Our response to rising frailty in younger people must address prevention burden

We read with interest the Article by Joanna Blodgett and colleagues analysing severity and lethality of frailty in the USA between 1999 and 2018.[1] Their findings that frailty is increasing in prevalence and severity in adult men of all ages and in women over age 35 years has wide-reaching implications, and highlights the importance of primary prevention and the potential effect on health inequalities. In their accompanying commentary, Conroy and colleagues highlight that the key tenets of lifestyle change (ie, diet, exercise, smoking, and alcohol) are poorly adhered to, and argue that they must be tackled in combination, adding that "targeting of such interventions in a way that they are acceptable to the individuals they are intended to benefit… is an area that is much neglected".[2] We agree, but would further argue that our response must take account of prevention burden: the workload associated with tackling multiple risk factors in the context of an individual's capacity to undertake that work.[3] This burden falls most heavily on people experiencing socioeconomic deprivation, in whom risk factors often cluster.

Frailty, particularly at younger ages, is closely linked with lower socioeconomic status. In our analysis of UK Biobank participants aged 37–73 years, 42% of individuals living with frailty were within the most deprived 20% of the cohort.[4] Furthermore, an analysis of the Whitehall II cohort revealed social inequalities were associated with increased risk of developing frailty, multimorbidity, and disability, but not with risk of mortality once these states had developed.[5] Therefore, if the rising prevalence of frailty in younger ages is to be addressed, it must be at the level of primary prevention, with particular attention to the multiple challenges of socioeconomic deprivation.

If this challenge is to be faced, people must be supported to overcome prevention burden at individual, community, and societal levels.[3] This support includes individualised approaches to identifying realistic targets for behaviour change and recognising deep-rooted health and cultural practices that contextualise these behaviours and how any response must respect and engage with this context. Crucially, health policies must confront upstream determinants and contextual or structural barriers to health, which often disadvantage those living with socioeconomic deprivation or experiencing social exclusion.

These challenges are complex. However, as Blodgett and colleagues' findings highlight, failing to overcome these challenges risks exacerbating the already stark inequalities in health seen in many societies. If we are to age well as a society, prevention burden is a challenge we must address.

We declare no competing interests. PH is funded by the Medical Research Council. The funder had no role in this piece or in the decision to submit.

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