The US eldercare workforce is falling further behind

There is a major and rapidly growing deficiency in the US eldercare workforce at all levels, especially among physicians. Efforts to increase recruitment and retention into geriatrics have failed, especially among critically important educators and researchers. Possible strategies to assure adequate care for older persons are discussed.

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The proportion of the US population that is over 65 years old will rise from the current 16 to 22% by 2050 (ref. [1]). As older persons require a disproportionate share of healthcare resources, accounting for over 25% of doctor visits and over 35% of hospital stays[2], this growth will create a further need for geriatric physicians, nurses and other healthcare workers to provide care across sites ranging from hospitals to long-term care and community settings. Geriatric care spans areas often underemphasized in clinical training, including comprehensive assessment of older persons, managing multiple-impaired, frail older persons and management of common geriatric syndromes, such as dementia, delirium, falls and incontinence. The specialized professional eldercare workforce includes physicians, registered and advanced practice nurses, social workers and public health professionals. There is a large additional cadre of licensed practical nurses, home health and personal care aides, certified nursing aides and informal care providers, such as family caregivers. While these latter groups are not specifically addressed in this Comment, they are an essential and very large component of the eldercare workforce which must be strengthened as well, and many of the proposed recommendations are relevant to these provider groups. In addition, restrictions on immigration are especially damaging to this critical backbone of the eldercare workforce and must be addressed.

Fundamental to an understanding of potential strategies toward strengthening geriatric care is recognition that the professional eldercare workforce serves three interrelated missions: (1) providing and supervising geriatrically sophisticated care; (2) education of all future providers who will encounter older persons in the basic tenets of geriatric care while serving as respected role models to attract providers to the field, and also providing advanced training for the next cohort of geriatricians and geriatric researchers; and (3) developing new knowledge through research that can inform and enhance the effectiveness of geriatric care.

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There are major deficiencies related to all three missions of the professional eldercare workforce. Mindful of deficiencies in the care of older persons and the three core roles noted above, in 2008, the Institute of Medicine (IOM) released a landmark report titled *Retooling for an Aging America: Building the Health Care Workforce*[3], which proposed a three-pronged approach.

Enhancing the competence of all individuals providing geriatric care

Most care for older persons is not delivered by providers with specific geriatric training. Rather than being a subspecialty of internal medicine or family practice, geriatrics is often described as a 'meta' specialty comprising of core principles that should be incorporated in the training of all providers who encounter older patients. Since the IOM report, we have made reasonable progress in enhancing the amount of geriatric content in the curriculum of medical and nursing schools and residencies, but this progress is restrained by the inadequate numbers of trained physicians, nurses and other providers who can provide education and training in geriatrics. The social determinants of health is an often-neglected area that is critically important for many elders and must be integrated into these curricula for all eldercare workforce trainees[4].

Developing and disseminating new models of care

New models of care delivery have proliferated over the past decade, with many relying on interdisciplinary teams, new technologies and strategic deployment of geriatric practitioners to enhance their effectiveness. These include programs

that are hospital-based as well as efforts that focus on the acute to post-acute care transition, community and palliative care. Some are successful, but others have not been replicated on a broad scale and are limited by resistance to multidisciplinary efforts from traditional department-oriented academic institutions, archaic funding models or resistance from entrenched forces in the healthcare system, such as hospital resistance to initiatives that improve quality and lower costs while reducing hospital revenue.

Increasing recruitment and retention of the eldercare workforce

Efforts toward this crucial goal have failed badly. There is a serious and growing deficiency in the number of geriatric physicians, nurses, dentists, social workers, occupational and physical therapists, dieticians and public health professionals. And the triple-mission of care, education and research pertains to all these providers.

Geriatricians. Fewer than 1% of US physicians are certified in geriatrics. The American Geriatrics Society estimates that the USA will need 30,000 geriatricians by 2030 (ref. [5]). While this goal seems woefully unrealistic, it may be a low estimate, as it is focused on providers of care, with less attention to the equally important education and research roles. The number of Board-certified geriatricians in the USA has fallen from 10,270 in 2000 to 8,502 in 2010, and to the current level of 7,300 (ref. [5]). Continuing this trend, in the recent December 2020 National Match, a dismal 52% of 400 available fellowship slots were filled[6]. A major driver of persistently low physician recruitment into geriatrics is compensation. In addition to incremental debt associated with geriatric fellowship training, a board-certified geriatrician can expect to make US$20,000 yr^{-1} less than an internist largely because all geriatric patients are on Medicare, which pays less than the commercial insurance common in a general internist's practice[7]. Medicare does not reward physicians for extra training or Board certification in geriatrics. Geriatricians, general internists and family physicians receive the same reimbursement for managing a clinical issue. In addition to pay, low prestige of the specialty, despite high job satisfaction and lack of exposure to strong geriatric role models during training, are also cited as contributors.

Numerous approaches, including curricular revisions and shortening the required fellowship period from two years to one year, have had little effect in increasing recruitment[7]. Increasing compensation would seem an obvious strategy and it would cost Medicare little, as there are so few geriatricians. The specific approach to accomplishing this, such as a general increase in primary care payments or a specific higher payment for board-certified geriatricians, will doubtless depend on Medicare regulations and preferences. Another financial strategy that holds promise is loan forgiveness, as has been useful in the past in recruiting to underserved populations such as the Indian Health Service. There has been some progress at the state level on this front, and there is hope the new administration will consider such programs favorably.

Geriatric and gerontological nurses. Nursing is expected to grow from the current level of 3.6 million to 4.2 million by 2030, reflecting a surge in millennials, which is more than compensating for the retirement of over a million baby-boom generation of nurses. Growth is especially strong among nurse practitioners who will increase from the current level of 200,000 to 400,000 over the next decade, a projection which has stimulated discussions regarding their most effective deployment[8]. The largest nurse practitioner specialty (55%) is family practice, followed by adult (15%) and gerontology, which accounts for only 8%, with small numbers working in long-term care. Fewer than 1% of registered nurses, and fewer than 3% of advanced practice registered nurses, are certified in geriatrics, according to the American Geriatric Society. And many nurses lack even basic training in the care of older adults and geriatrics. However, lack of progress in strengthening the eldercare workforce has not been for lack of effort. Three notable — and valuable — initiatives include: The Eldercare Workforce Alliance (The Tides Center, San Francisco, California), a group of thirty-five national organizations focused on workforce issues; the Geriatric Workforce Enhancement Program of the Health Resources and Services Administration, which supports over 40 centres[9]; and the Nurses Improving Care for Health system Elders Program, which provides practice-based education to enhance geriatric skills for 40,000 nurses in 449 hospitals[10].

Going forward

Taking into account developments since the IOM report, including continued failure to recruit physicians and nurses to geriatrics as well as the dramatic increase in the number of advanced practice nurses, and continuing to be guided by the IOM report's three central aims, we must mount a coordinated, well-funded national campaign drawing on all parts of the healthcare system to bolster the eldercare workforce. This campaign should aim to:

- Provide financial incentives, including higher payments for geriatricians and advanced practice geriatric nurses, loan forgiveness, scholarships and stipends, and increase the number of services for which nurses can bill Medicare, including the time-consuming efforts to mitigate the social determinants of health.
- Provide strong financial incentives, or penalties, to professional schools — especially nursing schools, hospitals and health systems — to advance our eldercare capacity.
- Increase the proportion of nurse practitioners choosing geriatrics. Driven by the addition of 200,000 NPs over the next decade, this effort requires increasing the scope of practice of nurses to permit them to practice at the full extent of their certification[11]. This crucial step, backed by strong evidence and endorsed by the National Academy of Medicine, has been attained in fewer than half the states, and continues to be doggedly resisted by some components of organized medicine despite gross and growing deficiencies in the eldercare workforce. We must get past the turf war and take care of the patients. Extension of the short-term increase in scope of practice enacted by several states during COVID-19 is a logical starting place.
- Dramatically enhance the number of geriatric healthcare professionals. Perhaps the greatest geriatric workforce deficiency is in geriatric public health professionals. The literature regarding strategies to enhance geriatric care rarely makes reference to the public healthcare system. Yet, as the USA and many other nations become 'aging societies', we must develop population-focused and evidence-based policies and programs to support wellbeing in the elderly[12]. If this was not previously apparent, the pandemic, during which the elderly suffered grossly disproportionate morbidity and mortality, especially those in long term care facilities, should awaken us to the need for major state and federal efforts — perhaps a Geriatric Public Health Corps — to bolster our capacity to protect this population.
- Relax immigration restrictions that are damaging to the long-term care sector.
- Remove academic, regulatory and financial impediments to interdisciplinary education and models of care.
- Implement recently formulated consensus recommendations regarding the

care of community-dwelling elders with serious illness, including specific initiatives regarding expanding the pipeline, incorporating family caregivers into teams, supporting home care providers, leveraging technology, enhancing cultural competency and refining payment models[13].

- Increase the number of geroscientists trained and funded to conduct research into the pathogenesis, prevention and management of common geriatric disorders. Numerous approaches, including various types of financial support and commitments of governments and strengthening training-related funding at the National Institutes on Aging and other foundations, are needed[14].
- Lastly, consideration should be given to a new type of geriatric care provider, a hybrid of nursing and social work. Given the emergence of interdisciplinary care, the importance of social determinants of health, a progressive merger of the medical and the social in eldercare; broadened training, perhaps via dual degree programs; or a Certificate of Added Qualifications, earned in a social work track in nursing school or during nurse practitioner training, would provide a unique and valuable cadre to supplement our eldercare workforce capacity.

The time has come to take this seriously. We cannot afford to fall further behind in our capacity to provide much-needed care for the rapidly growing elderly population. ❐

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Competing interests

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