The Journal of Frailty & Aging 15 (2026) 100152

Contents lists available at ScienceDirect

The Journal of Frailty & Aging

journal homepage: www.elsevier.com/locate/tjfa

Original Research

Geriatric medicine across countries: Specialised workforce, training and system integration challenges

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ARTICLE INFO

Keywords:
Geriatrics
Ageing
Care
Health
Global health
Older people

ABSTRACT

Background: The development and integration of geriatric medicine into national health care systems vary widely across countries. While a robust care workforce requires providers from several disciplines, including nursing, social sector, rehabilitation, psychiatry, neurology, and others, a strong core of highly qualified geriatricians is essential to delivering older person-centred and integrated care. The number and professional profile of geriatricians, along with the status of the specialty, are important to informing efforts to reshape health care systems in response to the global ageing scenario.

Methods: WHO developed and distributed a structured questionnaire to representatives of national geriatrics and gerontology societies beginning in March 2025. The survey collected data on the status of the geriatric medicine specialty, including its formal recognition at the country level, the estimated number of practising geriatricians, and information on training curricula, professional environments, and systemic challenges.

Results: A total of 48 national societies completed the survey. Recognition of geriatric medicine ranged widely, from full specialty status in some countries to subspecialty or non-recognition in others. The number of practicing geriatricians per 100,000 persons aged 60 years and older ranged from <0.1 to >30 across countries, illustrating marked workforce disparities and some severe shortages. Where the geriatric medicine specialty is formally available, pre-service training durations ranged from 24 to 96 months. Geriatricians worked in diverse settings,

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https://doi.org/10.1016/j.tjfa.2026.100152
Received 21 January 2026; Received in revised form 18 March 2026; Accepted 26 March 2026
Available online 10 May 2026

though integration into primary care and public health was limited. Training in and exposure to geriatric medicine principles during undergraduate and postgraduate medical training were minimal in many countries. Key challenges included workforce shortages, fragmentation of care, and undervaluation of the speciality's role in informing health care for older people. Strategic priorities reported by respondents included investment in training, policy development, and institutional support.

Conclusions: The survey highlights disparities in geriatric medicine across countries and identifies several challenges and priorities. Strengthening education, policy, and workforce development is essential to meet the needs of ageing populations and support healthy ageing worldwide. At the same time, countries should also think of innovative approaches and building capacity of existing other health occupations to improve geriatric care. Future updates of this survey will provide longitudinal insights into workforce evolution. These findings provide a global evidence base to guide workforce planning and policy under the United Nations Decade of Healthy Ageing (2021–2030).

Box 1. Definitions of geriatrician as proposed in *Lancet Healthy Longev* 2024;5;100,644 (DOI:10.1016/j.lanhl.2024.100644).

Simplified: A geriatrician is a medical doctor who specialises in caring for older people and who formally possesses skills to assess and manage older people with medical and psychological issues, including social consequences.

Detailed: A geriatrician is a medical doctor who specialises in caring for older people. Geriatricians are usually board certified either in geriatric medicine (in countries where geriatric medicine is a recognised medical specialty) or, more often, in internal medicine or family medicine, with subsequent advanced clinical training and certification in geriatric medicine. The training and certification processes differ depending on the country and could affect the scope of practice. Geriatricians possess specialised skills to assess and manage older people with medical and psychological issues, as well as their social consequences; these issues are characterised by complex clinical presentations and include geriatric syndromes such as frailty, mobility disorders, falls, incontinence, malnutrition, pressure ulcers, dementia, and delirium. A geriatrician's skills are fundamental to delivering comprehensive, high-quality care to older people during acute episodes, when managing long-term conditions, and when providing rehabilitation. Geriatricians are experts in promoting good health in later life, preventing illnesses, reducing disability, and judiciously using palliative care and end-of-life support by taking a capacity-oriented approach to address an older person's needs and priorities. Geriatricians respect the autonomy of older people and strive for well-informed, shared clinical decision making with patients. Geriatricians also discuss the plan for transferring care across settings (e.g., hospital discharge arrangements) with older people and their care givers and involve other care partners to ensure the continuum of care. Geriatricians are usually involved in leading and guiding a multidisciplinary team of health-care professionals and understand and respect the expertise and skills of the other team members. No specific chronological age qualifies older people for geriatric care because advancing age is characterised by substantial heterogeneity between individual trajectories and the experience of ageing-related declines in health.

1. Introduction

Population ageing, together with ongoing epidemiologic health transitions, presents one of the most significant public health challenges of the 21st century. As life expectancy increases and the proportion of older adults grows, health systems must adapt to meet the complex needs and rights of this demographic group [1,2].

Geriatric medicine, as a medical speciality, is uniquely positioned to address the diverse health issues of older people, including frailty, physical and cognitive impairments, multimorbidity, polypharmacy, and social vulnerability [3]. Nevertheless, the development and integration of geriatric medicine into national health care systems vary widely across countries, often reflecting differences in policy priorities, educational structures, and healthcare resources [4–6].

In response to global population ageing, the United Nations (UN) launched the Decade of Healthy Ageing (2021–2030) [7], a comprehensive initiative aimed at improving the lives of older people, their families, and communities. The World Health Organization (WHO) is leading the coordination and technical implementation of this effort, which includes building capacity across health systems as a critical enabler to ensure a continuum of integrated care for older people, spanning from health promotion to long-term care [8]. Building on the 2008 World Health Report [9], the 2016 Global Strategy on Human Resources for Health: Workforce 2030 [10], and the recent Working for Health 2022–2030 Action Plan [11], WHO has demonstrated enduring, flagship leadership in strengthening and investing in health and care workforce capabilities as a cornerstone for achieving universal health coverage.

To support this goal, WHO launched a global survey in March 2025, targeting national geriatric societies to estimate the number of medical doctors either formally trained in geriatrics or, when a formal training was not available in that country, possessing specific competencies in the care of older people. It also sought to gather structured information and expand existing evidence on how training is organised within each country [12,13], as well as insights into the current status of geriatric medicine, including key challenges and strategies to strengthen and expand care for older people. In addition, the survey provided an opportunity to test and validate the recently proposed international definition of a "geriatrician" (Annex 1) [3], fostering consensus on core competencies and professional roles.

By collecting and analysing data from diverse national contexts, this survey provides foundational insights into the global state of geriatric medicine and identifies key areas for strategic intervention. The findings may also serve as an additional resource to enrich the assessment and monitoring of advancements in improving the quality of care for older persons across countries, as part of the UN Decade of Healthy Ageing (2021–2030). This paper presents the first set of findings from this ongoing global initiative and outlines key implications for workforce development and system integration.

2. Methods

The survey specifically targeted national geriatric societies, as these organizations are best positioned to provide informed estimates of the professionals they represent and to contribute to validating the competency-based definition of a "geriatrician" developed through this initiative.

The questionnaire (Annex 1) was distributed electronically through DataForm, an online data-collection platform hosted by WHO. An initial email describing the initiative was sent to the leaders or designated representatives of the national geriatric societies, using publicly available contact information. If the society expressed willingness to participate, a unique survey link was then provided to complete the

questionnaire. The European Geriatric Medicine Society (EuGMS), which signed a Memorandum of Understanding (MoU) with WHO specifically focused on the improvement of care for older people [14], was invited to contact affiliated geriatric societies through their representatives in its General Assembly. For countries outside the EuGMS network, national geriatric societies were identified through their official websites and publicly available directories (e.g., website of the International Association of Gerontology and Geriatrics). In addition, a non-systematic PubMed search was conducted to identify researchers who had published on the status of geriatric medicine in their respective countries. These individuals were contacted to facilitate connections with the national society (if available) or other relevant expert groups in geriatrics.

The comprehensive survey included the following domains:

1) Contact details of the focal persons completing the questionnaire;
2) Status of formal recognition of geriatric medicine in the country;
3) Estimated number of board-certified geriatricians currently practising;
4) Pre-service training pathways and their duration required to become a certified geriatrician;
5) Typical practice settings for geriatricians in the country;
6) Status of geriatric medicine education in medical schools and across other specialities, and
7) Perceived standard of care provided to older persons within the national health system (*"How would you rate the overall quality of geriatric care in your country?"*).

Additionally, respondents were invited to provide qualitative information about system-level challenges, professional barriers, and strategic priorities for improving geriatric care.

Furthermore, to assess the international relevance and applicability of the recently published definition of a geriatrician (Box 1) [3], respondents were asked: "To what extent does this definition reflect how geriatricians are defined in your country?". Responses were collected using a five-point Likert scale, with the following options and scoring: 1) Completely not aligned; 2) Poorly aligned; 3) Fairly aligned; 4) Well aligned; and 5) Completely aligned.

Data collection began in March 2025 and continues to allow for updates and the inclusion of data from additional countries. Respondents were encouraged to substantiate their answers with official documentation when completing the questionnaire.

The number of geriatricians per 100,000 persons aged 60 years and older was calculated:

$$\text{Geriatricians per } 100,000 \text{ older persons} = \frac{\textit{Number of geriatricians}}{\text{No. of persons aged 60 and over}} \; x \; 100,000$$

The denominator was based on the reported number of persons aged 60 years and older in each country. The numerator was obtained from national registries where available or estimated using the best available national data (e.g., number of medical doctors completing geriatric fellowship programmes over the past 30 years, number of geriatric fellows funded by national health authorities). In countries where geriatric medicine is not formally recognised (NFR), respondents were asked to estimate the number of medical doctors with specific competencies in the delivery of geriatric care.

Quantitative data were analysed descriptively. Qualitative data underwent thematic content analysis to identify recurring patterns and insights.

3. Results

A total of 72 national geriatric societies were invited to complete the survey. Questionnaires were completed by 48 (66.7 %). Although all the WHO regions were represented (African Region: $n = 2$, Region of the Americas: $n = 8$, Eastern Mediterranean Region: $n = 1$, European Region: $n = 28$, South-East Asian Region: $n = 3$, Western Pacific Region: $n = 6$), most of the responses (75 %) were coming from Europe and Americas. Responses were from 31 (64.6 %) high income countries, 12 (25 %) upper middle-income countries, 5 (10.4 %) lower middle-income countries, and no low-income country according to the World Bank Income groups.

Recognition of geriatric medicine as a formal speciality varies substantially across countries (Table 1), with some (e.g., Belgium, Brazil, Italy) having it established as a standalone speciality and others (e.g., Canada, Indonesia, Thailand) as a subspecialty. In several countries (e.g., Albania, Greece, Slovenia), geriatric medicine is not formally recognised 4.

Training for geriatricians is also diverse (Table 1), reflecting differences in medical education systems and speciality recognition, sometimes even within the same country (e.g., Germany). In countries where geriatric medicine is a subspecialty, trainees often complete foundational training in internal medicine, family medicine, psychiatry, or physical medicine and rehabilitation before pursuing geriatric specialisation. In contrast, countries with lone-standing speciality models offer direct entry into geriatric training programs. Training durations varied markedly, from 24 months in some countries to 96 in others, reflecting diverse educational structures. For instance, in Ireland, completing the specialty requires a minimum of eight years, which includes dual certification in geriatric medicine and general internal medicine, an established norm in the country.

The number of board-certified, practising geriatricians also shows wide disparities (Table 2). For example, the United States of America has an estimated number of 6,671 geriatricians serving a population of almost 85 million people aged 60 and older, resulting in a ratio of 7.85 geriatricians per 100,000 older adults. In contrast, several countries face severe workforce shortages, even with fewer than 10 geriatricians operating for the entire population.

Geriatricians work across a wide range of care settings, reflecting the interdisciplinary nature of the speciality. Annex 2 illustrates the variety of clinical settings. Acute care units, outpatient clinics, nursing homes, and rehabilitation centres are among the most common settings. In Brazil and Spain, geriatricians are involved in nearly all care settings, including emergency departments, home care, palliative care, and universities. In many countries, geriatricians remain with limited roles in primary care and public health agencies.

When respondents ($n = 45$) were asked to rate the alignment of the proposed definition of geriatrician (Box 1) [3] with their national context, the average score was 4.09 (standard deviation, SD 0.87) out of 5, indicating strong agreement. About 80 % of respondents viewed the definition as either well-aligned or fully aligned with their national understanding of the profession.

Results showed limited integration of geriatric medicine into undergraduate medical education in many countries, as previously reported 16. The average rating for geriatric education in medical schools was 1.64 (SD 1.03; possible range from 0 [not offered] to 4 [comprehensive]), with only 6.7 % of respondents describing it as comprehensive and well-integrated. At the post-graduate level, exposure to geriatric principles in specialties other than geriatrics (e.g., neurology, psychiatry, family medicine) was also minimal (average score 1.31, SD 0.56; possible range from 0 [no exposure] to 3 [extensive and well-structured]). Most respondents (73.3 %) rated the exposure as limited (score=1).

The perceived quality of care offered to older persons varied across countries. The average score was 3.13 (SD 1.12; possible range from 1 [poor] to 5 [excellent]), indicating moderate satisfaction.

3.1. Barriers, challenges, and strategies

Each respondent was asked to identify up to three systemic barriers

Table 1
Training of geriatricians across countries, based on responses from 48 national geriatrics societies.

Country	Status	Length of training (months)	Parent specialty when geriatrics is a subspecialty
Albania	NFR	-	-
Argentina	SAS	48	
	Sub	24	IM, Neu, FM, Psy, PMR
Austria	Sub	27	IM, Neu, FM, Psy
Belgium	SAS	72	
Brazil	SAS	48	
Brunei Darussalam	Sub	36	IM
Cameroon	NFR	-	-
Canada	Sub	48	IM
Colombia	SAS	48	
	Sub	36	IM, FM
Croatia	SAS	60	
Cyprus	SAS	60	
Denmark	SAS	72	
Dominican Republic	SAS	48	
	Sub	24	IM
France	SAS	48	
Germany	Sub	18	IM (FM, Neu, PMR, Psy)
Greece	NFR	-	-
Hungary	SAS	58	
Iceland	SAS	58	
India	SAS	36	
Indonesia	Sub	24	IM, Psy, PMR
Ireland	SAS	96	
Israel	SAS	54	
	Sub	24	IM, FM, PMR
Italy	SAS	48	
Japan	Sub	24	IM
Lithuania	SAS	48	
Luxembourg	SAS*	-	-
Malaysia	Sub	36	IM
Malta	SAS	96	
Mexico	SAS	48	
Nepal	SAS	36	
North Macedonia	Sub	24	IM, Neu, FM, Psy, PMR, Oth
Philippines	Sub	24	IM, FM
Poland	SAS	60	
	Sub	24–36	IM, Neu, FM
Portugal	MC	-	-
Romania	SAS	60	
San Marino	NFR*	-	-
Singapore	SAS	36	
Slovenia	NFR	-	-
South Africa	Sub	24	IM
Spain	SAS	48	
Sweden	SAS	60	
Switzerland	Sub	36	IM
Thailand	Sub	24	IM, Psy
	Sub	12	FM
Trinidad and Tobago	NFR	-	-
Tunisia	SAS	60	
Türkiye	Sub	36	IM
United Kingdom	SAS	48	
United States of America	Sub	12	IM, FM, Psy

FM: Family Medicine; IM: Internal medicine; MC: medical competence; Neu: Neurology; NFR: not formally recognised; Oth: Other; PMR: Physical medicine and rehabilitation; Psy: Psychiatry; SAS: Stand-alone specialty; Sub: subspecialty.
When both "SAS" and "Sub" are indicated for a country, it means that certification in geriatric medicine can be obtained through either pathway—either as a dedicated specialty or as a subspecialty—depending on national regulations or institutional frameworks.
* Only recognition of specialty obtained in other countries.

Table 2
Number of geriatricians across countries, based on responses from 48 national geriatrics societies.

Country	Geriatricians (n)	Persons aged 60 years or older[1]	Ratio[2]
Albania	(10)	711	(1.41)
Argentina	800	7.752	10.32
Austria	(1,139)	2.574	(44.25)
Belgium	386	3.232	11.94
Brazil	3.167	35,083	9.03
Brunei Darussalam	4	55	7.27
Cameroon	(3)	1.300	(0.23)
Canada	400	10,784	3.71
Colombia	210	7.981	2.63
Croatia	1	1.212	0.08
Cyprus	2	276	0.72
Denmark	200	1.646	12.15
Dominican Republic	135	1.410	0.96
France	2.000	18,807	10.63
Germany	3.400	26,222	12.97
Greece	(20)	3.142	(0.64)
Hungary	65	2.556	2.54
Iceland	20	85	23.53
India	200	164,776	0.12
Indonesia	115	33,470	0.34
Ireland	158	1.114	14.18
Israel	100	1.546	6.47
Italy	4.500	19,345	23.26
Japan	1.755	44,724	3.92
Lithuania	48	799	6.01
Luxembourg	27	150	18.00
Malaysia	67	4.377	1.53
Malta	43	140	30.71
Mexico	1.377	17,380	7.92
Nepal	5	2.949	0.17
North Macedonia	(80)	467	(17.13)
Philippines	115	11,202	1.03
Poland	594	10,215	5.81
Portugal	NA	3.183	-
Romania	225	4.713	4.77
San Marino	(11)	10	(100)
Singapore	170	1.582	10.75
Slovenia	(2)	619	(0.32)
South Africa	17	5.733	0.30
Spain	2.400	13,636	17.60
Sweden	550	2.847	19.32
Switzerland	370	2.448	15.11
Thailand	90	17,647	0.51
Trinidad and Tobago	NA	292	-
Tunisia	294	1.907	15.42
Türkiye	180	12,313	1.46
United Kingdom	2.328	18,080	12.88
Unites States of America	6.671	84,944	7.85

NA: Not available.
For countries where the geriatric specialty is not formally recognized, it is reported (in parenthesis) the estimated number of medical doctors who, regardless of board certification, may have adequate competencies in and provide geriatric care.
[1] Thousands of persons aged 60 years and older (last data available on November 5, 2025 [15]).
[2] Number of geriatricians per 100,000 persons aged 60 years and older.

impacting the organisation of care for older people. Among the 122 provided entries, the most frequently cited issues were care fragmentation (22.7 %) and limited or poorly allocated resources (18.2 %). Other challenges included the limited number of geriatricians (13.6 %) and a lack of competencies in managing older patients (13.6 %). Additional concerns included weaknesses in the structure of the care system (e.g., lack of a formal LTC system; 12.7 %).

Respondents were also asked to report up to three specific challenges that geriatricians face as professionals. The most reported issue among the 114 provided entries was the under-recognition and undervaluation of the specialty (27.2 %). Other challenges included competition with

other specialties (14.6 %) and inadequate pre-service training programs (12.6 %).

Finally, to address these systemic and professional challenges, respondents proposed a range of strategic interventions ($n = 117$ entries). The most recommended strategy was increased investment in geriatric training (34.9 %). This includes expanding training programmes, improving curricula, and enhancing the quality of post-graduate training in geriatrics (e.g., assigning responsibility for postgraduate training in geriatrics to a geriatrician in countries where this specialist is recognised). The development of policies for older persons and the support of geriatric care were also emphasised (15.6 %). Efforts to integrate care for older people (15.6 %), promote multistakeholder engagement on geriatric care (14.7 %), and increase the visibility/formalisation of geriatric medicine (14.7 %) were indicated as additional strategies.

Overall, responses reveal a consistent call for investment in training, policy support, and greater visibility of the specialty as foundations for more age-inclusive health systems.

4. Discussion

This study represents the first WHO-led comparative assessment of geriatric medicine across countries. By engaging 48 national geriatric societies, this study offers comparative insights into the recognition, structure, and practice of geriatric medicine across multiple countries. The findings reveal substantial disparities across 48 countries in specialty recognition, workforce capacity, training models, and integration into health care systems, highlighting the uneven and fragmented development of the field. The survey results also shed light on systemic and professional challenges, such as under-recognition, limited or inadequate training, and workforce shortages, while capturing strategic recommendations from national experts. These insights are highly relevant to global ageing policy and workforce planning, offering actionable evidence to inform initiatives under the UN Decade of Healthy Ageing (2021–2030) and to advance the integration of geriatric care into national health systems.

This survey was intentionally designed as a high-level global assessment to estimate the geriatric medicine workforce and document broad features of training, practice environments, and system-level challenges. Given the wide heterogeneity in national contexts and the need to ensure feasibility for respondents, the questionnaire emphasised structured items to preserve comparability. Notably, the instrument did include qualitative fields (e.g., barriers, professional challenges, and strategic priorities), which we synthesised into cross-cutting themes. However, the global scope, variation in the depth and format of responses, and the baseline, cross-sectional design did not permit a granular interpretation of local innovations or contextual determinants that would be methodologically robust across regions. Generating such detailed insights will require specifically designed qualitative or mixed-methods studies, including region-focused surveys, interviews, and case studies. These efforts can then be complemented by future survey waves that incorporate deeper modules while maintaining international comparability.

The strong alignment between the recently published, consensual definition of a geriatrician (Box 1) [3] and the national contexts reported by respondents underscores its international relevance. The definition shows strong potential as a unifying framework for the profession and is validated by its applicability across diverse health systems and cultural settings. This consensus is particularly significant given the wide variation in how geriatric medicine is recognised and practiced globally. By offering a shared conceptual foundation based on core competencies, the definition supports efforts to standardise the professional identity of geriatricians, facilitate international collaboration, and guide policy development aimed at strengthening the role of geriatrics in ageing societies. It also provides a reference point for educational institutions, health authorities, and professional organisations seeking to enhance the visibility, recognition, and integration of geriatric medicine within healthcare systems and, more broadly, health and social sectors.

The survey results highlight a critical mismatch between the growing needs of ageing populations and the current capacity of countries to provide specialist geriatric care to them. These disparities have direct implications for workforce planning and policy prioritisation. Many countries, especially low- and middle-income ones, are experiencing an exponential increase in the absolute and relative number of older persons yet facing severe shortages in the geriatric workforce. In some cases, fewer than ten board-certified geriatricians serve entire countries. Even in countries with more established systems, the ratio of geriatricians to older persons remains alarmingly low. Compounding this issue is the lengthy and complex training pathway required to become a geriatrician, which varies widely across countries and often spans several years. Paradoxically, the training of geriatricians in some countries occurs under the responsibility of specialists in disciplines other than geriatrics. This lag in workforce development poses a serious threat to the sustainability of health and care systems, which are increasingly strained by the demands of ageing populations. Addressing this gap requires a broader approach to workforce development that goes beyond training geriatricians, encompassing primary care physicians, nurses, community health workers, and other professionals to ensure integrated and coordinated care for older people. Indeed, it is important to emphasize that achieving age-inclusive health systems requires a skilled multidisciplinary team and improved models of care. This need is universal, relevant not only to low- and middle-income countries but also to high-income settings, where expanding access to primary care is critical.

Nevertheless, it is noteworthy that strengthening the geriatric workforce requires not only formal recognition and training but also coherent incentive structures and system-level support. The United States may offer an instructive example: despite well-established speciality recognition and active geriatric training programmes, workforce sustainability remains vulnerable due to wider structural factors [17,18]. The “US paradox” illustrates how systemic factors (e.g., financial incentives, perceived career attractiveness, integration within health and care systems) may still challenge recruitment, regardless of the speciality recognition or training capacity *per se*.

Focusing on geriatricians, addressing the challenges posed by population ageing requires a strategic rethinking of the role of geriatricians within higher education and health systems. Concerning the former, in countries where geriatrics is recognised as a standalone speciality or subspecialty, geriatricians should be more consistently involved in undergraduate and postgraduate medical training, having full responsibility for specialist geriatric training. In contrast, in countries where geriatric medicine is still underdeveloped and the critical mass of teaching staff is not yet available, academic mobility and the use of technology should be considered to ensure that training is delivered effectively. Beyond their role as specialist clinicians, geriatricians must also serve as educators and system leaders, building capacity across the broader health and care workforce. This dual role is critical to ensure, as noted above, that all healthcare professionals are equipped with the competencies required to manage the complex and heterogeneous needs of older adults. By embedding geriatric expertise into diverse care settings, this approach fosters more integrated, person-centred systems that are better prepared to respond to the demographic realities of the near future. This becomes particularly relevant at the primary care and public health levels.

Survey respondents echoed this vision, proposing strategic actions that go beyond isolated improvements and call for systemic transformation. Their recommendations (e.g., expanding geriatric training programmes, integrating geriatrics into medical education, and establishing dedicated academic departments) reflect a shared understanding that geriatrics must be positioned not as a niche specialty, but as a foundational component of modern healthcare in the context of population ageing. These are not merely technical adjustments, but strategic

moves to elevate the visibility, legitimacy, and influence of the field and meet the needs and rights of populations.

It is also noteworthy that respondents highlighted the need for structural support through policy integration and improved funding mechanisms. Without political engagement, and investments that require resource allocation, even the most well-designed initiatives will struggle to scale. The proposed actions reflect the ambition to reposition geriatricians as leaders and system-level thinkers, professionals who can shape age-friendly policies, advocate for integrated care models, and guide the transformation of health systems to ensure sustainability in the face of rapid population ageing, particularly in low-resource settings.

The barriers identified by respondents reflect broad system-level challenges reported across diverse regions. While more detailed contextual factors (e.g., differences in public-private engagement, social determinants, or informal care structures) influence the organisation of geriatric care, the study design and heterogeneous reporting did not allow region-specific stratification of these determinants. More focused work will be required to analyse these complexities in depth.

In addition to calls for investment in training and policy support, strengthening health workforce information systems through stakeholder engagement is essential to improve data availability and guide evidence-based decisions. The WHO *National Health Workforce Accounts: A Handbook (2nd edition)* [19] and its *Implementation Guide* [20] provide a framework for countries to systematically collect, analyse, and use health workforce data, including for geriatric specialties.

The findings of this survey offer a valuable baseline for monitoring country-level progress over time, especially throughout the UN Decade of Healthy Ageing (2021–2030). Some of the indicators calculated based on this survey could complement the WHO's existing indicators on healthy ageing [15]. By capturing key indicators related to recognition, training, workforce capacity, and integration of geriatric medicine, the survey may provide a structured framework to assess how national systems are evolving to meet the needs of ageing populations. As countries are required to implement reforms and strategic interventions (e.g., formal recognition of the specialty, expanding geriatric training, improving care coordination, integrating geriatrics into health policy), repeated assessments using this tool can help track advancements, identify persistent gaps, and guide evidence-informed decision-making.

Although the survey includes data from 48 countries, it may not fully capture the global landscape of geriatric medicine, as many nations do not have a national geriatric society. Some regions are less represented than others because several national societies that were contacted did not respond despite multiple direct and indirect solicitations. However, this initiative is conceived as an ongoing process, and additional countries may still contribute data in subsequent iterations (see below). Most responses came predominantly from high-income countries, suggesting that geriatrics is more developed and integrated within advanced health systems. In this context, the present work probably provides an optimistic view of the global scenario. The lack of such a national geriatric society may signal the need to strengthen health care for older people. When attempting to contact the national geriatric societies, we also encountered issues related to their limited online presence, with contact information often being outdated or inaccurate, which potentially impacted the response rate. Despite being aware of these limitations upfront, national geriatric societies were selected as the primary respondents because of their unique position to provide informed workforce estimates and to contribute to refining the newly proposed competency-based definition of a "geriatrician". Finally, while the survey does not establish causal links between the number of geriatricians and health outcomes or system performance, the estimated figures remain a valuable proxy for monitoring workforce capacity over time. They provide a baseline for tracking progress, identifying gaps, and informing strategic planning to strengthen health systems in response to population ageing.

The survey remains open to national geriatric societies that have not yet participated, as well as to established groups of experts in geriatric medicine from countries where such societies may not formally exist. Their contributions are critical to achieving a more comprehensive and globally representative understanding of the status of geriatric medicine. Expanding participation will strengthen the evidence base and support more inclusive policy and workforce development efforts. Interested parties are invited to contact the corresponding author of this article, Matteo Cesari (mcesari@who.int), to access the data entry platform and receive the necessary instructions for completing the survey.

In conclusion, this survey provides a timely and critical overview of the current status of geriatric medicine and the professional landscape of geriatricians across diverse national contexts. The substantial heterogeneity observed across countries highlights both the complexity and the urgency of global strengthening the specialty. By highlighting existing gaps, opportunities, and systemic challenges, this ongoing initiative contributes to a shared understanding of geriatric medicine and its evolving role. It supports global efforts to build more age-friendly and sustainable health systems, reinforcing the overarching goal of promoting healthy ageing worldwide.

Disclaimer

The authors alone are responsible for the views expressed in this article, and their views do not necessarily represent the views, decisions, or policies of the institutions with which they are affiliated.

Credit authorship statement

Matteo Cesari (conceptualization, methodology, data curation, data analysis, drafting of the manuscript), Jotheeswaran Amuthavalli Thiyagarajan (conceptualization, methodology, data analysis, critical review of the manuscript), Antonio Cherubini (conceptualization, critical review of the manuscript), Theresa Diaz (methodology, critical review of the manuscript), Marina Kotsani (critical review of the manuscript), Teena Kunjumen (conceptualization, methodology, critical review of the manuscript), Tahir Masud (critical review of the manuscript), John W Rowe (conceptualization, methodology, critical review of the manuscript), Ritu Sadana (critical review of the manuscript), Mirko Petrovic (conceptualization, methodology, critical review of the manuscript).

Funding

This work had no dedicated funding.

Ethical statement

The study involved a survey of national professional societies and did not include human participants, patient-level data, animals, or identifiable personal information.

Data availability

Aggregated data are available upon request to the corresponding author. National societies of geriatrics willing to be considered in this initiative or update their information can contact the corresponding author.

Declaration of the use of generative AI and AI-assisted technologies in scientific writing and in figures, images and artwork

AI or AI-assisted technologies wew not used in the present manuscript.

CRediT authorship contribution statement

Matteo Cesari: Writing – review & editing, Writing – original draft, Validation, Supervision, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Jotheeswaran Amuthavalli Thiyagarajan:** Writing – original draft, Methodology, Conceptualization. **Antonio Cherubini:** Writing – review & editing, Validation, Data curation. **Theresa Diaz:** Writing – review & editing, Methodology. **Marina Kotsani:** Writing – review & editing. **Teena Kunjumen:** Writing – review & editing, Methodology. **Tahir Masud:** Writing – original draft, Conceptualization. **John W Rowe:** Writing – original draft, Methodology, Conceptualization. **Ritu Sadana:** Writing – review & editing. **Mirko Petrovic:** Writing – original draft, Supervision, Methodology, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

None.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.tjfa.2026.100152.

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