorities
Slovakia	YES, endorsed by government
Slovenia	YES, endorsed by government
Sweden	YES, endorsed by government
UK	YES, endorsed by government (England) YES, process of guideline production endorsed by government (Scotland)
Austria	YES, not endorsed by government
Belgium	YES, not endorsed by government
Czech Republic	YES, not endorsed by government
Denmark	YES, not endorsed by government
Germany	YES, not endorsed by government
Latvia	YES, not endorsed by government
Malta	YES, not endorsed by government
Spain	YES, not endorsed by government
Cyprus	Not yet. Will be necessary when new scheme is inacted.
Ireland	NO
Lithuania	Being developed with Ministry of Health
Luxembourg	Being developed and will be endorsed by government
Poland	NO

Guidelines on diagnosis, treatment and care

Guidelines are effective tools for promoting evidence-based clinical practice. Since some aspects of osteoporosis management vary according to country (eg. availability of resources), country-specific guidelines are required. The majority of European countries now have guidelines but an important next step is to ensure that these are endorsed by their governments. Also, it is essential that financial assistance is received from governments so that the guidelines can be effectively disseminated to health professionals. The use of guidelines must be audited to define resulting changes in clinical practice, and they must be updated regularly.

Osteoporosis in Europe: Indicators of progress

Summary

It is evident that some progress has been made to date, with numerous governments – in particular Finland, France, Greece, Hungary, Ireland, Italy, Latvia, Portugal, Spain and the UK – paying more attention to osteoporosis. However, much more needs to be done to ensure high levels of bone health for all Europeans.

➜ Obtaining accurate data on the numbers of hip fractures and related costs remains a challenge. This demonstrates the need for the coordinated collection of fracture data.

➜ Guidelines on diagnosis, treatment and care in a large number of Member States are still not endorsed by national governments or are not yet available. Government endorsement and funding are vital to ensure that these guidelines are effectively implemented.

➜ Many Member States are under-resourced in diagnostic facilities. Even in those Member States that appear to have adequate scanners, many are not available to the public health care system and/or have patchy distribution within the Member State. This results in poor access and long waiting times in many countries.

➜ In a number of Member States, the lack of appropriate reimbursement of diagnosis and treatments to prevent fractures caused by osteoporosis continues to result in unnecessary suffering and excessive health care costs.

Important actions for the immediate future include:

➜ Developing a coordinated collection of fracture data so that preventive strategies can be evaluated, realistic health targets set and future health care resources allocated.

➜ Ascertaining that all Europeans affected by osteoporosis have access to appropriate diagnostic and treatment interventions, through the development and implementation of national, government endorsed, evidence-based guidelines.

Osteoporosis patient and medical societies are located in all Member States

Some 70 patient and medical societies in the European Union (members of the International Osteoporosis Foundation) are working to raise awareness and improve knowledge of osteoporosis among the public and health professionals. These organizations carry out important programmes and educational initiatives, set up self-help groups for patients, and work with experts, partners and policy makers to help prevent osteoporosis and improve the care of people with osteoporosis.

Austria: Aktion Gesunde Knochen, Austrian Menopause Society, Austrian Society for Bone and Mineral Research, Dachverband der Österreichischen Osteoporose-Selbsthilfegruppen
Belgium: Belgian Association for Osteoporosis Patients, Belgium Bone Club, Societé Royale Belge de Rhumatologie
Cyprus: Cyprus Society Against Osteoporosis and Myoskeletal Diseases
Czech Republic: Czech Osteoporosis League, Czech Society for Metabolic Skeletal Diseases
Denmark: Danish Bone Society, Osteoporoseforeningen
Estonia: Estonian Osteoporosis Society
Finland: Finnish Bone Society, Finnish Osteoporosis Society
France: Association des Femmes Contre l'Osteoporose, Group de Recherche et d'Information sur L'Osteoporose, Societé Française D'Ostéodensitometrie Clinique
Germany: Bundesselbsthilfe-verband für Osteoporose; Deutsche Gesellschaft für Osteologie, Deutsches Grünes Kreuz E.V., German Academy of the Osteological and Rheumatological Sciences, German Society for Endocrinology, Int. Society for Fracture Repair, Kuratorium Knochengesundheit E.V., Orthopädische Gesellschaft für Osteologie
Greece: Hellenic Endocrine Society – Panhellenic Association of Endocrinologists; Hellenic Foundation of Osteoporosis, Hellenic Society for the Study of Bone Metabolism, Hellenic Society of Osteoporosis Patient's Support
Hungary: Hungarian Osteopo-rosis Patient's Association, Hungarian Society for Osteoporosis and Osteoarthrology
Ireland: Irish Osteoporosis Society
Italy: Donneuropee Federcasalinghe, Italian Society for Osteoporosis, Mineral Metabolism and Skeletal Diseases, Italian Society of Rheumatology, Lega Italiana Osteoporosi, Mediterranean Society for Osteoporosis and Other Skeletal Diseases
Latvia: Latvian Osteoporosis Patient and Invalid Association, Latvian Society of Osteoporosis,
Lithuania: Lithuanian Association of Metabolic Bone Diseases incorporated into the Lithuanian Endocrine Society, Lithuanian Osteoporosis Foundation
Luxembourg: Association Luxembourgeoise D'Etude du Métabolisme Osseux et de L'Ostéoporose, Association Luxembourg Osteoporose
Malta: The Malta Osteoporosis Society
The Netherlands: Dutch Society for Calcium and Bone Metabolism, Osteoporose Stichting, Osteoporose Vereniging
Poland: Multidisciplinary Osteoporotic Forum, Polish Foundation of Osteoporosis, Polish Osteoarthrology Society, Stowarzyszenie Entuzjastow Zdrowej Kosci-Z Koniecznosci (STENKO)
Portugal: Ass. Portuguesa de Osteoporose, Associaçao Nacional Contra a Osteoporose, Colégio Ibero-Americano de Reumatologia, SPODOM
Slovakia: Slovak Society of Osteoporosis and Metabolic Bone Diseases, Slovak Union Against Osteoporosis
Slovenia: Slovene Bone Society, Slovene Osteoporosis Patient's Society
Spain: Associacion Espanola Conte La Osteoporosi, Fundacion Hispana de Osteoporosi y Enfermedades Metabolicas Oseas, Sociedad Espanola de Investigaciones Osea y Metabolismo Mineral (SEIOMM)
Sweden: Swedish Osteoporosis Patient Society, Swedish Osteoporosis Society
UK: Bone and Tooth Society, European Calcified Tissue Society (ECTS), National Osteoporosis Society (NOS), Osteoporosis 2000

For contact details visit: www. osteofound.org

Outcomes from the European Parliament Osteoporosis Interest Group and European Union Osteoporosis Consultation Panel Meeting Wednesday, November 10, 2004

A meeting of the European Parliament Osteoporosis Interest Group was held on November 10, 2004 in the European Parliament, in conjunction with the 3rd meeting of the European Union Osteoporosis Consultation Panel. Over 70 committed stakeholders from more that 20 Member States, including MEPs, Commission officials, Permanent Representatives, national health advisors, and NGOs attended the meeting.

"We need to work together to ensure that those most at risk are identified and advised before the first fracture happens ..."

M. Skar of the European Commission, directorate general public health, speaking on behalf of the European Commission

"A Council Conclusion on Osteoporosis is essential"

M. Honeyball, MEP (left) and A. Niebler, MEP both stressed the need for a Council Conclusion on Osteoporosis to ensure that priority is given to this disease at the national level.

A press release issued on the occasion brought attention to a new report by Professor John Kanis, director of the WHO Collaborating Centre for Metabolic Bone Diseases in Sheffield, UK, and Professor Olof Johnell, vice chairman of the IOF Committee of Scientific Advisors. The report shows that the number and availability of DXA scanners in Europe is inadequate to effectively diagnose and treat osteoporosis fractures. It concludes that, even with effective screening, both DXA availability and usage is sub-optimal in many countries and that the burden of osteoporosis will continue to grow dramatically unless decisive action is taken now at national and European levels.

Participants at the meeting called for EU Member States to take concrete action to ensure that those at risk from osteoporosis receive timely diagnosis, lifestyle advice and treatment, as outlined in the 1998 Recommendations of the European Commission. To aid this goal Mary Honeyball, MEP and Angelika Niebler, MEP, on behalf of the EP Interest Group, called for a Council Conclusion on Osteoporosis to ensure that priority is given to this disease at national level.

A selection of photos taken at the meeting:

Adamos Adamou
MEP, Cyprus

Georgs Andrejevs
MEP, Latvia

John Austin
MP, England

Pilar Ayuso Gonzalez
MEP, Spain

John Bowis
MEP, UK

Milan Cabrnoch
MEP, Czech Republic

Ingrida Circene
policy maker, Latvia

Dorette Corbey
MEP, Netherlands

Den Dover
MEP, UK

Alessandro Giordani,
Member of Commissioner Kyprianou's cabinet

Pepita Groeneveld
policy maker,
Netherlands

Caroline Jackson
MEP, UK

"Help from the Commission to collect and record fracture data across Europe is vital so that preventive strategies can be evaluated, realistic health targets set, economic modelling conducted and future health care resources allocated" Prof. J. Compston, chair of the EU Osteoporosis Consultation Panel

"We must raise awareness among policy makers ... the link between bone mineral density (BMD) and fracture risk should be as obvious as is the link between high blood pressure and cardio-vascular disease."

Prof. S. Papapoulos, EU Osteoporosis Consultation Panel senior advisor

Experts and policy makers set clear targets for the near future: A Council Conclusion, evidence-based guidelines and fracture registry

The co-chairs of the European Parliament Osteoporosis Interest Group, Angelika Niebler and Mary Honeyball, were also at hand to welcome the Consultation Panel to the all-day working meeting. Mariann Skar of the European Commission, directorate general public health, spoke on behalf of the European Commission. Saying that the Commission would support osteoporosis prevention through the promotion of healthy lifestyles and possibly assist with fracture data collection, Mariann Skar concluded, "We need to work together to ensure that those most at risk are identified and advised before the first fracture happens, and that known ways of reducing the risk for this disease are widely promoted."

Prof. Juliet Compston, chair EU Osteoporosis Consultation Panel and IOF Board member stressed the need for a Council Conclusion on Osteoporosis to assist Member States with the ongoing implementation of the recommendations of the 1998 European Commission report. Also speaking at the meeting were Mary Anderson, EU Osteoporosis Consultation Panel co-ordinator and IOF Board member; Prof. Liana Euller-Ziegler, Bone & Joint Decade French Network co-ordinator; Prof. Christel Lamberg-Allardt, Finnish Bone Society and Finnish Osteoporosis Association; Prof. David Marsh, president, International Society for Fracture Repair; Prof. John Kanis, WHO Collaborating Centre for Metabolic Bone Diseases; Prof. Olof Johnell, WHO working group & vice-chair, IOF Committee of Scientific Advisors.

In his closing remarks, Prof. Socrates Papapoulos, EU Osteoporosis Consultation Panel senior advisor & IOF Board member, underlined the fact that so far quite a lot has been achieved in a step-by-step approach and by following clear targets. He reminded participants that the main concrete action requested at the European Union level is a Council Conclusion which may then influence national governments to take action. Furthermore, two specific issues should be seen as priorities for 2005: furthering the publication of clinical guidelines in each country and establishing a fracture registry. The fracture registry will provide the hard evidence of the burden of osteoporotic fractures which will encourage governments to focus on osteoporosis.

Meeting report, presentations and press release are available on the IOF website: www.osteofound.org

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IOF is the only non-governmental organisation dedicated to the global fight against osteoporosis. Its membership includes leading researchers and physicians in the field of osteoporosis and some 168 member societies from all over the world. For further information about IOF visit: www.osteofound.org

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