BROKEN BONES, BROKEN LIVES:
A roadmap to solve the fragility fracture crisis in Spain
The International Osteoporosis Foundation (IOF) is a registered not-for-profit, non-governmental foundation based in Switzerland that has been granted Roster Consultative Status with the Economic and Social Council of the United Nations. IOF functions as a global alliance of patient societies, research organizations, healthcare professionals, and international companies working to prevent osteoporosis and fragility fractures worldwide. Striving for a world without fragility fractures, in which healthy mobility is a reality for all, IOF is dedicated to advancing research and education, promoting policy change, increasing awareness of bone health, and improving patient care.

The Spanish Osteoporosis and Arthritis Association (AECOSAR) was founded in 1994 and has since become a benchmark in the fight against Osteoporosis in Spain. The association has three objectives with regard to osteoporosis: 1) promote prevention measures; 2) raise awareness of the risks of osteoporosis; and 3) help patients and relatives affected by the disease. AECOSAR has a broad scope, from the development of a comprehensive health program, to recreational activities and services that can be implemented by the individual patient. To succeed in this, it partners with multidisciplinary professionals and the public administration.

The development of this report has been supported by UCB.

Full publication of the data included in this report is currently in development.
As Spain’s population ages, the challenge of preserving the independence and active lifestyles of the aging population has become a multifaceted challenge that technology, social initiatives, and healthcare policy can help tackle.

With approximately 330,000 new broken bones occurring in Spain in 2017, fragility fractures are a major obstacle to healthy aging, impacting the independence and quality of life of 2.8 million women and men living with osteoporosis in Spain.

Fragility fractures can be prevented, but their prevention and management have long been neglected despite the massive associated costs for the Spanish healthcare system (€4.2 billion in 2017) and these are set to increase to €5.5 billion by 2030.

The burden of fragility fractures in Spain is similar to those for chronic obstructive pulmonary disease (COPD) and exceed those for ischemic stroke.

After a fragility fracture, patients are five times more likely to experience a second fracture within the next 2 years. Despite this, an estimated 72% of Spanish women aged 50 years and above do not receive preventative treatment after an initial fragility fracture. Not unique to Spain, this massive treatment gap is observed consistently across Europe, reflecting the low importance that has been given to fragility fractures to date and the current urgency to prioritize post-fracture care in our aging societies before costs get out of control.

With life expectancy continuing to increase, fragility fracture incidence in Spain is predicted to increase by almost 30% by 2030; now is the time to break the cost spiral, and take action to put an end to the dire consequences of fractures on patients.

Policies have a significant role to play in promoting, funding, and implementing care solutions, such as coordinated care models for patients following a fracture, with the most common coordinated care model for post-fracture patients being a ‘Fracture Liaison Service’ or FLS. Such models have proven to be both clinically effective and cost-effective: reducing further fractures, and lessening the burden on both healthcare and individuals at a reasonable level of investment.

While coordinated care models appear as a universal solution to improve patients’ diagnosis, treatment, and follow-up, local policy solutions adapted to the specificities of healthcare systems and policies – within and across countries – should also be considered.

In recognition of the growing fragility fracture burden, the Spanish national roadmap calls for policy care efforts to be focused across seven key areas:

1. Greater prioritization of secondary fracture prevention in national and regional health plans
2. Development of national consensus care protocols (Código de Fractura) to facilitate the identification of patients and optimize the delivery of available treatments
3. Development of post-fracture care models with standardized guidance
4. Improved monitoring of fragility fractures and their management through national registries that capture robust real-life data to help understand the true fragility fracture challenge
5. Reduction of waiting times for hip fracture surgery
6. Quality standards and indicators to measure progress and improve post-fracture care
7. Campaigns to increase patient awareness, engagement, and empowerment to improve patients’ self-management and health-related quality of life
DID YOU KNOW THAT...

- Osteoporosis (which means ‘porous bone’) is a disease that weakens the density and quality of the bone, thus increasing the risk of fracture. The loss of bone is symptomatically silent and progressive, until the first fragility fracture occurs due to a low-trauma event, such as a fall from standing height or even a minor bump.

- One in five men and one in three women aged ≥50 years will experience a fragility fracture in their remaining lifetime.

- A fragility fracture is a warning sign that has to be taken seriously: a fracture increases the risk of a subsequent fracture, which can occur at a different site.

- It is not only important to treat the existing fragility fracture but also to prevent subsequent breaks, i.e. secondary fracture prevention.

- “By missing the opportunity to respond to the first fracture, healthcare systems around the world are failing to prevent the second and subsequent fractures” (Professor Kristina Åkesson).

Something else that affects my everyday life is fatigue. Pain results in incredible fatigue, which I think is difficult for others to be able to understand.

Anita, Sweden

Now I walk with a cane, my back is very curved, and I can’t bend over. I cannot have a life as active as I would like...

Carmen, Spain

THE SILENT BURDEN OF FRAGILITY FRACTURES FOR INDIVIDUALS AND HEALTHCARE SYSTEMS

Fragility fractures affect men and women across Spain

Prevalence of osteoporosis across Spain

Approximately...

2.2 million

0.6 million

2.8 million people in Spain have osteoporosis (assessed in 2015).

Prevalence of osteoporosis in Spain (22.5% for women; 6.8% for men) over the age of 50 years is comparable to that of France, Germany, Italy, Sweden, and the UK, which together with Spain are hereafter referred to as the EU6 nations.
The lifetime risk of sustaining a fragility fracture varies for women and men, and by fracture site.

There is a marked difference in the risk of fracture between the EU6 countries, with Northern European countries having the highest fracture rates observed worldwide.

The reasons for the difference in fracture risk between countries are unknown and cannot be explained by differences in bone density. However, plausible factors include differences in body mass index, low calcium intake, reduced sunlight exposure and, perhaps the most crucial factor, socio-economic prosperity, which in turn may be related to low levels of physical activity.12,13

Regardless of differences in fracture risk, the number of fractures in all countries is expected to increase due to an increasingly elderly population.

Lifetime risk of fragility fractures from the age of 50 years in Spain1,7,12,14–20

Estimated number of fragility fractures in Spain and the EU6 in 2017, by fracture category

Fragility fracture incidence

An estimated 330,000 fragility fractures occurred in Spain in 2017.5

The lifetime risk of a major osteoporotic fracture (MOF) among Spanish men is similar to that for the collective EU6 male population, but lower for Spanish women than their EU6 counterparts.7

The silent burden of fragility fractures for individuals and healthcare systems
Fragility fractures incur substantial healthcare costs

Fragility fractures are associated with significant healthcare costs

In 2017, fracture-related costs totaled approximately €4.2 billion in Spain. Of these costs, which included short- and long-term fracture costs as well as costs associated with nursing home stays, hospital admission and length of stay in secondary care following a fracture were important drivers.

Estimated annual fracture-related costs in Spain in 2017

<table>
<thead>
<tr>
<th>Fracture Type</th>
<th>Costs (€ billion)</th>
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<tbody>
<tr>
<td>Vertebral</td>
<td>0.50</td>
</tr>
<tr>
<td>Other</td>
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<td>MOF</td>
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<td>Total</td>
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Fragility fractures place a high burden on patients and healthcare systems

The burden of fragility fractures on individuals is demonstrated here with the annual loss of quality-adjusted life years (QALYs). QALYS are a measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health. QALYS are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality-of-life score (on a 0 to 1 scale). It is often measured in terms of the patient’s ability to carry out the activities of daily life, and freedom from pain and mental disturbance.

The loss of QALYS as a result of fragility fractures varies across the EU6 countries. These differences are largely driven by variations in the risk of fractures and age distribution between countries.

The total health burden in 2017 due to fragility fractures in Spain is estimated to be 118,825 QALYs; 57% of which is attributable to fractures occurring among women.

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Fragility fractures can significantly impact the working population

Although fragility fractures mostly affect people in later life, an estimated 20% of fractures occur at pre-retirement age. In 2017, a total of 355,306 sick days were taken in Spain among individuals of pre-retirement age affected by fragility fractures. An average number of 13 sick days are taken per 1,000 people following a fragility fracture in Spain; the lowest estimate of any EU6 nation.

Fragility fractures have a multifaceted impact on the individual and society

Reduced independence and lifestyle impairment

Reduced independence can be one of the most distressing outcomes for fracture patients. The disability associated with hip fractures can be severe. One year after hip fracture, 40% of patients are still unable to walk independently, and 80% are restricted in other activities, such as driving and grocery shopping.

A fracture not only affects people physically, but also emotionally. Knowledge of their increased fracture risk can negatively affect patients’ outlook, causing them to change their levels of social interaction and to avoid certain activities: impairing their overall quality of life.

The long-term loss of independence and mobility can put physical, emotional, and financial strain on patients, as well as their relatives and friends, potentially leading to the need for institutional care, particularly in older age groups.

Across Europe, the proportion of patients that move into long-term care (LTC) within a year of sustaining a hip fracture increases with age, from 2.1% at age 50–60 years to 35.3% above 90 years. An estimated 10.4% of Spanish patients aged 50 or above who suffer a hip fracture are admitted to LTC within 12 months of the fracture, one of the highest proportions of any of the EU6 countries.

The silent burden of fragility fractures for individuals and healthcare systems

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Patients suffering fragility fractures depend on care from family and friends

As a result of reduced mobility and ability to complete activities of daily living, individuals who have suffered a fragility fracture may rely on informal caregivers, such as family members or friends. During the first year after a fracture, the hours of care provided by relatives vary greatly by fracture type and country.\textsuperscript{44} The more serious the fracture, the more support is needed.

**Vertebral**

- 263 hours care per 1,000 individuals

**Hip**

- 370 hours care per 1,000 individuals

**Other**

- 130 hours care per 1,000 individuals

In countries where cross-generational support is more established, the impact of fragility fractures on caregivers is generally higher.\textsuperscript{11}

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\textsuperscript{44}To measure the average burden placed on informal caregivers per year, survey responses from ICUROS\textsuperscript{28–30} were also used to determine the caregiver burden due to osteoporotic fracture. It was measured in terms of hours of care per year provided by relatives in ICUROS Europe (a substitute measure for the EU6), as well as selected countries.

The silent burden of fragility fractures for individuals and healthcare systems

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FRAGILITY FRACTURES IN THE CONTEXT OF PUBLIC HEALTH PRIORITIES

Fragility fractures represent a health risk for individuals aged 50 or above. In Spain, the lifetime risk of suffering a hip fracture in this older population is 9.8% for women and 8.5% for men; higher than for vertebral fractures (7.0% for women; 6.1% for men). Furthermore, the lifetime risk of suffering a MOF at age 50 in Spain (20% for women; 18% for men) is comparable to that of stroke in Europe (20% for women; 14% for men).32,33

Fragility fractures are the fourth leading cause of chronic disease morbidity, rising from a ranking of sixth in 2009. Across the EU6, fragility fractures now account for more than 2.6 million DALYs (a measure of the impact of a disease or injury in terms of healthy years lost) annually, more than for hypertensive heart disease or rheumatoid arthritis.7

In Spain, an estimated 12 DALYs are lost per 1,000 individuals aged over 50 due to fragility fractures. The Spanish burden is higher than the national burden associated with other major chronic diseases of aging, such as stroke.34

The fragility fracture burden in the EU6 is greater than that of many other chronic diseases (including COPD). It is surpassed only by ischemic heart disease, dementia, and lung cancer.34
FRAGILITY FRACTURES ARE A GROWING CHALLENGE IN THE PUBLIC HEALTH LANDSCAPE

An ever-growing public health challenge is emerging: an estimated 330,000 fragility fractures occurred in Spain in 2017, and the annual incidence is estimated to increase to 420,000 by 2030.6

The projected increase in fracture incidence in Spain (28.8%) is higher than predictions for the EU6 average of 23.3% over the same period.6

My daily life has changed completely. I now walk with two canes. I can't bend down and I'm constantly in pain. I cannot carry things and, therefore, cannot go shopping. I miss my active life, very, very much.

Inger, Sweden

Estimated number of fragility fractures by fracture category for Spain in 2017 and 2030

Fracture-related costs are set to rise

With life expectancy in Spain increasing, so too is the fragility fracture incidence and related use of healthcare services. With fragility fracture incidence predicted to increase by a further 28.8% between 2017 and 2030, the associated care costs are projected to increase by 30.6% over the same period, slightly comparable to the overall rate for the EU6 of 27.7%.6

Although hip fractures make up 1/5 of total fractures, they are estimated to incur an estimated 62% of total fracture-related costs
**Fracture-related patient burden is set to increase**

Based on population projections, the QALY losses associated with fragility fractures will increase between 2017 and 2030, with Spain facing an increase of 29.8% over the period; slightly higher than the EU6 average of 25.6%.6

**Relative risk of all subsequent fractures calculated as a mean from the first fracture (grey line) and per separate year of follow-up (orange line)**

Adapted from van Geel et al. 200935

**EFFECTIVE MANAGEMENT CAN IMPROVE OUTCOMES AND REDUCE COSTS**

If the fracture I suffered in my spine had been spotted earlier than it was, I would have been spared a great deal of pain and suffering.

Christine, UK

**One fragility fracture leads to another**

For women aged 50 to 80, after their first fragility fracture, their risk of a subsequent fracture within the first year after a fracture is five times greater than women who have not had a prior fracture.35

Subsequent fracture risk is highest in the first 2 years following an initial fracture, when there is an imminent risk of another fracture at the same, or other, sites.26 This is why it is critically important to identify patients as soon as possible after fracture to optimize fracture prevention treatments and keep the patient from having another fracture.

Similar patterns of imminent fracture risk have been observed in most countries evaluated,21,22 but between-country comparisons are limited by data availability.
Most eligible patients do not receive treatment to prevent fragility fractures following their first fracture.

With appropriate medical treatment, many fragility fractures can be avoided.

The treatment gap in Spain has increased by 40% for men and 43% for women since 2010, and it is estimated that as little as 28% of Spanish women receive a treatment for fracture prevention in the year following an initial fracture.6

Proportion (%) of female patients (50 years and above) untreated within a year of osteoporotic fracture6,37,38

<table>
<thead>
<tr>
<th>Country</th>
<th>Hip</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td></td>
<td></td>
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<tr>
<td>Sweden</td>
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Multidisciplinary models for secondary fracture prevention can contribute to closing the treatment gap.

Post-fracture coordinated care models, such as a Fracture Liaison Service (FLS), are multidisciplinary healthcare delivery models for secondary fracture prevention. Systematically, they identify, diagnose, and treat (by referral) all eligible patients within a local population who have suffered a fragility fracture, with the aim of reducing risk of subsequent fractures. In the FLS model, care is usually coordinated by a dedicated, specialist nurse who helps patients navigate the way through the various departments of relevance (e.g. orthopedic surgery, radiology, and primary care) and improve their overall care experience.

Post-fracture coordinated care models, like FLSs, offer the potential for a cost-effective care delivery model that reduces the risk of re-fracture and mortality by increasing the number of patients being treated and improving adherence to treatment.5,41-44 Data published from the FLS in Glasgow, Scotland, showed that FLSs are cost-effective for the prevention of further fractures in fragility fracture patients, resulting in fewer fractures and cost savings for healthcare systems.5,41

A recently published systematic literature review and meta-analysis based on 159 scientific publications highlighted the benefits of FLSs.45

<table>
<thead>
<tr>
<th>Outcome measure45</th>
<th>Effect of FLS (absolute change)</th>
<th>95% CI</th>
<th>Duration of follow-up (months)</th>
<th>Number of studies included</th>
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<tbody>
<tr>
<td>BMD testing</td>
<td>+24%</td>
<td>0.18 to 0.29</td>
<td>3–26</td>
<td>37</td>
</tr>
<tr>
<td>Treatment initiation</td>
<td>+20%</td>
<td>0.16 to 0.25</td>
<td>3–72</td>
<td>46</td>
</tr>
<tr>
<td>Treatment adherence</td>
<td>+22%</td>
<td>0.13 to 0.31</td>
<td>3–48</td>
<td>9</td>
</tr>
<tr>
<td>Re-fracture rate</td>
<td>-5%</td>
<td>-0.08 to -0.03</td>
<td>6–72</td>
<td>11</td>
</tr>
<tr>
<td>Mortality</td>
<td>-3%</td>
<td>-0.05 to -0.01</td>
<td>6–72</td>
<td>15</td>
</tr>
</tbody>
</table>

BMD, Bone Mineral Density
A meta-analysis demonstrated that adoption of the 3 “I” model, with core priorities of Identify, Investigate and Intervene, offered greater effectiveness in patient assessment and treatment than 0–2 “I” models.

<table>
<thead>
<tr>
<th>Model</th>
<th>Identify</th>
<th>Investigate</th>
<th>Intervene</th>
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<tbody>
<tr>
<td>3 “I” model</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2 “I” model</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1 “I” model</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>0 “I” model</td>
<td>No</td>
<td>No</td>
<td>No</td>
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Adapted from Ganda et al.46

The effect of different models of care on osteoporosis treatment and frequency of BMD testing were evaluated in a meta-analysis by Ganda et al.46

<table>
<thead>
<tr>
<th>Model</th>
<th>BMD Testing</th>
<th>Osteoporosis Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 “I” model</td>
<td>79%</td>
<td>46%</td>
</tr>
<tr>
<td>2 “I” model</td>
<td>60%</td>
<td>41%</td>
</tr>
<tr>
<td>1 “I” model</td>
<td>43%</td>
<td>23%</td>
</tr>
<tr>
<td>0 “I” model</td>
<td>No</td>
<td>8%</td>
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Based on a survey sent to a number of FLSs in the EU6 enrolled in IOF’s CTF® network, it is estimated that only 11–25% of hospitals in Spain and 1–10% of GPs report having a referral system for fracture patients. A recent health economic analysis suggested that the introduction of an FLS for all individuals aged over 50 could prevent an estimated 1,249 subsequent fragility fractures in Spain every year and a net saving of €18.4 million annually.45

**Capture The Fracture® (CTF®): A global initiative of IOF**

CTF® aims to ‘facilitate the implementation of coordinated, multidisciplinary models of care for secondary fracture prevention’. CTF® has created a set of internationally endorsed standards and guides for best practice to bridge the gap between FLS providers and to help in the development and implementation of new FLSs. CTF® includes the largest network of individual FLS providers in the world. Providers undergo a CTF® audit to determine service quality, with a gold, silver, or bronze star awarded.

There are huge variations between and within countries in terms of the availability of coordinated care models. A CTF® survey reported that such models only existed for 2.8% of responders in Italy and up to 37.5% of responders in Sweden for hospital referrals, reducing to 1–10% for general practitioner referrals. In contrast, in the UK, the National Osteoporosis Society estimated that 55% of the UK population has access to an FLS.

**FLSs are a cost-effective option for patient management**

Several studies have showed FLSs to be a cost-effective healthcare delivery form in European countries. Although not specifically evaluated for Spain, in Sweden and the UK the cost of improving patient outcomes through an FLS has been estimated to be €7.44

**Cost implications of extending an FLS to all individuals over 50 years in Spain**

The World Health Organization (WHO)59 provides guidance on how an intervention with a benefit expressed in QALY value equivalent to 1 year’s gross domestic product (GDP) per capita or less is considered to be reasonable expenditure, representing the likelihood of achieving at least 1 additional year of healthy life per capita.

Although an FLS extension would result in a net increase in healthcare costs, with the Spanish GDP estimated to be €32,405,60 FLSs still offer clear cost-effectiveness, as well as the possibility of improved care for the Spanish population.
Even if Spain fares slightly better than other countries in terms of fragility fracture management, a lot of work is still required to achieve excellence in managing this growing public health problem. As the Spanish population continues to age, so too will the magnitude and impact of fragility fractures unless measures are put in place to address the variation in care practice, and improve the quality of care. Policy has a strong role to play in recognizing that fragility fractures are a hidden public health threat that requires immediate action.

1. Prioritize secondary fracture prevention
As part of their prioritization exercise, national and regional health authorities should include fragility fracture prevention and management in their health plans to ensure sufficient priority is given to the challenges faced, but also the solutions available. In particular, the national strategy for health promotion and prevention could help frame the problem, as well as recommending solutions to improve patient care in terms of diagnosis, intervention, and follow-up.

2. Create national consensus care protocols (Código de Fractura)
As for other public health challenges, it is essential to establish national and regional care pathways – Código de Fractura – to facilitate the identification of patients and optimize the delivery of available treatments. Such protocols should be implemented in both primary care and hospital settings.

3. Support the development and implementation of post-fracture care models
Since their creation in Scotland at the end of the 1990s, post-fracture coordinated care models have proven to be effective care interventions by being able to reduce the risk of subsequent fractures and improve patient outcomes. Such care models are commonly known as FLSs. There are currently 54 FLSs and 87 post-fracture coordinated care units in Spain. The IOF CTF®’s Map of Best Practice reveals a certain level of variation in terms of performance of Spanish FLSs. Such variability may be due to a current absence of standardized guidance for healthcare professionals seeking to establish a post-fracture coordinated care pathway.

It may also be beneficial to develop formal guidance documents outlining issues that can aid or impede the success of FLSs, as developed in Sweden’s Vastra Gotaland county.51 Such guidance could be developed in specific provinces, or professional organizations, such as the Sociedad Española de Directivos de la Salud – Spanish Society of Healthcare Executives.

In addition, it would be beneficial to put in place clear quality metrics to drive post-fracture coordinated care units’ quality of care, and potentially identify support measures if significant variability in performance is identified.
4. Strengthen registries tracking fragility fractures and FLS’ impact

Two recent initiatives have been launched in Spain to track fragility fractures and their impact:

- The first was launched in 2016, when 190 healthcare professionals from various specialties (geriatrics, orthopedics, internal medicines, rehabilitation) created a national hip fracture database (Registro Nacional de Fracturas de Cadera) that collects data from 54 hospitals. As it is based on the Fracture Fracture Network’s Minimum Common Dataset, data can be compared across, or aggregated at, a European level. The annual reports capture key epidemiological data and outline the trends in terms of care pathway. They also show a certain degree of variability in the care that patients may receive, highlighting a need for further harmonization of standards in hip fracture care. The database was developed through the joint efforts of dedicated and motivated healthcare professionals who manually entered their patients’ records into the database. Moving forward, it would be appropriate to consider national and/or provincial funding for such initiatives, as well as funding from the European Union to create an IT interface that can support data collection, analysis, and sharing, and thus facilitate the study of analysis of patients’ health outcomes over the longer term.

- The second initiative, by SECOMM, is a dedicated database – Registro Español de Fracturasó – designed to track the epidemiology of all types of fragility fractures and the impact of FLS on patients’ health outcomes. This initiative also requires support from the national and provincial health authorities to expand the scope of the database and ensure it delivers meaningful results over time.

5. Develop a guidance to reduce waiting time for hip fracture surgery

While early hip fracture surgery may improve patients’ outcomes (especially in terms of morbidity), the median time between the admission and surgical intervention for patients with hip fracture is around 3 days in Spain.13 Up to 25% of patients, however, have to wait more than 6 days from their fracture before they receive surgical intervention, which is significantly longer than the “on the day or, or the day after admission” that is recommended by the UK’s National Institute for Health and Care Excellence (NICE).14 These databases will also be able to help identify hospitals that provide timely care, as well as those centers where more targeted efforts may be required to help improve standards of care.

Similar to NICE, a standardized protocol for hip fracture management in Spain and quality standards for the optimum timing of hip fracture surgery could help reduce variations and improve patient outcomes.

6. Improve and harmonize post-fracture care through quality standards and indicators

Post-fracture care is subject to significant variation in Spain, and the quality of care that patients may receive can depend on the existence of FLSs in their locality and on their healthcare professionals’ familiarity with post-fracture care interventions.

In order to improve and standardize post-fracture care across the territory, the Spanish Ministry of Health should implement fragility fracture monitoring using clear indicators and quality metrics. Quality targets can focus on a number of aspects of care, such as standards for: time-to-surgery (with a view to reducing waiting times, as discussed above), or treatment targets that encourage use of secondary fracture prevention interventions. In Sweden, for example, a treatment-related quality indicator was set in 2015 that called for a 30% increase in the proportion of women aged 55 and above prescribed osteoporosis drugs in the 6–12-month period post-fracture.26 Such targets, however, can only be effective if properly monitored, re-emphasizing the need to strengthen the current fragility fractures database initiatives described above.

7. Patient awareness and engagement campaigns

Information campaigns about bone health and healthy lifestyles, as well as patient education programs, can support patients’ adherence to treatment and also increase their engagement in activities that can improve their overall health and reduce the risk of subsequent fragility fractures. It is essential that patients play an active role in managing their own health, to understand when to seek medical support from appropriate specialists, and to have informed discussions about fragility fracture prevention and management. Patient engagement and improved health literacy can help to optimize the use of available resources and reduce unnecessary visits to primary care centers, emergency units, and hospitals.

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Our vision is a world without fragility fractures, in which healthy mobility is a reality for all.