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Letter to the Editor

Heatwaves and aging population: Is geriatric medicine the key to addressing vulnerability in LMICs?

The world is already experiencing a record of 1.2°C increase in global temperature above the pre industrial levels with a continuously increasing age group of 65 years and above. Among them two-thirds will live in lower and middle income countries (LMICs) by 2050 according to the UN estimates. By this inevitable confluence of population aging with global warming, acute healthcare services are likely to face challenges in dealing with an overwhelming number of older patients with heat-related illnesses such as heat cramps, heat exhaustion, and heat stroke in both hospital and care homes due to their limited thermoregulatory responses and relatively higher prevalence of chronic conditions [1,2].

Limited thermoregulatory responses in older adults include a natural decline in the sweat and thirst mechanism. During medication reviews either conducted separately or as a part of comprehensive geriatric assessment, drugs like beta-blockers, anti-cholinergic drugs, some neuroleptic agents, diphenhydramine, benztropine, etc. are often found on their prescriptions, which might potentially impair their thermoregulation further [3]. Respiratory and Cardiovascular comorbidities complicating heat-related illnesses are very common in older adults which in turn are also worsened in extreme weather [2,4]. All these are compounded by early aging and frailty encountered by the poor and nutrition deprived population of the lower and middle income countries.

The statistics of the British Geriatrics Society shows that a total of 2,803 people aged over 65 died due to the heat waves in England in 2022, and it is predicted that the number of heat-related deaths per year may triple by 2050. If such is the conditions in a country where Geriatric Medicine is a well-established specialty [4], what might be the scenario of the developing LMICs where Geriatric Medicine is non-existent or still in its infancy burdened with extreme resource limitations, cultural prejudice, and lack of political will for the better medical care of older adults [1]? It is not counterintuitive to appreciate the fact that data on mortality and hospital admissions related to heat-related illnesses are not yet available in many countries delaying conclusive decisions from policy makers ensuring holistic care of older adults living in these regions.

These critical emergencies could be the potential to advocate for the health rights of the older adults. Introducing sections specific for older adults e.g. concepts of front-door frailty assessment, comprehensive geriatric assessment and deprescribing to the National Guidelines available for heat-related illnesses may serve as the stepping stone. The benefit of allocating separate hospital wards for older adults will be helpful beyond the heatwaves across the year. Similar models like the virtual wards can be trialed. Physicians can attend e-learning modules and hybrid conferences to enrich themselves in serving their older patients. However, with the constant raise in global temperature and aging population, permanent solutions are to be sought proactively. Establishing Geriatric Medicine in the LMICs by facilitating return of immigrant physicians serving in high-income countries (HICs) to their own lands should be considered. For this the National Medical Councils should come forward to establish criteria for recognizing their foreign degrees in Geriatric Medicine, providing incentives and proper opportunities to serve in their homelands [1,5]. Nevertheless, it will not be an easy task in LMICs. Yet, the question is not whether they will ever get there, but how we can collaborate to overcome the complexities of establishing Geriatric Medicine, to address the challenges posed by the overlap of population aging and global warming.

Declaration of competing interest

The authors have no conflicts of interest.

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