ing sight, hearing and other functions. Simple eyesight and hearing tests are often a first step, as conditions affecting these functions can often be detected at an early stage and treated. Sadly, this does not happen very often. But we could avoid a large burden of disability related to eyesight and hearing, if we screened for those conditions routinely at primary health care level.

Q: You mention the vast amount of scientific evidence on preventing the conditions associated with old age, to what extent is this evidence being used to inform public health policy and programmes?

A: It is happening, but not systematically. We need to change public health policy and practice. For example, we need to develop ambulatory care for older patients because if they are hospitalized they often lose physical and mental functioning. We should be targeting frail people in the community and intervening as early as possible to prevent their physical and mental deterioration. If we wait until a later stage, they will end up in a hospital emergency department or in long-term residential care. This is not an efficient way for health services to deal with such patients and, of course, it's terrible for their quality of life. Most countries don't do enough in this respect. General practitioners in some countries already give older people advice, for example, to take more physical exercise and improve their diet. But this must be done systematically at primary care level, based on current guidelines and other evidence-based recommendations and with the help of specialist services.

Q: Do general practitioners have the diagnostic tools they need to intervene?

A: At the Gérontopôle, we developed a simple questionnaire for general practitioners to screen patients aged 65 years and over for frailty. After reviewing their findings for several frailty criteria, including recent tiredness and memory loss, the health professional makes a clinical judgement as to whether the patient is frail and at risk of further impairment or disability. We found that this questionnaire correctly identifies more than 95% of patients referred as frail or pre-frail. There are other simple tests too, for example, the seven-point Clinical Frailty Scale developed by Canadian specialists. Last year, the Frailty Consensus Conference in Florida, USA, recommended that people aged 70 years and older – as well as older people with 5% or more weight loss over the past year due to chronic illnesses – should be screened for frailty.

> "We should be targeting frail people in the community and intervening as early as possible to prevent their physical and mental deterioration."

Q: How can countries like China and India rise to the challenge confronting them of increasing rates of frailty?

A: Most western countries in Europe and North America have waited too long to act and now we face an epidemic of severe dependency for daily activities – such as washing, dressing, going to the toilet, preparing food and eating – a dependency that is often irreversible. It is only now that public health professionals are starting to tackle these problems at an earlier stage. Countries such as China and India do not have to wait until people become totally dependent and end up sitting in a hospital bed. They can look out for frailty and intervene to prevent a large proportion of frailty now.

Q: A WHO Knowledge Network on Frailty is due to be launched next month, can you tell us about your collaboration with the World Health Organization (WHO) on this and its purpose?

A: We are working with WHO to implement frailty prevention in geriatric practice so that patients can maintain their autonomy. We are also working with a WHO expert group in collaboration with the International Association of Gerontology and Geriatrics on recommendations on how to develop and implement interventions in clinical practice to target frail people.

Q: Why has this area been neglected?

A: Geriatric medicine is still a new speciality and we are not listened to in the same way as experts from more established fields. Most governments have not anticipated the extent to which their populations are ageing. The solution is not a new drug – like statins for lowering cholesterol – and, therefore, this is not something that journals and medical conferences get excited about. However, this attitude is now changing and governments are realizing that the problem of dependency in older people can be extremely expensive and demoralizing for all concerned, considering the burden on families and social and health services.

Q: How can the forthcoming WHO Global Report on Ageing and Health address the need for prevention of conditions associated with old age?

A: Hopefully it will make governments and public health professionals more aware of the need to adapt current clinical practice to a rapidly ageing population to maintain their physical and cognitive functions as far as possible. This means maintaining mobility and memory and the ability to live at home rather than in institutions. Today's medical practice employs highly sophisticated technologies to diagnose clinical problems but often forgets that patients need to maintain their basic functions and autonomy in everyday life. I hope that this report will convey the urgent message that we need to change clinical practice now, we cannot wait until it is too late and we have an epidemic of dependency. ■

Corrigendum

In Volume 92, Issue 8, August 2014, page 620, the first sentence of the first paragraph under "Competing interests" should begin: "PB reports an honorarium from Eli Lilly and Company to conduct a training session on men's health, …".