



# Geriatric Medicine Matters

## The added value for Healthcare systems and Policymakers

**Current demographic challenges due to population ageing result in an unprecedented pressure on healthcare systems, in terms of workforce tension, social impact and financial sustainability.**

**Geriatric Medicine** [1]  is a specialty of medicine [2]  concerned with physical, mental, functional and social conditions in acute, chronic, rehabilitative, preventive, and end of life care in older patients. It focuses on individuals living with frailty and multimorbidity, whose needs extend beyond traditional organ-based paradigms of care and demand multidisciplinary, holistic management aimed at preserving function, autonomy, and quality of life.

**Beyond being a medical specialty**, Geriatric Medicine also exemplifies a **clinical approach** tailored for older people, while encompassing age-attuned aspects of healthcare. This approach can be perceived as an additional key skill for healthcare providers, granting a unique competence-based framework for managing frailty, multimorbidity, cognitive impairment, polypharmacy and functional decline - conditions that increasingly dominate **healthcare utilization** and **expenditures** in ageing societies.

Establishing Geriatric Medicine successfully in healthcare systems is a **cost-effective** [3] , system-level **solution** to population ageing that improves functional outcomes [3] , reduces hospital burden [4] , and strengthens **health system sustainability** [5]. 

Geriatric Medicine is not an optional specialty—it is **the core component of health systems** required to deliver effective, person-centered and sustainable care in modern European societies. It can lead the **transformation** to a healthcare environment more attuned to older people's needs. No European citizen should be deprived of the equity in quality healthcare.

## Key messages

Healthcare systems are challenged by the specific needs of a continuously growing and heterogenous ageing population.

Geriatric Medicine is essential for sustainable health systems especially in societies with a growing share of older people, reducing costly healthcare and hospital use and institutionalization.

Geriatric Medicine also improves outcomes that matter to the older person and society: namely functional ability and quality of life.

Policies promoting education of the health workforce, establishment of adequate geriatric structures and services and integration of care have the potential to enhance care for older people.

Investment now prevents system overload later.



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## I. Why Geriatric Medicine matters

**SYSTEMIC MISMATCH** | Current systems, primarily designed around single-organ diseases rather than adopting a holistic approach, need to evolve to respond to the needs of older adults with complex overall health needs, as dramatically revealed during the COVID-19 pandemic.

**QUALITY OF CARE IMPROVEMENT AND SOCIETAL APPRAISAL** | Fragmented and poorly coordinated care fuel increased costs, inefficiency, inequity and user dissatisfaction. The holistic approach exemplified by Geriatric Medicine enables integrated care [6] and improves patient-relevant outcomes [7] such as quality of life and disability-free longevity [8], providing service satisfaction to the biggest share of healthcare users [3].

**FINANCIAL EFFICIENCY** | Geriatric Medicine, as a clinical approach, can be a high-return investment that saves money by preventing unhealthy ageing trajectories in late life [5], reducing inappropriate polypharmacy, reducing outpatient [8] and emergency department [9] visits, shortening lengths of hospital stay by 4.1 days [10], saving a mean of €620 per fragility fracture admission and up to €1,320 per patient in perioperative care [11,12], reducing up to 51% hospital readmissions [13], preventing costly complications, such as functional decline [13,14] and nursing home admissions by 22% [15], and alleviating end-life disability [16].

**ENHANCED PRODUCTIVITY** | Geriatric Medicine-aligned systems extend independent living, supporting longer active lives, while reducing long-term care expenditure, as well as the major social and financial burden of informal caregiving [17], which can reduce family income by up to 45%.

**POLICY ALIGNMENT AND INTERNATIONAL ACCOUNTABILITY** | Implementation of policies targeting older adults' healthcare aligns national health plans with international standards, such as the United Nations Decade of Healthy Ageing and World Health Organization (WHO) priorities. [18]

*Better care, lower costs.*

*Health systems need geriatric expertise to function effectively.*

## II. What policy changes are needed to achieve meaningful impact



### Healthy Ageing as a Policy Priority

Moving from a disease-centered model to one that prioritizes functional ability and independence in self-care in older age and promotes preventive public health policies for healthy longevity. [3]



### System Integration

Ensuring access to high-quality, integrated and continuous care [19,20] for older people across healthcare services, in line with the WHO ICOPE (Integrated Care for Older People) framework. [6]



### Workforce Optimization

Addressing the workforce challenge by training healthcare professionals on basic skills of older adult care, developing a critical mass of specialized professionals and creating frameworks to promote interprofessional teamwork and professional skill-mix. [21]

### III. The “How”: Implementation aspects

Depending on the baseline status of each system and the strategic priorities locally defined, different implementation actions need to be selected and adapted. [22] 

#### 1. CONTEXT-SENSITIVE IMPLEMENTATION AND GOVERNANCE

- Conduct **country-specific gap analyses** to map existing resources, identify needs and prioritize domains to guide investment.
- Develop **National Frameworks** adapted to local contexts and aligned with European and international standards [18] , to deal with the multi-dimensional challenges of ageing and related health and social issues.
- Promote **co-creation with stakeholders** (health professionals, policymakers, academia, civil society) and support **implementation research** to ensure scalability and sustainability.
- Create the framework for providing **independent scientific input** to policymakers for evidence-informed decision-making.
- Implement **national benchmarking, audit systems, and accreditation mechanisms** supported by real-world data to monitor quality, cost-effectiveness and system performance and **scale up** effective practices.

#### 2. REFORMING AND STRENGTHENING HEALTH SYSTEMS AND SERVICE DELIVERY

- Establish **minimum standards and quality criteria** for geriatric structures and services, including workforce requirements.
- Develop **centres of excellence in Geriatric Medicine** with regional coordination, training, research and innovation roles, connected to community services.
- Deploy **mobile multidisciplinary geriatric teams** across hospitals and community care to improve access and continuity of care.
- Support **primary care** and enable the assessment of older people’s overall health and functional ability [6] , and the early identification and management of common age-related conditions.
- Leverage **digital tools and innovative technologies** (telemedicine, electronic health records, artificial intelligence-AI) to **optimize resources, enhance integration and reach** and promote gerotechnology and digital health solutions to **support independent living** and monitoring. [3] 
- Reform **financial models that incentivize protocol and procedure** implementation and **reward functional outcomes and prevention** (e.g. pay-for-performance, adapted nomenclature, Patient-Reported Outcomes Measures and Patient-Reported Experience Measures). [23] 

#### 3. CAPACITY BUILDING THROUGH EDUCATION AND TRAINING

- Recognize **Geriatric Medicine as a specialty or subspecialty** across all countries and strengthen **the role of geriatricians** [2] 
- Create the basis for multidisciplinary teamwork by:
  - a) building a **critical mass of trained healthcare professionals** through targeted investment, including vocational training, “train-the-trainer” models and international twinning programs;
  - b) establishing **mandatory core competencies** and facilitating **continuous professional development in the care of older adults** for all health workers;
  - c) integrating basic geriatrics into **undergraduate education** for all healthcare professionals and providing opportunities for **postgraduate education**.

- Strengthen the role and leverage the outputs of **universities, scientific societies, and European networks** (such as PROGRAMMING COST Action 21122) [↗](#) in education, research, and knowledge dissemination. Leverage **national and international expertise**, including advisory groups and scientific networks, to support strategic planning and implementation.

#### 4. PUBLIC AWARENESS AND SOCIETAL ENGAGEMENT

- Implement **national healthy ageing campaigns** to raise awareness, empower older people and combat ageism. [24] [↗](#)
- Improve access to **reliable health information**, including health and digital literacy initiatives (e.g. seminars, hotlines, community information centers).
- Engage citizens and caregivers as **active partners** in care design, delivery and quality evaluation.

## Key Conclusions

Effective implementation of Geriatric Medicine requires **coordinated action** across the spheres of policy, financing, workforce, and service delivery, **adapted** to national contexts and focused on measurable improvements in functional outcomes and quality of life for older people.

Without structural implementation of Geriatric Medicine principles, healthcare systems **risk** becoming increasingly inefficient, fragmented and economically unsustainable under the pressure of demographic ageing.

**Investment in Geriatric Medicine** should therefore not be viewed as an additional healthcare expense, but rather as a strategic societal investment in sustainability, functionality and dignity across the life course.

**Transparency statement:** Generative AI was used solely to assist with editorial revision of an initial human-authored manuscript, including improving language, shortening text, and synthesizing complex ideas into concise wording. AI also assisted in identifying potentially relevant literature, whereas, all references were independently verified, critically appraised, and selected by the authors. The evidence base, policy recommendations, interpretation, and final content were developed, critically reviewed, and approved by the authors, who retain full responsibility for the document.

**MORE RESOURCES** (available at [www.cost-programming.eu/](http://www.cost-programming.eu/)): [↗](#)

1. PROGRAMMING Advocacy Briefs: Geriatric Medicine matters: The added value for... Healthcare Educators and Curriculum Developers | Healthcare Professionals | Older People and Civil Society [↗](#)
2. PROGRAMMING COST Action 21122 publications [↗](#)
3. 90" video on what PROGRAMMING COST Action 21122 is [↗](#)
4. Short video explaining Geriatric Medicine [↗](#)
5. PROGRAMMING Glossary of Geriatric Medicine terms [↗](#)



**PROGRAMMING COST  
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