

Fifth European Union Osteoporosis Consultation Panel Meeting

April 18, 2007

Hotel Leopold, Brussels, Belgium

The fifth meeting of the [EU Osteoporosis Consultation Panel](#) took place in Brussels on April 18, 2007. The panel meeting was chaired by Mary Honeyball MEP (UK), who together with Angelika Niebler MEP (Germany), co-chairs the [European Parliament Osteoporosis Interest Group](#), key partners of the Consultation Panel in its efforts to encourage health policy officials to focus attention and resources on osteoporosis at the EU and national levels. The meeting was attended by representatives from 24 of the 27 European Union member states.

Meeting Report

The purpose of the meeting was to launch a major new EU-wide audit process on the prevalence of osteoporosis and status of its management in Europe for publication in 2008, to assess progress and challenges a decade since publication of the [Eight Recommendations](#) in 1998. The audit will form the basis for an up-to-date and authoritative report that is intended to be a catalyst for action by health ministries across the Union. It will also provide an opportunity for those countries which have only recently joined the EU, and were therefore not included in a previous audit [published in 2001](#), to carry out their first audit assessing the status of osteoporosis incidence, prevalence and care provision in their country. The audit will measure incidence and prevalence of fractures, accessibility of diagnostic testing, availability and access to evidence based therapies, economic costs, national health ministry support as well as public and professional education. The audit will be published in 2008. It is hoped that this second European Union Osteoporosis Audit will be a significant contribution to the advancement of osteoporosis policy, not only in Europe but internationally as a model of regional cooperation.

Welcome address by the Chairs of the EP Osteoporosis Interest Group and the Chair of the EU Osteoporosis Consultation Panel

The meeting was opened by **Donna Spafford**, meeting moderator and Senior Policy Consultant to IOF, who outlined the purpose and agenda of the meeting, and introduced the speakers. The welcome address and an introductory speech were given by the meeting chair, **Mary Honeyball MEP**. Mrs Honeyball thanked all participants for attending the meeting, and gave a special welcome to the representatives of the new EU member states including the most recent members, Bulgaria and Romania, who joined in January 2007. Mrs Honeyball stressed the importance of the new audit, and encouraged all representatives to participate in the initiative, which is expected to provide a significant impetus to the osteoporosis movement. Mrs Honeyball highlighted the fact that osteoporosis is still considered a 'low priority' disease by the health ministries of the UK and many other member states, despite its increasing prevalence and escalating costs in the face of changing population demographics. "In all our countries, medical services are stretched across the board – there is increasing demand for care provision and treatments for many chronic diseases, and also raised expectations among patients and the public. All our governments are going to have to work hard to make the available resources stretch to meet the increasing demands", said Mrs Honeyball. She added that the audit will not only provide an extremely valuable and up-to-date overview of the status of osteoporosis and its management in the Union, but that "it will be the launching point for a major public awareness campaign, and is likely to generate enormous press coverage, helping to raise the profile of osteoporosis and give it the attention it deserves". Mrs Honeyball closed by pledging the continuing support of the EP Osteoporosis Interest group to the ongoing work of the Panel, and

noted that the Group will be meeting in Strasbourg in autumn 2007, in order to apprise members of the audit progress and preliminary results.

In her welcome speech, **Mrs Angelika Niebler MEP** stated that osteoporosis remains one of her top health policy priorities, and underlined the key role the EP Interest Group members play in maintaining high level interest in the disease in political bodies at the EU and national levels. She discussed the pressing need to improve the level of awareness of osteoporosis, and to convince policy makers “that this disease is *preventable*, it is not an inevitable part of human ageing”. Mrs Niebler went on to describe aspects of the health agenda for the current German Presidency of the EU, as they apply to osteoporosis. These include the promotion of a healthy lifestyle for the prevention of chronic disease, publication by the Commission of a paper on nutrition, physical activity and lifestyle, and a follow-up paper on sustainable lifestyle measures for disease prevention to be published in May 2007, all of which stress the contribution that disease prevention can make to reducing health care costs in the long term. Mrs Niebler then informed participants that health care research has been prioritised in the Seventh Framework Programme (FP7), the EU’s chief instrument for funding scientific research and technological development during the period 2007 through 2013. The health research programme will be launched this year with a budget of 50 billion euros for the life of FP7 for transnational research activities, and the call has been issued for osteoporosis to be included in the programme.

The final welcome address was given by **Professor Juliet Compston**, Chair of the EU Osteoporosis Consultation Panel and International Osteoporosis Foundation (IOF) board member.

Prof Compston began by paying tribute to the late **Professor Olof Johnell**, who passed away suddenly only a few days after the fourth Osteoporosis Consultation Panel meeting in April 2006. Prof Compston stated that “not only did the IOF and the Consultation Panel lose a great friend and colleague, but Olof made an enormous contribution over the years – to the field of osteoporosis, to the IOF, and to the health policy work of the Panel. His hard work truly helped to shape the health policy agenda for osteoporosis. Latterly, his contributions to the establishment of the WHO Fracture Risk Assessment initiative were significant, as we heard at last year’s meeting when he and Prof John Kanis presented crucial new data on the economic burden that osteoporosis imposes”.

Prof Compston continued by outlining the agenda and speakers for the day’s meeting, and again welcomed all participants including representatives of the new member states. She also stressed the importance of the new audit, recognising and acknowledging the hard work that will need to be carried out by all member states in researching and assembling the facts and statistics for their countries.

The Audit – Speaker Presentations

Introduction to the Audit

Prof Juliet Compston, Chair, EU Osteoporosis Consultation Panel; Professor of Bone Metabolism, University of Cambridge; IOF Board member

In an introductory talk, Prof Compston provided the background and described the rationale to the new audit. In 1996, the European Parliament requested the European Commission to prepare recommendations aimed at making the prevention and management of osteoporosis and related fractures a health care priority in all Member States. The Commission responded by publishing eight recommendations in a [Report on Osteoporosis in the European Community – Action for Prevention](#), in 1998. This report created the cornerstone for all subsequent EU

Osteoporosis Policy activities. In 2001 IOF received funding from the European Community, and the first EU-wide audit was completed which indicated that while some progress had been made in implementing these recommendations, in a number of member states, important care gaps still existed to fulfill the recommendations, care gaps that continue to require advocacy efforts. This first audit was published under the title [Osteoporosis in the European Community: A Call to Action](#). Also in 2001, an informal, all-party group, the European Parliament Osteoporosis Interest Group, was founded by Mel Read, former UK MEP. This was followed in 2002 by the formation of an EU Osteoporosis Consultation Panel comprised of health policy makers and osteoporosis experts with EU-wide membership. Prof Compston noted that since that time, several Consultation Panel and Interest Group meetings have continued to strengthen the osteoporosis messages, and to work to advocate for improved access to diagnostic examinations and evidence based therapies. She stated that “although much has been accomplished over the years, worryingly, there remains inconsistent and inadequate access to both diagnosis and treatment. In many countries, treatment is not reimbursed until *after* the first fracture – a scenario that could have been prevented with earlier intervention”.

- Prof Compston went on to explain that although there have been some success stories – from increased numbers of diagnostic scanners, to enhanced awareness among governments, to growth in national osteoporosis societies – there are still those at high risk for fragility fractures who are not being identified, never referred for treatment, or not having access to proven treatments due to reimbursement restrictions. She cited the example of the UK, where only 20% of patients with fractures receive any treatment for osteoporosis. “And the incidence of hip fractures, the most serious and costly fractures, is on the rise in Europe”, she warned.

Prof Compston then outlined the strategy for the audit, including the development of a template document to be completed by all countries, which will parallel the original (2001) template to facilitate a comparison of ‘then’ and ‘now’, but with some areas enriched to provide more robust data. The template was developed with the assistance of a dedicated Audit Working Group, chaired by Prof Juliet Compston, and comprised of one EU Consultation Panel member from those countries forming the current and upcoming EU presidencies, and the most recent past presidency. Prof Compston advised that each member country had received an individualised template on a CD in their meeting packs, containing data from their previous audit in 2001 (if applicable), all IOF publications since 2001 with country data, together with instructions on template completion and timelines.

Learnings From the 2001 Audit

Prof Socrates Papapoulos, Senior Advisor to the EU Osteoporosis Consultation Panel; Professor of Endocrinology, Leiden University, Netherlands

Prof Papapoulos outlined the historical perspective to the current audit, noting that the [Eight Recommendations](#) published in the inaugural report on osteoporosis in the EC in 1998 were largely the work of medical experts in the field, and may have been interpreted by some as specific actions to be immediately implemented, rather than as a guiding blueprint for government health officials to utilise, in assessing the extent of the problem in their country and developing strategies for action. He added that Recommendation 1 (*governments should explicitly adopt osteoporosis prevention as a major health care target and establish awareness campaigns; prevention of osteoporosis should be a major priority in health promotion, and the education and training of health care professionals*) was intended as the top priority, and that Recommendation 2 (*establish co-ordinated systems for monitoring fracture rates at both national and European Community levels; data can be used to determine various causes of osteoporosis, assess potential preventive strategies, and to estimate cost involved in preventing*

and treating osteoporosis) was intended to provide the necessary *evidence* in support of the call to prioritise osteoporosis. However, although Recommendations 3 through 8 were more specific, concerning reimbursement, education, research and guideline development, the intention was not that these be implemented across the board and immediately, but rather that they would form a set of recommendations that government officials could consider, as resources permitted. “It’s possible that this mis-interpretation is one of the reasons for the slow progress in osteoporosis policy improvements in the Union”, said Prof Papapoulos, adding that “health officials might have felt overwhelmed by what they saw as a list of goals that could not all be achieved”.

Prof Papapoulos went on to stress the need to focus on what *can* be achieved, rather than on idealistic scenarios. As shown in the 2005 EU policy report, [Indicators of Progress](#), some progress had been made in individual member states in specific areas such as obtaining data on hip fracture rates, and improving access to diagnosis and treatment reimbursement. However, it was evident that these achievements were the result of local, individual efforts, and that a ‘central commitment’ to the problem by the national government was still missing. Acknowledging this fact, the concluding recommendation of the 2005 report was even more focused and restricted, calling for only two actions for immediate implementation: 1) the coordinated collection of fracture data, to facilitate the development of preventative strategies, together with realistic health care targets and future resource allocation, and 2) the development of national, government-endorsed, evidence-based guidelines. In summarising, Prof Papapoulos noted that although there have been laudable local achievements, much more remains to be done in order to secure a place for osteoporosis as a priority disease in national and EU health care agendas. He outlined the three ‘key learnings’ from the previous few years, since publication of the 2001 audit:

1. Political commitment is required at the national level, and more importantly, this must be *central commitment* from the government: a top-down approach will have maximum impact.
2. Recommendations for action must be *focused*, so that they are achievable, and so that the credibility of the political movement for osteoporosis is maintained.
3. Efforts need to be coordinated; for example, there is an ongoing need to establish an EU-wide hip fracture registry, and decisions would need to be taken on actions and roles, if this is to be achieved.

How Do We Define Cost Effectiveness?

Prof David Reid, Professor of Rheumatology, University of Aberdeen, UK; Chair of Medical Board, National Osteoporosis Society, UK

In order to assist Consultation Panel members in their completion of the new audit, Prof David Reid gave an overview of the definitions and principles underpinning the principle of cost effectiveness. This is an increasingly critical concept guiding healthcare provision by all governments, facing escalating health care costs in society, particularly for care of the elderly as longevity rises. Prof Reid began by outlining two important components of the cost-effectiveness equation: ‘opportunity cost’, which is the willingness to forego the benefits of not using a resource in an alternative manner, and ‘willingness to pay’, which is how willing a country is to pay for an aspect of health care, and is dependent on country resource and the proportional spend on health. There is no agreed threshold for willingness to pay, and it is often assessed as 2 X gross domestic product (GDP) per capita. He then went on to outline the different approaches to assessing cost effectiveness: 1) cost-benefit analysis, which attempts to place a monetary value on loss of life and increases or decreases in quality of life; 2) cost

effectiveness analysis, which avoids the problem of monetarising health benefits by measuring them in their natural units (e.g. BMD increase in g/cm²); and 3) cost utility analysis, which measures health care benefit in terms of utility, which can be thought of as a measure of overall 'well-being'. For the latter, a patient's quality of life is measured via questionnaire and converted (usually) into quality-adjusted life years (QALYs). A QALY essentially weights a person's life expectancy by some adjustment for quality of life.

Prof Reid went on to compare costs per QALYs for a range of interventions across several different diseases, and explained the many issues that render cost-effectiveness analysis an 'inexact science', including the marked variations in costs of 'events' (e.g. fractures) by country and by health care system. Costs of interventions to prevent reduction in quality of life (e.g. bisphosphonates for osteoporosis) can be easily obtained, but again vary markedly between countries. Loss or gain of QALYs are difficult to assess outside of the clinical trial setting, and other factors such as rates of discounting for costs and/or benefits are highly variable between countries (discounting allows for costs expended 'now' to be set against the costs that would have been expended had the event occurred years later). Prof Reid went on to explain the distinction between a country's 'ability' (GDP/capita) and 'willingness' (health care expenditure as a percentage of GDP) to pay, and showed that this is not always a straightforward relationship based on the country's wealth.

In the final section of his presentation, Prof Reid demonstrated that osteoporosis is an expensive disease, in terms of global burden of disease – disability and loss of life due to osteoporosis exceeds that of all common cancers (including colorectal, breast and prostate cancer), with the exception of lung cancer. Looking at data showing the ten-year probability of hip fracture in different age groups above 50 years, he showed the critical impact of age on fracture risk, regardless of BMD (for any given BMD T-score, the risk is higher with increasing age). In discussing how the cost of treatment impacts on cost effectiveness modelling, Prof Reid showed how with increasing cost of a therapy, the older patients would have to be in order to intervene with that therapy, for it to be cost-effective in terms of fracture risk reduction. Finally, he showed how the probability of fracture at a given age is influenced by the type and cumulative number of risk factors in addition to low BMD, for example prior fracture, glucocorticoid use and family history of fracture – risk factors used in the upcoming WHO guidelines for improving the assessment of fracture risk (for further details of this initiative, see the 2006 report [Osteoporosis in the EU: improving the assessment of fracture risk](#)).

The Audit Template

Prof Liana Euler-Ziegler, Professor of Rheumatology, University Hospital of Nice, France; Consultation Panel member for France

Prof Liana Euler-Ziegler's presentation covered the format of the audit template document itself, and gave guidance on how to source the required data, and how to complete the document. In a detailed, step-by-step fashion, Prof Euler-Ziegler took the meeting participants through the template, demonstrating the information required. The template is divided into two broad sections. The data required in the first section of the template includes population demographic information (size of the population, and population over 50 years by gender), the incidence and prevalence of fractures, costs of hip fractures (individual hospital costs, and total direct hospital costs), days spent in acute care as a result of fracture, days in rehabilitation or long term care, the number of diagnostic scanners (DXA) per capita, DXA waiting times, number of DXA scans performed (central DXA only), costs for DXA scans, DXA reimbursement criteria, and reimbursement of proven therapies. For those countries that participated in the 2001 audit, the IOF pre-included the data from that audit on the template document, together with any updated information supplied for the 2005 progress report, and individualised electronic copies of the

template were supplied. The second broad section of the template lists the eight recommendations, and asks specific questions related to each of the recommendations in turn. Again, country-specific information given in the 2001 audit was included on each country's template, where available. New members, who did not participate in the 2001 audit, were asked to provide back-data as far as possible, in order to show progress made over the previous few years in their country, arriving at the current situation in 2007. Countries that submitted interim progress reports, for inclusion in meeting reports and IOF publications between 2001 and 2007, were asked to include this information in a dedicated column on the template, in addition to completing the information for the current status in 2007.

Prof Euler-Ziegler urged participants to give as much detail as possible, in answering each of the specific questions for the audit. For example, for DXA scan waiting times, there will be a range of waiting times regionally within a country, according to the national distribution of scanners, and this information should be given along with the average waiting time. She also stressed the importance of giving sources and references for the information that will be quoted in the report. Examples of source documents include: publications; national statistics; registries; hospital data; ministry of health data; insurance statistics; pharmaceutical industry data on file. The audit is to be completed by 30 September 2007. Professor Euler-Ziegler concluded by thanking the participants for their support for the audit, and stressing the need for high quality information for all countries, in order to provide the strongest possible tool for successful lobbying efforts upon publication.

Expectations and Timelines

Prof Helmut Minne, German Academy of the Osteological and Rheumatological Sciences, Germany; IOF Board member

Prof Helmut Minne informed participants of the timelines for the completion, publication and launch of the audit report. He stressed the need for those taking responsibility for compiling their country's template to begin work as soon as possible, in order to meet the deadline of September 30, 2007 for submitting completed templates to the IOF. He also highlighted the need to complete the template as thoroughly as possible, giving detailed answers and as much explanation as possible, for each of the questions. Prof Minne also reiterated that participants should seek information from as many sources as possible, in order to obtain as much information as possible, including health departments, national statistics, insurance companies, local or national research, pharmaceutical and scanning hardware companies, and last but not least, colleagues. Sources for all facts given in the template should be referenced.

"The Big Bang!", or, How We Can Develop a Social Activism Campaign

Paul Sochaczewski, IOF Head of Communications

After a brief discussion period, Paul Sochaczewski gave a lively, interactive and informative presentation on IOF's plans for a policy theme for the World Osteoporosis Outlook Campaign for the years 2008–2010, which will be entitled '**Stand Tall – Speak Out For Your Bones**'. He explained how the new EU audit would form an integral component of this campaign, and for Europe, will provide a powerful tool for lobbying and a focal point for the development of impactful, imaginative national and regional awareness-raising campaigns.

Mr Sochaczewski outlined the key challenges we all face in our efforts to move the political agenda for osteoporosis forward, and convince health authorities of the seriousness of the disease and the economic and social consequences of inaction:

1. Show osteoporosis is a **major health problem**, comparable to other diseases.

The traditional view of osteoporosis is that it is a normal part of ageing, that there is little we can do about it, and that it is not a very 'serious' problem in comparison with other diseases, such as cancer and cardiovascular disease. This is not the case, and the consequences of osteoporosis and its associated fractures for the individual are extremely serious. A large body of research has shown that osteoporotic fractures – particularly of the spine and hip – are associated with increased morbidity and mortality. The number of osteoporotic fractures occurring in the EU each year is staggering – every 30 seconds, someone in the EU has a fracture as a result of osteoporosis. Due to changing population demographics and other factors, the yearly incidence of hip fractures alone in the EU is expected to more than double from approximately 500,000 to 1,000,000 over the next 50 years. Governments must take note, and take action. "As a costly disease that ruins lives, we belong at the table", said Mr Sochaczewski, "and the data from this audit will be a powerful weapon at our disposal".

2. Show governments can **reduce costs** by preventing the first fracture.

The economic argument is already strong. In Europe and the USA the combined annual cost of treating osteoporotic fractures is estimated at 42 billion euros – an amount that can only escalate, given the projected increases in fracture incidence in these regions, and elsewhere. Governments and health ministries need to be convinced that this is not inevitable – osteoporosis can be prevented, easily diagnosed, and treated. Prevention and early diagnosis are critical – once a patient has experienced one osteoporotic fracture, they are at greatly increased risk of subsequent fractures.

3. Improve **national competitiveness** by working longer.

Mr Sochaczewski showed demographic data demonstrating that the percentage of the global population over 60 years of age is increasing dramatically, due to increasing life expectancy as a result of improvements in health care and other factors such as nutrition. By 2050, more than 30% of the EU's population will be aged over 60 years. If this ageing population – and increasingly, a necessary part of the workforce – does not remain in good health, the increased costs to governments to pay for health care and social services for older people will be staggering, and ultimately untenable. The message is simply that no country will be able to ignore the potential economic and social burden imposed by osteoporosis, if action is not taken to reverse current trends. He also showed some national advertising campaigns in the EU, in which governments are already recognising this potential time bomb, and are encouraging employers to employ and retain their senior staff in the workforce.

4. Recognise that we represent a powerful **political force**.

IOF, as the umbrella organisation for national osteoporosis societies worldwide, hosts a 'family' which currently represents 82% of the global population (and 99% of the EU population!). IOF member societies in these 87 countries represent 5.33 billion taxpayers, voters and consumers - "a potentially powerful political force to be mobilised and reckoned with", noted Mr Sochaczewski, "and ultimately a social movement". The challenge for the osteoporosis movement is to make its voice heard, and to implement and mobilise a campaign for action of equal strength to those for other 'causes' (for example, cancer, AIDS, smoking, landmines, the environment).

Mr Sochaczewski went on to outline the IOF's communication plans for the campaign, including targets, objectives, key messages, strategies, key actions and timelines. As is customary for

World Osteoporosis Day campaigns, IOF will develop some 'central' resources such as publications, posters, media activities and campaign suggestions, which will be provided to national societies for translation and local use as required. Within the EU, we will need to work together to develop creative ideas for using the audit and associated statistics to capture attention and generate policy changes. "We need the facts, but we also need the activism", said Mr Sochaczewski, "a winning combination of *science* and *heart*". Mr Sochaczewski also made some suggestions for eye-catching events and outreach activities for World Osteoporosis Day itself, such as 'Ring the Bell Every 30 Seconds' to highlight fracture occurrence, the creation of large wishbone sculptures to be exhibited around the country (similar to the colourful cow sculptures that have been displayed globally), projecting giant bone-shaped lighting onto tall buildings in a city, sporting events (such as relay races with a bone as the baton), television advertising campaigns.

Mr Sochaczewski ended by discussing the need for the osteoporosis movement to find its '**voice**', a tone for the campaign that feels comfortable and appropriate. He showed examples of campaigns by other movements from health and social causes, which use different levels of force and emotion to capture attention. He observed that as well as having data, statistics and economic costs, it will be essential to add the **human story** to the campaign, to emphasise the pain, distress and loss of quality and length of life that osteoporosis incurs.

In the ensuing discussion session, Mary Honeyball pointed out that where campaigns have been successful, the key to success was that the government gave its full support to the disease, in a sense "adopting" it. She cited examples from the UK, including the adoption of action against smoking as a major public health policy, and also cancer – in the case of breast cancer and cervical cancer, all women automatically receive periodic screening. Professor Juliet Compston stressed the need for very focused, hard targets for disease prevention, that will be considered cost-effective and achievable among the population; for example, in the case of osteoporosis, this could be DXA screening in the over 65s or over 70s.

Maintaining Momentum

Prof Gerold Holzer, Department of Orthopaedic Surgery, University of Vienna Medical School, Austria; Consultation Panel member for Austria

In the final presentation of the day, Prof Gerold Holzer, Consultation Panel member for Austria, gave an overview of recent policy-related activities in Austria, as an example of how to mount a successful policy and lobbying campaign, and maintain the momentum. Prof Holzer reviewed the current status in diagnosis and treatment of osteoporosis in Austria, and advised that both DXA scans, and also evidence-based treatments, are fully reimbursed by National Social Security – successful policy outcomes for Recommendations 5 and 6 of the eight Recommendations. He noted that Austria has a representative on the European Parliament Osteoporosis Interest Group, Karin Scheele MEP. Several successful and high profile social events in the name of osteoporosis have been held in Austria, including a Bone and Joint Decade (BJD) Gala Dinner at the Imperial Palace in Vienna, in 2004, which received an international award from the BJD in the category of 'Awareness'. Speaking to Recommendation 4 (policies to advise the public and health professionals about the importance of calcium and vitamin D nutrition), Prof Holzer advised that considerable work had been carried out in the area of adolescent nutrition and bone health – a critical time of life for accruing maximal peak bone mass. In addition, a new lifestyle project has recently been implemented in younger age groups, entitled 'Healthy School and Kindergarten', teaching children about the importance of healthy nutrition (including calcium and vitamin D) and exercise.

During the Austrian Presidency of the EU in 2006, osteoporosis featured prominently as a key health issue as a component of an overall advocacy programme on women's health. The Federal Minister for Health, Mrs Maria Rauch-Kallat, spoke about the importance of osteoporosis at several meetings, including the Fourth EU Osteoporosis Consultation meeting in April 2006. In addition, at the EPSCO Council meeting on 1-2 June 2006, the Austrians succeeded in including osteoporosis under item 12 in the Council Conclusions on Women's Health of their Presidency of the EU – the first time that osteoporosis has been included in a document presented to the EU Commission. Finally, much work has also been accomplished in the research areas of Recommendation 8, including the development of falls prevention strategies in the elderly. Prof Holzer concluded with some advice on how to maintain political momentum and media interest in osteoporosis: 1) Find, and generate the interest of, high level health administrators; 2) Convince them of the importance of osteoporosis; 3) Keep in continual contact with administrators and their staff through personal visits, telephone calls and emails; 4) Invite them, and the media, to meeting openings and gala dinners.

Panel discussion

The meeting concluded with an open discussion among the speaker panel and the meeting participants. Several suggestions for clarifications to the audit template were made.

Anne Simpson (UK) noted the need for societies to seek the assistance of professional public relations agencies to develop the media and marketing strategies for The Big Bang!, where such capacity is not available in-house. Paul Sochaczewski agreed, and added that although the IOF will be producing some general outreach materials for use by national societies, the success of the national campaign will depend on the resources and skills available within the country.

Angela Jordan (UK) made the point that successful national lobbying depends on the creation and sustenance of long-term relationship building, and that societies should not expect overnight results. Angela also noted that the IOF had achieved significant successes at the EU level, for example securing verbal pledges of support from Health Commissioners, and that it will also be crucial to maintain this level of support. Prof Istvan Marton (Hungary) stated that there are plans to link the Austrian and Hungarian campaigns to the 'Ageing Europe' concept, to reinforce the point that osteoporosis incidence and prevalence is set to increase dramatically, unless action is taken.

Further information:

See [PowerPoint presentations](#) from meeting

See [press release](#) issued on the occasion of the meeting

See [photo gallery](#) These and other photographs are available in high resolution upon request, please contact mwalker@osteofound.org