DISCUSSION PAPER

Redefining Aging: A Call to Action for Society to Address a Demographic Shift in Health Care

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ABSTRACT | *With more than half a million people globally living beyond the age of 100, it is time to rethink how health professionals and educators view older adults and the aging process. "Redefining aging" begins with transforming the mindset of current and future health professionals through targeted education. This involves encouraging them to reconsider how they address the unique needs of older adults and identifying those who can drive this change. Educators, health professionals, administrators, and policymakers must collaborate to reshape systems and attitudes. Together, they can build a well-trained workforce that is not only prepared but motivated to address the complexities of aging that may include chronic disease and functional decline but also opportunities for growth and innovation. The barriers to achieving a change in mindset and solutions for overcoming challenges prompt a call to action. This paper is an entreaty by a group of interprofessional educators passionate about ensuring all health professionals are trained to meet the complex needs of older adults.*

Introduction

Life expectancy in the United States has increased dramatically due to advancements in public health, including infrastructure (e.g., sanitation), living conditions, medical treatments, vaccinations, and nutrition. However, increased gains in longevity have also brought about new challenges, such as rising incidence of chronic disease and multimorbidity and the presence of two or more long-term health conditions simultaneously. Starting in 2030, Americans 65 years and older will make up 21 percent of the population and are projected to outnumber children by 2034 for the first time in US history (Vespa et al., 2018). The economic implication of this demographic shift is concerning as older adults are found to spend an average of three weeks (20.7 days) at health appointments per year, with 11 percent spending 50 or more days per year (Ganguli et al., 2024). Additionally, stakeholders in eldercare likely do not understand the full scale of challenges brought on by a growing demographic or may underestimate their preparedness for the resulting changes (Jones and Dolsten, 2024). The current US health care industry prioritizes disease management and acute care over prevention and healthy aging. To meet the needs of growing longevity, health care will need to focus on both quantity and quality

of life using holistic approaches to health care that consider proactive planning and prevention strategies as well as efficient and effective strategies to manage chronic diseases ensuring thriving and resiliency as we age.

Redefining Aging

Embedded within current societal perceptions about aging is a lack of awareness and knowledge about the aging process. Just as a human's well-being encompasses more than physical health, human aging is an integrated whole-body process based on biology, behavior, and the individual's social/physical environment. Healthy aging is, therefore, interpreted from the entire duration of life and functional perspectives and is defined by the World Health Organization (WHO) as the preservation of functional ability that enables well-being in older adults (WHO, 2015). Recent advancements in understanding the cellular mechanisms of aging offer potential approaches to mitigate age-related diseases, thereby promoting healthy aging and longevity. The emerging field of geroscience focuses on the biology of aging and the period of life that presents a clinically healthy outward picture while molecular changes are occurring at the cellular level leading to eventual chronic and age-related diseases. The field of healthy aging and longevity is dedicated to developing solutions that prevent and attenuate chronic age-related diseases, making the transition from an emphasis on lifespan to the emerging term healthspan. As people live longer, the biology of aging becomes a key risk factor influencing both life expectancy and quality of life (Olshansky, 2018). Adopting a proactive approach centered on disease prevention and anti-discrimination policies for older adults could yield significant socioeconomic benefits (Scott, 2021). These include extending older workers' active participation, boosting productivity among older adults, and reducing the health care burden of geriatric care. Additionally, this shift offers substantial economic opportunities fostering growth in the longevity sector and its related industries.

Shifting Societal Norms

Ageism is defined by explicit or implicit age-specific stereotypes that often result in bias and discrimination with effects on individual (self-perception), interpersonal (denigration/patronization), institutional (social norms/unfair rules), national (reduced GDP), and global (poor health, social isolation) levels (WHO, 2021). These negative and inaccurate stereotypes have become so ingrained in culture that they often go unnoticed. Shifting societal norms would require raising awareness of ageism, its negative effects, and why it is not a productive public narrative. Ageism costs a staggering $63 billion in just one year when assessing the effect of age discrimination on health care costs for the most expensive age-related health conditions such as cardiovascular disease and musculoskeletal disorders (Levy et al., 2020). The assumption that older people are always frail, dependent, and a burden to society lead to excessive use of health care resources and a reliance on institutions to care for older populations. 1.3 million residents in the US live in 15,300 nursing homes, 70 percent of which are for-profit establishments (Centers for Disease Control and Prevention , 2020). While many older persons require assistance with daily living, close to 80 percent of those aged 50 and over want to remain in their communities and homes as they age, as indicated in an AARP survey (Ratnayake et al., 2022; AARP, 2018). Recognizing the importance of supporting this preference, policies and community-based initiatives have emerged globally to enable aging in place. For example, in 2008, Iceland's Minister of Health mandated that older people exhaust all available community-based service options before undergoing assessment for institutional placement (Björnsdóttir et al., 2015). By the end of 2024, Reykjavik, Iceland, collaborated with 15 other regional cities in the Nordic Network for Age-Friendly Cities and Communities to share strategies and implement long-term, cross-sectoral approaches to healthy aging. These cities are part of a larger global network established by the WHO, known as Age-friendly Cities and

Communities, and include some cities in the United States (WHO, n.d.). The City of Columbus and Franklin County in Ohio joined the network in 2016 to combat ageism and negative stereotypes of older adults in the community. Ageist views are a global concern and affect how care providers work with and treat older patients when health system pressures, such as lack of resources, impact the ability to manage the complex social, physical, and mental health challenges of older persons (Jeyasingam et al., 2023). Additionally, internalizing societal messages about aging can negatively impact a person's health and well-being. Societal perceptions that older adults are a burden should be corrected when, in fact, many are making important contributions to the community and workforce.

Building Partnerships to Redefine Aging

Today, living as an older adult with potentially complex health and social needs requires a combination of services provided by a fragmented health workforce made up of multiple professions, mostly working in silos. One US model, known as Community Aging in Place—Advancing Better Living for Elders (CAPABLE), is attempting to shift this paradigm. In this program, occupational therapists and registered nurses work together to understand an older adult's mobility and function goals then hire a handyman to make the necessary home modifications to enable the person to achieve their goals, which may include preparing meals, walking downstairs, taking a shower, or getting dressed without pain (Szanton and Bonner, 2022). Studies funded by the Center for Medicare and Medicaid Innovation (CMMI) and National Institutes of Health (NIH) have demonstrated that an investment of $3,000–$5,000 per person can prevent more than $22,000 in Medicare costs, primarily by reducing hospitalizations (Davidson and Szanton, 2018).Currently available in 33 US states is the Program of All-Inclusive Care for the Elderly (PACE), a comprehensive medical/social service delivery system using an interdisciplinary team approach to provide all needed preventive, primary, acute, and long-term care services to adults over 55 with chronic medical conditions so they can remain independent in their homes and community. The typical PACE participant is nursing home eligible with an average of eight medical conditions, limitations in three activities of daily living, and a 50 percent likelihood of having dementia (Sanford, 2020). Despite high care needs, PACE program participation results in lower hospitalization rates, shorter lengths of stays in hospitals, and reduced care giver burden. (Arku, 2022). PACE costs significantly less than institutional care while providing a highly interprofessional team (led by the participant's primary care provider) that includes nurses, pharmacists, therapists, nutritionists, behavioral health, and specialists such as dentists, podiatrists, and optometrists. In addition to cost effectiveness, a study found that 80 percent of PACE participants that initially presented with depression no longer showed symptoms after nine months of being in the program, indicating a higher emotional quality of life (Vouri, 2015).

Interdisciplinary Teams

Like the United States, governments around the world are also looking to bridge the gap between fiscal constraints and meeting the increasing needs of older adults (Graff and Vabø, 2023). Many European countries are looking at reablement as a potential solution. Reablement is an interdisciplinary approach to short-term rehabilitative care for older adults that helps them regain independence and limits their need for costly long-term care. All older adults have access to interim care as part of national tax-funded health and care services; however, the degree to which a program can actively engage in goal-setting with patients varies by country (Graff and Vabø, 2023). In Norway, older adults in the reablement program express their goals to interdisciplinary teams often made up of at least three different health professionals, including physiotherapists, nurses, and occupational therapists (Birkeland et al., 2017). Birkeland and colleagues noted that the

teams foster a close and collegial collaboration centered on the older adult's goals rather than hierarchical structures (Birkeland et al., 2017). Positive interactions among reablement team colleagues also enhance the well-being of team members. Similarly, function-focused care in the United States is a care philosophy that focuses on optimizing and maintaining functional abilities and physical activity through collaboration across all settings of health professionals. A 2025 literature review studying the impact of Interdisciplinary Team-Based Care (ITBC) on chronically ill patients and their outcomes demonstrated that ITBC enhances patient self-improvement, improves health outcomes, enhances providers' work performance, promotes shared decision-making, and optimizes health care utilization (Kongkar, 2025). These findings advocate for the integration of ITBC models into health care delivery systems to improve care quality and patient outcomes.

Interprofessional Education

Interdisciplinary and interprofessional teams involve health care professionals from different disciplines working together toward shared goals in patient treatment. While both highlight collaboration, the main difference is in the level of integration and shared responsibility. Interprofessional teams go beyond collaboration and coordination to emphasize mutual respect, shared decision-making, communication, and collective accountability for patient outcomes (Zimmerman, 2024). Interprofessional education aims to cultivate these skills through team-based education and practice providing rising professionals the specific training in competencies that interprofessional collaboration requires. Learners should be taught healthy aging and interprofessional teamwork through simulation, experiential learning, and workshops (Erica et al., 2022; Henderson-Kalb et al., 2023; Winkler et al., 2021). Education in each of these forms helps learners understand their professional role in working with older populations within a larger health system that necessitates communicating with colleagues from other professions. While learning interprofessionally has demonstrated benefits, faculty themselves need to buy into the value of interprofessional education (Collis et al., 2024; Fahs et al., 2017). Programs like PACE and Norway's reablement underscore why interprofessional collaborations are essential in working with older adults. Educating learners interprofessionally can normalize the practice of collaboration across professions so the next generation of care providers are less resistant to interprofessional collaboration.

Non-profits/Religious Groups

The collective power of nonprofit organizations and faith-based entities can be pivotal in advancing health and education programs for older adults in communities (DeHaven et al., 2004; West End Home Foundation, 2024). Across the United States, organizations that support older adults range from meal assistance, ride share programs, legal aid, exercise programs, to educational offerings and more. Many of these organizations represent untapped potential for community-engaged learning, a pedagogical approach to teaching that integrates community engagement into coursework, thereby deepening student academic and civic learning. The Oasis Institute is a nonprofit organization that is active in over 250 communities and aims to promote healthy aging through lifelong learning, active lifestyles, and volunteer engagement (Oasis Institute, 2024). Oasis actively encourages partnerships and could bring new possibilities for health professions faculty seeking experiential learning and research opportunities for their students (McNaughton and Weiss, 2024). Other potential resources for community-engaged learning include Caring Together, Living Better (CTLB) and the Center on Aging and Community Living (CACL). CTLB is a partnership of nonprofit and faith-based organizations that created a culturally appropriate regional network of supportive caregiver services in Chicago's south suburbs (Iris et al., 2014). CACL is a collaboration between the Institute on Disability (IOD) and the Institute for

Health Policy and Practice (IHPP) at the University of New Hampshire (Fox et al., 2015). Jointly, IOD and IHPP provide ongoing support in designing, implementing, and evaluating systems change initiatives related to aging. This multi-stakeholder partnership has resulted in the creation of aging-friendly communities in New Hampshire.

Family and Informal Caregivers

As global demographics shift, a growing number of older adults, particularly those with chronic conditions or disabilities, will rely heavily on informal caregiving which is most often provided by spouses, adult children, and other relatives or friends. Informal caregiving has a heavy toll on mental and physical health leading to increases in psychological distress that is most notable in those transitioning to the role at younger ages and those caring for loved ones with dementia (Lacey et al., 2024). The nongovernmental organization out of Chile called Hogar de Cristo provides support to both older adults and their caregivers at home using volunteers and student interns (Campos-Romero et al., 2020). The interns provide psycho-affective companionship support and is a community-engaged learning model for working with caretakers and across professions (Dedzoe et al., 2023). Humans are interdependent and all rely on some level of care throughout their lives. However, the lack of community support systems and home assistance services needed often result in strained family relationships, caregiver burnout, and ultimately an increased demand for formal long-term care systems.

A Call to Action and Key Steps Toward a Competent Health Workforce

The landscape of health professions education for older adults in the United States is shaped by forces outside the confines of education and traditional patient care. These forces, such as societal views of aging and payment models for reimbursement, can force potential workforce candidates into pursuing more lucrative specialties with higher earning potential. Current US health care payment and reimbursement structures prioritize procedures and acute care over preventive and long-term care creating financial disincentives for health care providers to specialize in primary care or geriatrics. Registered dietitian nutritionists, for example, are recognized as Medicare providers in areas like diabetes care (i.e., prevention of T2DM), but can only bill "incident to" when they provide Medicare approved Intensive Behavioral Therapy for Obesity. Additionally, current salaries for professionals with geriatric expertise do not reflect the knowledge, skills, and time required to identify and manage complex conditions associated with aging. This financial disparity dissuades and prevents many professionals from entering geriatrics because it is impossible to serve patients when a provider cannot generate enough revenue to cover the basic costs of that care. Financial disincentives contribute to the scarcity of formally trained experts in the field. Providers who specialize in health care are confronted with a fractionalized disease-based health care system that is often inefficient and costly with gaps in coordination, quality, and access. As currently structured, most of the systems do not incentivize preventive accomplishments or reimburse for health and well-being measures despite a focus on these factors at earlier stages of life which will lead to a healthier life as one ages. Pervasive ageist attitudes that permeate society should be addressed as they only discourage professionals from wanting to work with older adults and fuels negative views about the aging process. To address these challenges, society must advocate for reforms that redefine perspectives on aging. Equally important is securing a commitment from state and federal policymakers to restructure the health care system. The following section highlights key issues in a table format, paired with specific calls to action to guide meaningful change (see *Table 1*).

In addition to policy-level interventions, health professionals can support the narrative from geriatric treatments to healthy aging in practice (see *Table 2*). Those who have limited understanding of the aging process should pursue continuing

TABLE 1 | Calls to Action for Society

Society SHIFTING SOCIETAL NORMS	
Issue	**Call to Action**
Healthcare payment and reimbursement models prioritize acute care and disease management over preventive and long-term care.	Advocate for policy reforms that incentivize preventive care and support a holistic, long-term approach to aging health.
Limited public awareness and societal emphasis on chronic disease rather than ageing prevention.	Launch and support public health messaging campaigns to increase awareness about the importance of healthy aging and preventive care.
Financial disincentives discourage healthcare providers from specializing in geriatrics.	Develop policy incentives that support geriatric specialization, including reimbursement for preventive care services.
Public and private sector health initiatives focus predominantly on disease treatment than preventive aging measures.	Establish initiatives that engage middle-aged adults in preventive screenings and focus on health monitoring for intrinsic capacity.

SOURCE: Created by the authors.

TABLE 2 | Calls to Action for Health Professionals

Health Professionals FOCUSING ON HEALTHSPAN	
Issue	**Call to Action**
Public focus on lifespan over healthspan limits understanding and support for quality-of-life initiatives in aging.	Integrate geroscience and healthspan principles in practice, consumer education, and professional development to emphasize quality of life throughout aging.
Society's reactive approach to aging prevents early interventions that could significantly improve later-life health.	Promote health system models that proactively focus on health and disease prevention throughout the lifespan.
Limited awareness about healthy aging among policymakers precludes meaningful initiatives and perpetuates wasteful spending.	Collaborate with policymakers to develop age-friendly communities and health systems that encourage healthy aging.
Fragmented care and limited integration of early preventive strategies reduce long-term quality of life in aging populations.	Support research initiatives linking social, behavioral, and biological aging insights to develop comprehensive health strategies across the lifespan.

SOURCE: Created by the authors.

TABLE 3 | Calls to Action for Health Professions Educators

Health Professions Educators EDUCATING A COMPETENT WORKFORCE	
Issue	**Call to Action**
Lack of geriatrics and aging-specific care content in health profession curricula along with implicit/explicit ageism drive overall disinterest in working with older adults.	Incorporate older adults and aging-related content into health professions curricula, ensuring it includes biological and preventive aspects while fostering mutual understanding and interest in geriatric care.
Knowledge deficits in the biology of aging among healthcare professionals limit preventive, holistic care approaches.	Include gerontology and geroscience content in health professions curricula to support proactive, evidence-based approaches to aging.
High-stakes exams do not prioritize geriatrics-related topics, reducing incentives to engage in geriatric training.	Collaborate with licensing boards, certification and accreditation bodies to prioritize geriatrics and require residencies to include geriatric training.
Government funds a large share of elderly healthcare but lacks geriatrician workforce support.	Advocate for designated government funding within graduate medical education (GME) to ensure a trained geriatric workforce.

SOURCE: Created by the authors.

education and professional development so that aging is no longer perceived reactively but rather as an ongoing process. Physical aging entails a trajectory of change in human biology that progresses steadily through months, years, and decades of physiologic adaptations influenced by a myriad of factors that either promote or impede healthy aging. Practicing a geroscience approach can mitigate the impact of, or prevent, multiple diseases. Refocusing society to embrace healthy aging could not only shift health professional education to the community where older adults are supported to live healthy lives but the providers would have the financial means to work and collaborate across professions and sectors to provide holistic care that does not burden any single provider.

Many health professions programs offer limited training in geriatrics and areas related to age-related care. Consistent across all health professions education is the lack of geriatrics-trained educators, little curricular content, and a low student demand for learning about how to care for older adults (Bardach and Rowles, 2012). This is despite the observation that "unless you go into pediatrics or obstetrics, you're going to be treating the elderly, [so] you should train in geriatrics" (Wong et al., 2023). The reality is that most graduates are not trained adequately in the principles of biological aging, communication approaches, and proactive planning strategies for adults middle-aged and older. In the past 50 years, growth in the number of practicing geriatricians can be attributed to the concerted efforts of philanthropies such as the John A. Hartford Foundation through scholarships, fellowships, and centers of excellence to strengthen geriatrics (Isaacs et al. 2019). Unfortunately, few health professionals choose to specialize in this field due to low reimbursement rates, lack of prestige, and the pervasive stereotypes that lead to internalized ageism in the practitioner. Currently learners are not required to take courses offered on geriatrics or unique needs of older adults although they will

inevitably work with older populations in their practice. Their delayed responsiveness to aging trajectories lead to failed preventive strategies and often focus on chronic disease management when lifestyle changes become more difficult. Health professional educators, deans, and administrators should support learner and educator competencies on healthy aging by making changes to curricula (see *Table 3*) and engaging in partnerships so that they appropriately shape the practice and education of the future health workforce.

Key Steps Toward a Competent Health Workforce

Achieving progress requires recognition of the issues and taking actionable steps to overcome existing barriers. Large-scale change entails a multi-system approach that involves action from a diverse array of stakeholders including health care providers, advocacy groups, industry, educators, administrators, and policymakers. To implement the call to action, these key steps will guide us toward building a competent health workforce.

1. *Require health professional training and education in working with older adults.* Accreditors can require training and education in care, prevention, and health promotion for older adults. Health professional education programs can offer at least one mandatory course in the science of aging including the biopsychosocial model of aging. Residencies and fellowships can include substantial geriatric training to apply evidence-based communication strategies to improve relationships with patients. For example, Geriatric Nurse Practitioner education requires time spent caring for older adults as a requirement before being able to sit for certification. Faculty can be trained to work with aging adults, so they transfer the needed skills and competencies to learners. Advanced practice boards can form partnerships with post-degree fellowships to incentivize completion of certification in geriatrics or gerontology. For example, the American Board of Professional Psychology's Geropsychology Board could increase its affiliations with accredited post-doctoral training programs in health service psychology. Finally, hospitals and institutions can provide structured caregiver education to support older adults.
2. *Work with policymakers to advocate for a community that supports healthy aging.* Policymakers can support programs that incentivize health professionals to receive training in working with older adults. Federal investments in Graduate Medical Education, such as Centers for Medicare and Medicaid, Health Resources and Services Administration, and the Department of Veterans Affairs can designate a percentage of funding to train and educate interprofessional teams of health professionals to work with the older adults. Professional regulatory groups across professions can mandate training needed through the maintenance of certification programs. State policymakers can work with regulatory agencies to improve scope of practice, particularly for nursing assistants and advanced practiced nurses who are needed to fill gaps in care and optimize the ability for older adults to age safely at home. Federal policymakers can incentivize the pharmaceutical industry to focus on healthy aging interventions. Advocacy groups and professional associations can partner with experts in aging to provide the data and evidence needed to inform policy.
3. *Shift societal views of aging and mitigate ageism.* Professional associations can launch wide-scale initiatives that promote awareness and support for proactive health strategies in aging. Psychologists and health care workers can take ageism training and understand the myths of aging. Civil society organizations, including nongovernmental organizations (NGOs), foundations (public and private), professional associations, unions, and co-operatives, can address institutional ageism and share effective strategies for mitigation.

State and local governments can implement age-inclusive policies, promote generational diversity, and provide training and development for older workers.

Conclusion

As population demographics shift and the percentage of older adults requiring care grows, implications to the health care system should be considered as it already faces fragmentation, workforce shortages, and capacity issues. To address the health care needs of this demographic shift, health care will need to transform from a reactive, diseased-focused, sick care model to a proactive, preventive one. The emerging fields of geroscience and human longevity are at the forefront of this transition focusing on the biology of aging and developing solutions that prevent age-related diseases and prioritize early intervention. Treating aging as a continuum can dramatically improve population health and bring significant socioeconomic benefits by reducing substantial health care costs in the future. This will require a multidisciplinary approach and the collaborative efforts of educators, health professionals, administrators, and policymakers as the agents of change. It is past the time to shift the entrenched views of older adults. Care for this growing population should be a priority and something society should want and know how to do. Instead of allowing the existing barriers perpetuated by ageism, the narrative should be refocused from geriatric treatments to healthy aging supported by the appropriate education of the health workforce. By redefining aging and implementing holistic, preventive approaches to health care, the US can secure a future where increased human longevity is accompanied by improved quality of life, reduced health care costs, and a more inclusive society for all ages.

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