Table 1. Cost-effectiveness and probability of being cost-saving or cost-effective of osteoporosis screening interventions

Intervention	*Median ICER (95% uncertainty interval)*	*Probability of being cost-saving*	*Probability of being under $50,000/DALY*
Screening + alendronate	Cost-saving (cost-saving to $21,000)	63%	100%
Screening + raloxifene	$170,000 (140,000 to 230,000)	0%	0%

The physical activity intervention was already cost-saving based on its effect on cardiovascular disease, diabetes and cancer. (See ACE Prevention results on physical activity.) The fracture prevention-effect adds a modest 134 DALYs (+0.6%) and cost-savings of $4.5 million (7%). At older ages, when fracture risks are higher, the health gains from physical activity interventions are likely to be greater.

6. CONCLUSIONS

Screening older women for osteoporosis followed by treatment with alendronate is effective and may be cost-saving. Screening and treatment with raloxifene is not cost-effective. Mass media campaigns to promote physical activity, already highly cost-effective based on effects via cardiovascular disease, diabetes and cancer, become even more so if a small reduction in fracture risks is included. The uptake of both interventions is likely to be greater among women with higher socio-economic status. Personnel shortages may limit the capacity for bone mineral density screening, especially in rural areas.

For more information on this topic area, please visit: **www.sph.uq.edu.au/bodce-ace-prevention**

ACE–PREVENTION PAMPHLETS

7. ABOUT ACE-PREVENTION

To aid priority setting in prevention, the Assessing Cost-Effectiveness in Prevention Project (ACE-Prevention) applies standardised evaluation methods to assess the cost-effectiveness of 100 to 150 preventive interventions, taking a health sector perspective. This information is intended to help decision makers move resources from less efficient current practices to more efficient preventive action resulting in greater health gain for the same outlay.

PAMPHLETS IN THIS SERIES

Methods:
A. The ACE-Prevention project
B. ACE approach to priority setting
C. Key assumptions underlying the economic analysis
D. Interpretation of ACE-Prevention cost-effectiveness results
E. Indigenous Health Service Delivery

Overall results
1. League table
2. Combined effects

General population results
1. Adult depression
2. Alcohol
3. Blood pressure and cholesterol lowering
4. Cannabis
5. Cervical cancer screening, Sunsmart and PSA screening
6. Childhood mental disorders
7. Fruit and vegetables
8. HIV
9. Obesity
10. Osteoporosis
11. Physical activity
12. Pre diabetes screening
13. Psychosis
14. Renal replacement therapy, screening and early treatment of chronic kidney disease
15. Salt
16. Suicide prevention
17. Tobacco

Indigenous population results
1. Cardiovascular disease prevention
2. Diabetes prevention
3. Screening and early treatment of chronic kidney disease

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