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# Care for ageing populations globally

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We are experiencing a global demographic transition of rapid population ageing, stemming from declines in both fertility and mortality rates. However, what is not fully appreciated is that this will disproportionately affect low-income and middle-income countries. Multiple sources estimate that by 2050, 80% of older people, aged 60 years and older, will live in low-income and middle-income countries, and that the rate of increase in the older adult population will surpass that of high-income countries. Approximately two thirds of people living with dementia currently live in low-income and middle-income countries.

Older adults in all countries have experienced disproportionately poorer outcomes of COVID-19, dictated by both greater age-related vulnerability and insufficient resources allocated to geriatrics. In exposing the fragility of geriatric care, the pandemic has uncovered an alarming reality: global health-care systems are underprepared for our ageing population. Ageing populations will place a large demand on health-care infrastructure, given the associated increase in age-related diseases and multimorbidity. There will also be an increased need for non-medical care: the number of older people who need support for activities of daily living in these countries is predicted to quadruple by 2050. To shoulder the burden, resources need to be funnelled into long-term care infrastructure, relieving financial strain for patients and families and alleviating the burden on informal caregiving, often carried out by female family members. For example, a Health Policy piece in our current issue reveals that the burden of dementia care in Latin America primarily falls on family members due to the lack of formal care structures and high out-of-pocket costs for long-term care.

In addition to funding, adequate health-care for older people is contingent on adequate human resources. A recent Comment reported a deficiency in geriatric care in Colombia, with the number of specialised geriatricians falling far below that required to meet increasing demands. A 2016 WHO survey of 36 countries revealed that 27% of medical schools globally do not include training in geriatric medicine. Therefore, the fact that students report low preferences for pursuing careers in gerontology is unsurprising, often citing low wages, lower perceived prestige of geriatric nurses and physicians, and a high burden of care and moral distress. Those individuals who do pursue a career in geriatric care report high levels of burnout, with concerning increases during the pandemic.

To ensure healthcare systems have the ability to care for ageing populations, specialised knowledge in geriatrics must be increased via educational strategies to encourage careers in gerontology, such as targeted curricula that improve understanding of the field, develop skills, and assuage common concerns of medical and nursing students. Such training must balance conveying a holistic approach that recognises the multimorbidity of the older adult population, and thereby complexity of older adult care, while concurrently dismantling ageist notions of equating older age with decline in functioning. To provide students with ample exposure to older adult care, and thereby preventing misconceptions of older people and ageing, geriatrics should be integrated into preclinical medical training. Capacity building must focus on upskilling not only medical students but also geriatric health-care professionals. A Comment by Bischof and colleagues in our current issue argues for strengthening longevity medicine training that upskills physicians with expertise in AI technology and biogerontology to promote precision medicine. Moreover, to alleviate demands on physicians, unlicensed health-care workers can be trained as care team navigators to support older patients in navigating health-care systems. Such patient navigation systems are not only cost-effective approaches, which could in part offset limited resources in low-income and middle-income settings, but have the important benefits of ensuring timely and appropriate care, increasing health literacy, and ultimately enhancing older patients' autonomy and engagement with their health needs. Finally, the multimorbidity and complexity of needs that characterise the older adult population require collaborative care models, particularly bridging health and social care: greater integration of health-care sectors increases consistency and quality of patient care.

Funding the care of older generations is not optional. It is an investment in the wellbeing and intrinsic capacity of older people as productive and valued members of society. ■ *The Lancet Healthy Longevity*

For more on **projections of population ageing** see https://www.who.int/news-room/fact-sheets/detail/ageing-and-health#:~:text=By%202050%2C%2080%25%20of%20all,was%20older%20than%2060%20years.

For more on **population ageing in low-and-middle income countries see** https://www.ageinternational.org.uk/policy-research/statistics/global-ageing/

For more on **health and ageing** see https://www.who.int/features/factfiles/ageing/en/

For the **Health Policy** see *Lancet Healthy Longev* 2021; **2:** e220–30

For more on **geriatric care in Colombia** see **Comment** *Lancet Healthy Longev* 2021; **2:** e123–24

For more on **geriatric training** see https://www.who.int/ageing/publications/health-workforce-ageing-populations.pdf?ua=1

For more on **burnout in geriatric medicine** see https://www.sciencedirect.com/science/article/pii/S187876491400182X

For more on **longevity medicine** see **Comment** *Lancet Healthy Longev* 2021; **2:** e187–88