Snapshot of the 2024/25 Cohort of our Secondary Fragility Fracture Prevention Programme in NZ

Australian & New Zealand Fragility Fracture Registry

This snapshot highlights key data from the third year of recruitment to the Australian & New Zealand Fragility Fracture Registry (ANZFFR). These patients were identified between 1 July 2024 and 30 June 2025, with 16-week follow-up completed by 31 October 2025. In New Zealand, Fracture Liaison Services (FLS) continue receiving funded support from the Accident Compensation Corporation (ACC), a crown entity. The 2024/25 cohort demonstrates sustained progress across most key performance indicators, with 77% identification of expected fragility fractures. We are making a measurable difference in preventing secondary fragility fractures. Australia continues building momentum, with three participating FLS services and growing clinical leadership supporting expanded coverage.

To view the full ANZFFR 2026 report please visit: www.fragilityfracture.co.nz or www.fragilityfracture.com.au

HOW MANY FRAGILITY FRACTURES DID WE IDENTIFY?

17,141 fragility fractures occurred

77% of predicted annual fractures in NZ

16,012 people identified in Registry

FLS TEAMS IDENTIFIED

69% of predicted non-spine fractures

99% of predicted spine fractures

OF WHICH 80% WERE TOP 5 FRACTURE SITES

- Hip **23%**
- Wrist **22%**
- Spine **18%**
- Humerus **10%**
- Pelvis **7.1%**

GETTING TO KNOW THE PEOPLE BEHIND THE NUMBERS

Three in four people were women (76%) consistent with 2023/24 cohort

- **76%** NZ European
- **4%** Māori
- **2%** Pacific Peoples
- **2%** Indian/SE Asian
- **3%** Chinese

Average age **76YEARS** nearly half (45%) were 80 or older

88% living in a private residence (including retirement village units)

65% were mobile without aids before their fracture, highlighting how fractures can suddenly impact independence

18% had known dementia or cognitive issues

THEIR JOURNEY THROUGH CARE

INVESTIGATION within 12 weeks of their fragility fracture

80% of patients had a bone health assessment

32% of target population had a DXA scan

80% had a falls risk assessment

INFORMATION

over 71% of patients were sent written or digital **INFORMATION** about bone health and **Know Your Bones™** for family member self-assessment

OVER 97% had a 16-week follow-up (successful or attempted)

55% of those recommended osteoporosis specific treatment were actively taking it

53% of those recommended Strength and Balance classes had started them

INTERVENTION

49% of all patients received an osteoporosis specific treatment recommendation

2,043 patients were already taking osteoporosis specific treatment at time of index fracture

INTEGRATION

63% of patients' primary healthcare provider received a long-term care plan about osteoporosis specific treatment

QUALITY

22 FLS TEAMS covering 18 out of 19 Health New Zealand districts serving

98.9% of the NZ population

FRACTURE FEST 2025

48 attendees

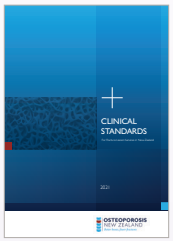
21 virtual education sessions

68 sessions accessible on demand

CPD enables knowledge sharing, networking, and best practice exchange between all FLS teams.

Towards Excellence

Improving Care and Building on Success



FLS teams deliver world-class secondary fracture prevention for people aged 50 and older who have sustained a fragility fracture. They identify patients, assess bone health and falls risk, recommend evidence-based treatment, and support long-term prevention through coordinated follow-up, guided by Clinical Standards that set the national benchmark for best-practice care and define the KPIs used to measure performance. With fragility fractures accounting for 190,000 hospital bed days annually (equivalent to 521 beds continuously occupied), the scale of the burden and the value of secondary prevention is clear.

Underpinning this work, the ANZFFR serves three critical functions: a real-time patient management system embedded in daily FLS clinical work, a quality improvement tool for benchmarking and identifying variation, and an outcomes measure tracking refracture rates. Reaching 50,000 patient journeys in November 2025, nearly 1 in 100 New Zealanders, the Registry reflects the national scale and maturity of the programme.

System-Wide Performance Highlights

22 FLS teams cover 98.9% of the NZ population, identifying 77% of predicted fragility fractures nationally in 2024/25 (an improvement from 55% in 2022/23).

Of all patients identified:

- **80%** had a bone health and falls risk assessment within 12 weeks.
- **49%** received a treatment recommendation, with **55%** actively taking osteoporosis-specific treatment by 16 weeks, performance that matches or exceeds international comparators.
- **63%** had a long-term care plan shared with their primary healthcare provider.

Refracture rates *in our most mature cohort (2022/23) demonstrate clear programme impact, with a 2-year rate of 8.0% compared with 11.3% internationally without FLS care. With peak risk occurring at 6–12 months, early intervention in the first year remains critical.*

	Overall FFR Population (N=43,779)	2022/23 Cohort (N=11,641)
Refracture by 1 year	3.5% (1,533 patients)*	4.5% (521 patients)*
Refracture by 2 years	5.2% (2,259 patients)*	8.0% (926 patients)*

*Represents observed refractures until 30 June 2025 - rates will increase as additional patients refracture.

Continuous **Quality Improvement** is now embedded across New Zealand services, strengthening consistency and equity. 19 services are internationally recognised through IOF Capture the Fracture® (12 Gold, 5 Silver, 2 Bronze).

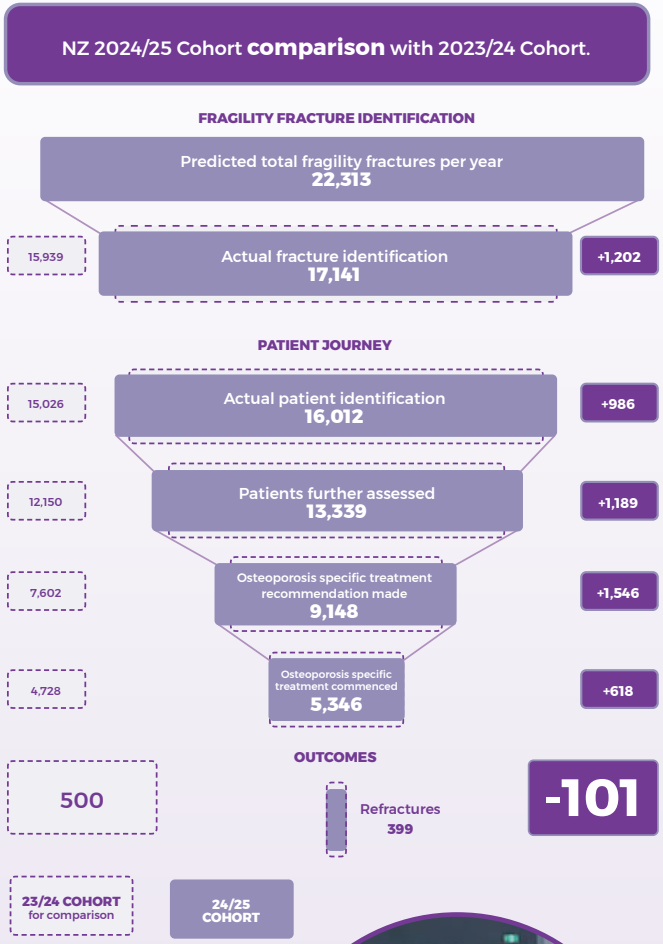
As the programme moves from establishment towards excellence, key **national priorities** include:

- Improving equitable access to DXA scanning, which remains a barrier to timely treatment recommendation across most regions.
- Strengthening shared-care pathways with primary care to support treatment initiation and long-term management.
- Ensuring sustainable workforce capacity across primary care, secondary care, and FLS teams to maintain and extend programme gains.

Where we are after Year 3

The treatment cascade illustrates the key phases of the programme for the 2024/25 cohort, from fragility fracture identification through bone health assessment to commencement of osteoporosis treatment. Overall, we enrolled more patients and improved performance across most metrics, a strong result for an entirely new cohort.

Refracture rates, tracked via our primary measure the Refracture Tracker, show **significant improvement:** 399 patients (2.49%) experienced a refracture, down from 500 (3.33%) the previous year. As enrolment is ongoing throughout the year, these figures reflect approximately six months' follow-up for each cohort, rather than full-year outcomes.



Real Stories, Real Impact

Read the full report to discover patient stories, from Annette's experience of an unexpected fracture and what she wishes she had known sooner about her bone health, to Helen's determination to get back on the pickleball court after a hip replacement, Chris finally understanding her diagnosis after one phone call from her FLS coordinator, and Marilyn and Linda's multigenerational journey with osteoporosis that changed both their lives.

OSTEOPOROSIS NEW ZEALAND
Better bones, fewer fractures

He Kaupare. He Manaaki. He Whakaora.
prevention. care. recovery.

LIVE STRONGER FOR LONGER
PREVENT FALLS & FRACTURES

Fracture Alliance
Making the first break the last