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Populations and the Rising Need for Geriatric Rehabilitation

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EDITORIAL

The world's population is ageing rapidly, with both the absolute number and the proportional share of older adults increasing across all regions, reshaping health-system priorities from predominantly episodic acute care toward sustained management of functional capacity and long-term care needs (1). The United Nations' World Population Ageing 2023 report underscores that older age cohorts are expanding faster than younger groups, with major implications for morbidity profiles, dependency, and health-system financing (1). As longevity increases, health systems must simultaneously respond to rising frailty, multimorbidity, and chronic noncommunicable diseases conditions that are strongly associated with functional decline and escalating service use. These demographic signals amplify the imperative for rehabilitation services designed to maintain or restore function, particularly for older adults in whom functional limitation often becomes the dominant determinant of quality of life and a principal driver of long-term care costs.

In this context, rehabilitation is increasingly recognized as a core health service rather than an optional adjunct. The World Health Organization's Rehabilitation 2030 agenda explicitly positions rehabilitation as essential for universal health coverage and calls for system-level investment in workforce, service delivery models, and monitoring indicators to close the gap between need and access (2). Ensuring that evidence-based geriatric rehabilitation is scalable, equitable, and responsive to heterogeneity in ageing trajectories is therefore both a moral obligation and an operational requirement. However, the current alignment between need, evidence production, and service delivery remains inadequate, particularly outside high-resource settings, creating a widening mismatch between demographic demand and functional health-system capacity.

The evidence base supports prioritization of geriatric rehabilitation. A recent systematic review and meta-analysis found that geriatric rehabilitation delivered in inpatient and day-hospital settings improves functional outcomes and reduces adverse downstream endpoints including institutionalization and mortality in older adults compared with usual care, reinforcing rehabilitation as a clinically and policy-relevant intervention (3). Nevertheless, substantial heterogeneity in trial populations, inclusion criteria, intervention intensity, and outcome measurement limits the generalizability of findings across settings and patient subgroups, complicating translation for policymakers attempting to scale models across high , middle-, and low-income environments (3). Standardized, pragmatic endpoints anchored in functional capacity, independence, and goal attainment are needed to enable comparability, guide commissioning decisions, and ensure that scale-up preserves clinical effectiveness under real-world constraints.

Three interconnected challenges shape the pathway forward. First, older adults present with marked heterogeneity in rehabilitation potential, goals, and response, driven by frailty severity, multimorbidity clusters, cognitive impairment, and social determinants; consequently, a one-size-fits-all approach risks both overtreatment and missed opportunity. Precision triage through structured frailty screening, functional trajectory profiling, and patient-goal elicitation can improve targeting of intensity and modality to outcomes that matter clinically and personally. Second, workforce limitations and delivery gaps constrain access: specialized interdisciplinary geriatric rehabilitation teams are scarce in many countries, and where they exist, pathways remain uneven due to geographic concentration, affordability barriers, and inadequate integration across post-acute and community care. Third, evidence remains thin for scalable, context-sensitive models, particularly in low- and middle-income countries; scoping evidence suggests promising delivery approaches spanning home- and community based rehabilitation and healthy ageing platforms, yet implementation and equity data remain limited (4). Digital and tele-rehabilitation may extend reach and enable longitudinal monitoring, but the evidence base in frail older cohorts is still developing, and inequities may widen if digital literacy, connectivity, and affordability are not explicitly addressed in design and evaluation (4).

A coherent response should reframe geriatric rehabilitation as a system-level priority with explicit implementation indicators access, fidelity, equity, and continuity paired with standardized functional outcomes such as activities of daily living independence, functional capacity measures, and goal attainment scaling. Research should prioritize pragmatic multicenter trials and implementation studies comparing inpatient, outpatient, home-based, and hybrid models using harmonized endpoints and explicit economic and equity analyses. Concurrently, health systems should invest in workforce development and task-sharing pathways training physiotherapists, nurses, and community health workers in geriatric principles under appropriate supervision to expand coverage beyond tertiary centers. Finally, digital solutions should be co-designed with older adults and tested for usability and effectiveness in frail cohorts, with parallel investments to reduce the digital divide. These priorities align with broader calls to strengthen rehabilitation through health policy and systems research, ensuring that scale-up is not only clinically effective but also feasible, affordable, and equitable across diverse contexts (5).

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