

Reorienting Frailty in Clinical Practice, Public Health and Policy: a Lancet Commission

The WHO's policy framework for healthy ageing from the World Report on Ageing and Health recognises frailty as the foremost geriatric syndrome in older adults and a key determinant of functional ability.¹ Frailty poses a major public health challenge, with a heavy impact on the people living with it, their families, healthcare systems and social support services.^{1,2} Yet, frailty remains one of the least understood medical conditions globally. Without an adequate understanding of frailty and its causal pathways, policy-makers cannot develop effective preventative strategies to reduce frailty prevalence and its associated burden. Moreover, there is an urgent need for pragmatic strategies to integrate public health approaches with wider health, social, and aged care systems to improve the support for older adults living with frailty.^{3,4}

Frailty is common, affecting between 12-24% of the general population aged 65 years and over, depending on how it is operationalised.^{2,5} Of high relevance to public and health policy, frailty disproportionately affects older adults experiencing socioeconomic disadvantage,⁶ those from culturally and linguistically diverse backgrounds⁷ and populations residing in low-middle income countries.⁸ Women are more likely to be affected by frailty than men.²

Clinically, frailty is defined as a state of vulnerability resulting from progressive declines in physiological reserves across multiple organ systems.^{2,9} Even a minor stressor can lead to rapid deterioration in the health of an individual with frailty.^{2,9} Consequently, older adults living with frailty are intensive users of health and social care resources,^{10,11} and are susceptible to an array of adverse outcomes including falls, loss of independence, lower quality of life, and mortality.^{2,9,12} This increased risk of adverse outcomes can only be partially explained by an individual's underlying comorbid conditions.¹³

To address these critical knowledge gaps and to inform and develop effective public policy to prevent frailty, *The Lancet* announces a new Commission on reorienting frailty in clinical practice, public health and policy. The Commission will be a scientific enquiry into frailty and will build on the original *Lancet* Series on frailty from 2019^{2,9} and Seminar on frailty from 2013.¹⁴ During our first Commission meeting in November 2024, we defined our Commission's core goal: to globally reorient healthcare and public policy to prevent the development and progression of frailty across the life-course, and to improve access to high-value, evidence-based care for older adults with frailty. To achieve this goal, four priority areas will be targeted.

First, frailty needs to be recognised as an actionable target of prevention and treatment across the life-course. The Commission will develop new knowledge of the causal pathways for frailty, and the life-course factors (including social determinants of health) that are either driving or delaying its development and progression.¹⁵

Second, the Commission will build new knowledge on early detection and diagnosis of frailty in a public health approach. There remains continued debate over which frailty instrument is

best for screening and assessment of frailty. Our Commission will develop a framework of diagnostics (which is urgently needed given the heterogeneity of frailty measurements) and the correlation to WHO's International Classification of Diseases (ICD) and International Classification of Functioning, Disability and Health (ICF). We will discuss the implications of the harms and benefits of frailty identification of older adults. For example, during COVID-19 peaks, frailty measurement was controversially used to triage against specific older adults receiving treatment without adequate research on the accuracy of this process.¹⁶

Third, the Commission will generate new knowledge on the optimal management of older adults living with frailty. Over the last five years, clinical care for individuals with frailty has become increasingly diverse, extending beyond geriatric medicine and into other medical specialties such as cardiology, oncology, orthopaedics, neurology, endocrinology, surgery, and emergency medicine. Concomitantly, there is an urgent need for research into frailty within these medical specialties (e.g., how frailty moderates disease and impacts treatment outcomes), which was perhaps less recognised as essential in the past. Our Commission will investigate incorporation of frailty as a prognostic indicator into medical specialties, and in turn, develop an adaptable implementation framework to guide patient care plans. We will also develop new understandings of how we can target interventions prior to a known stressor, such as elective surgery.

Fourth, frailty needs to be more widely adopted into public health policies for ageing. The Commission will develop policy recommendations for national public health strategy reform to include frailty. It will augment several global initiatives, including the United Nations' Decade of Healthy Ageing (2021-2030), the WHO's policy framework for healthy ageing from the World Report on Ageing and Health,¹ and the World Health Assembly's goal of reorienting healthcare to focus on primary care.¹⁷ To support these recommendations, resource implications of rising levels of frailty will be assessed.

Development of the Lancet Commission on Frailty will involve high-level topic experts across relevant fields including geriatrics and gerontology, allied health, nursing, public health, health policy, implementation science, palliative care, primary care, pharmacology, surgery, oncology, cardiology, social science, epidemiology, and geroscience. The Commissioners bring a diverse range of perspectives, balancing gender representation, geographical diversity, career stage, and multidisciplinary representation. Our Commission will place a strong emphasis on strategies which can be adapted to populations with disparities in access to care, including those residing in low-middle income countries, culturally and linguistically diverse populations and rural dwelling populations. The perspectives of older adults, including their perceptions of frailty, being identified as frail, and their health literacy towards active ageing will be sought when developing our Commission.

*Elsa **Dent**¹, Andrew **Clegg**², Regina **Roller-Wirnsberger**³, Davide L. **Vetrano**⁴, Emiel O. **Hoogendijk**⁵
edent@bond.edu.au

(1) Institute for Evidence-Based Health Care, Bond University, Robina, Queensland, Australia (ED); (2) Academic Unit for Ageing & Stroke Research, Leeds Institute of Health Sciences, University of Leeds, Leeds, UK (AC); Bradford Institute for Health Research, Bradford Teaching Hospitals NHS Foundation Trust, Bradford, UK (AC); (3) Department of Internal Medicine, Research Group on Old Age Medicine and lifelong Health, Medical University of Graz, Austria (RRW); (4) Aging Research Center, Department of Neurobiology, Care Sciences and Society, Karolinska Institutet and Stockholm University, Stockholm, Sweden (DLV); Stockholm Gerontology Research Center, Stockholm, Sweden (DLV); (5) Department of Epidemiology & Data Science and Department of General Practice, Amsterdam Public Health research institute, Amsterdam UMC, location VU University Medical Center, Amsterdam, the Netherlands (EOH).

Competing interests

AC led the development and national implementation of the UK electronic frailty index (eFI) which uses routinely available primary care electronic health record (EHR) data to support frailty identification. The eFI is available for research use and licensed to UK suppliers of EHR systems at no cost on the basis that a subsequent premium charge is not subsequently applied to the end user. AC also led the development of the eFI version 2 (eFI2). The eFI2 model equation and associated code lists used to define variables are available for research use. The eFI2 research team aim to make eFI2 available to suppliers of UK electronic health record systems, risk stratification software, and for use in national policy and commissioning under the terms of an agreed license agreement. AC is named on the eFI2 revenue share distribution, in the event of future commercialisation.

The Commissioners for The Lancet Commission on Frailty are: Andrew Clegg, Elsa Dent (Co-Chair), Shelly de la Vega, Jason R. Falvey, Linda P. Fried, Amanda Grenier, Danijela Gnjidic, Peter Hanlon, Emiel O. Hoogendijk (Co-Chair), Juulia Jylhävä, Heather H. Keller, Dae Hyun Kim, Ebony Lewis, Mara A. McAdams-DeMarco, Mario U. Pérez-Zepeda, Kenneth Rockwood, Erwin Stolz, Jotheeswaran A. Thiyagarajan, Davide L. Vetrano, Regina Roller-Wirnsberger, and Alfred E. Yawson.

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