

Status and Perspectives on Geriatric Medicine in Norway, Sweden, Finland, and Denmark: A Cross-National Comparative Analysis of Educational Needs and System Development - a sub-analysis of PROGRAMMING – COST ACTION 21122

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Abstract

Purpose

The Nordic countries, despite shared welfare models, have developed distinct approaches to geriatric medicine and education in response to ageing populations. We explored how geriatric medicine has evolved across Norway, Sweden, Finland, and Denmark over the past decade.

Methods

We conducted a cross-national comparative descriptive study. Data encompassed COST PROGRAMMING educational needs assessment survey, national workforce and policy reports, and contextual information from national geriatrics societies. Data were analysed descriptively and synthesised to compare workforce development, educational structures, organisational integration, and strategic prioritisation of geriatric medicine across countries.

Results

Substantial variation was identified across countries despite comparable demographic development. Norway, Finland, and Denmark demonstrated coordinated national workforce planning and increasing geriatric workforce capacity. Norway had by far the highest participation in the European Academy for Medicine of Ageing (EAMA), a two-year postgraduate leadership and academic training programme in geriatric medicine. In Finland, many geriatricians work in primary care and community-based services, reflecting a more community-oriented model. Structural integration of geriatric services within hospital systems varied markedly, with Swedish geriatric services showed markedly regional variation and organisational structure. Survey findings highlighted persistent barriers across countries, including perceptions of workforce shortages, low prestige associated with geriatrics, and fragmented care pathways. Respondents emphasised the need for educational support in managing frailty, multimorbidity, and interdisciplinary care, and preferred clinically integrated, case-based educational approaches.

Conclusions

The development of geriatric medicine in the Nordic countries is shaped by workforce planning, educational investment, academic development, and structural integration of geriatrics within healthcare systems.

Key summary points

Aim:

To compare the development of geriatric medicine in Norway, Sweden, Finland, and Denmark over the past decade.

Findings:

Norway showed strong growth of the geriatric workforce and postgraduate academic development, while Finland had a more community-oriented geriatric workforce, with many geriatricians working in primary care.

Denmark showed marked workforce growth supported by national workforce planning, whereas Sweden had substantial regional variation in the organisation and prioritisation of geriatric care.

Message:

Sustainable geriatric capacity requires coordinated workforce planning, strong educational and academic foundations, and strategic policy support, while the Nordic countries offer examples of different approaches to strengthening geriatric medicine that may inform and inspire development in other ageing societies.

Background

Like the rest of the world, the Nordic countries included in the paper – Norway, Sweden, Finland, and Denmark – are experiencing a growing proportion of older adults and shortage of healthcare workers, placing increasing demands on healthcare systems to deliver multidisciplinary and specialized geriatric care [1,2]. While these countries share tax-funded welfare models and comparable population health profiles, the development and integration of geriatric medicine have followed divergent paths. Geriatrics is recognized as a medical specialty in all four countries, but the degree of integration—such as the presence of dedicated geriatric departments in hospitals—varies, as does the accessibility of specialist training and the prioritization of geriatric education in medical curricula not only between countries but also between different universities.

Previous national analyses have highlighted variation across the Nordic countries in training capacity, the number of practising geriatricians, and the organisation of geriatric services [1,3,4]. In addition, variation in how geriatric medicine is structurally integrated within hospital services and educational programmes may influence both the visibility and perceived value of the specialty [5,6]. International educational initiatives, such as the European Academy for Medicine of Ageing (EAMA), may further have shaped national development in distinct ways, potentially reinforcing or compensating for local structural conditions [7,8].

Despite these apparent differences, there has been no comparative synthesis examining how geriatric medicine and geriatric education have developed across the Nordic countries over time. Such a perspective may help identify common challenges, context-specific barriers, and transferable strategies relevant to future workforce planning and educational development in ageing societies. To address this gap, we conducted a cross-national comparative analysis drawing on survey data from the COST Action PROGRAMMING CA21122 GeRiAtric Medicine in countries where it is still eMergING, educational needs assessment, supplemented by national workforce, policy, and contextual data [9-11]. Our aim was to compare the organisation, educational structures, and workforce development of geriatric medicine across Norway, Sweden, Finland, and Denmark, and to explore how these differences may relate to national educational needs and system development.

Methods

Setting

The Nordic countries included in this study provide predominantly tax-funded universal healthcare coverage through publicly governed systems, although organisational structures differ with varying degrees of national, regional, and municipal responsibility [12-15]. Municipalities play an important role in the provision of community-based health and social care, particularly for older adults, although the extent of their healthcare responsibilities varies between countries. Universities are mostly publicly funded, and academic geriatric medicine is embedded within university-affiliated institutions according to national and local organisational structures.

Study Design

We conducted a cross-national comparative descriptive study to examine the organisation, workforce development, and educational structures of geriatric medicine across Norway, Sweden, Finland, and Denmark. The study integrated multiple complementary data sources to enable comparison of national geriatric systems and educational contexts from both structural and professional perspectives.

Data Sources and Collection

Data were drawn from three complementary sources. First, survey data from the COST PROGRAMMING CA21122 educational needs assessment in geriatric medicine was included to provide perspectives of healthcare professionals in Norway, Sweden, Finland, and Denmark [10,11]. These perspectives included educational needs, barriers to geriatric training, and perceptions of care for older people across the Nordic countries [10,11]. Second, supplementary national data were collected from healthcare workforce reports, policy documents, official statistics, and national medical and geriatric societies. These sources provided information on the number and distribution of practising geriatricians, specialist training pathways, workforce planning, and the structural organisation of geriatric care within each country's healthcare system [16]. Third, participation data from the European Academy for

Medicine of Ageing (EAMA) were included to describe engagement in international postgraduate geriatric education as an additional indicator of educational development and professional investment in the specialty [7].

Data analysis

All data were analysed descriptively and synthesised using a comparative cross-national approach. Survey responses were summarised by country and used to characterise perceived educational needs, barriers to geriatric training, and perspectives on educational approaches in geriatric medicine. Educational domains characterised by high perceived relevance combined with lower self-reported knowledge were interpreted as indicative of potential educational gaps and unmet educational needs. Open-ended survey responses were reviewed descriptively and grouped into recurring themes related to educational challenges and clinical complexity in geriatric care. National healthcare workforce, policy, and organisational data were summarised to describe differences in specialist workforce capacity, educational infrastructure, service organisation, and strategic prioritisation of geriatric medicine across countries.

Findings from all data sources were integrated narratively to identify cross-national patterns, shared challenges, and contextual differences relevant to the development of geriatric medicine and geriatric education in the Nordic region. External peer review was undertaken to ensure that country-specific descriptions and interpretations were aligned with available evidence and not solely based on the authors’ own experiences or perspectives. The external peer reviewers were academic geriatricians with extensive clinical experience.

Ethical Considerations

The PROGRAMMING survey received Ethics approval in the countries where local regulations necessitated review by an ethics committee; each participant electronically provided informed consent at the beginning of the survey [10]. All survey data were pseudonymised prior to analysis. As the study relied on pseudonymised data collected under the COST PROGRAMMING 21122 initiative and publicly available data, no additional ethical approval was required by any of the participating countries’ legislation [10,11].

Results

Organisation of Geriatric Medicine in the Nordic Countries

Although all Nordic countries provide tax-funded, universal healthcare, the organizational integration of geriatric medicine varies across borders. In all four countries, the specialty emerged in the 1960s and 70s. Sweden was the first Nordic country to recognise geriatrics as an independent specialty in 1969, followed by Denmark in 1972. While geriatric medicine was historically established as a hospital-based speciality, the initial terminology used was "long-term medicine". Finland established its first academic chairs in the 1970s, followed by an expansion of hospital-based geriatric units in the 1980s. In Norway, geriatrics was a subspecialty of internal medicine until it became an independent specialty as part of the postgraduate training reform implemented between 2017 and 2019.

Denmark and Norway maintain similar models in which most geriatricians operate within the hospital sector, while municipalities or primary care providers handle rehabilitation and long-term care. In Finland, the 2023 healthcare reform transferred responsibility for health and social services to regional wellbeing service counties, aiming to improve integration across care sectors and support more coordinated and regionally equitable care for older adults [17]. This organisational model is also reflected in the Finnish geriatric workforce, where many geriatricians practice within primary care and community-based services. Sweden operates a highly decentralized model across 21 autonomous regions and no unified national policy regarding the distribution and number of geriatricians [18].

Table 1 Comparative table of countries

Dimension	Norway	Sweden	Finland	Denmark
Population (millions)	5.63	10.61	5.62	6.03
Population aged ≥80 years, n (%)	284,939 (5%)	683,961 (6%)	360,535 (6%)	368,192 (6%)
Number of Geriatricians working clinically	~180	~550	~250	~200
Clinical geriatricians per 100,000 population aged ≥80 years	~63.2	~80.4	~69.3	~54.3
Year specialty recognised	1975	1969	1976	1972
National geriatric societies				
Number of members	316 + 79 associate members Associate members are non-physicians	521	492	411
Professions eligible for membership		Mainly physicians	Mainly physicians	Physicians only
Number of annual specialist training positions and occupancy, 2025	53 ^a with full occupancy	Unknown ^b	~25 with 90% occupancy	27 with full occupancy
Entry requirements to training	Six years of medical school 18 months internship (12 months in hospital and 6 months primary care)	Six years of medical school 12 months of basic clinical training in 2 facilities including primary care	Six years of medical school 18 months early postgraduate clinical training including hospital and primary care	Six years of medical school 12 months of basic clinical training (6 months in primary care + 6 months in hospital) 1-year introductory position in internal medicine
	Total of 5 years	Total of 5 years	Total of 5 years	Total of 5 years
Training duration (years) to become a specialist in geriatric medicine	Variable internal medicine rotation and geriatric medicine	Variable geriatric training duration including internal medicine, psychiatry, memory clinics	9 months of primary care, 3 years of geriatrics, plus internal medicine, psychiatry and neurology	3 years of internal medicine rotation and 2 years of geriatric medicine
National strategy for geriatric care?	Yes [19]	No	Yes [20]	Yes [21]
Undergraduate geriatric teaching, ECTS (of 360), range	3-6 ECTS	3-6 ECTS	3 ECTS	3-6 ECTS
EAMA graduates since 2000	28	8	24	7
Geriatric professors	5	6	5	4
Collaborative models of care, number of centres ^c				
	Yes, 5	No	Yes, 1	Yes, 1

Geriatric oncology, n	Yes, 13	Yes	Yes, 10	Yes, 17
Ortho geriatrics, n	No	Yes	Yes, 25	No
Palliative care, n	Yes	Yes	Yes, 10	Yes, 14
Memory clinics	Yes	No	No	No
Geriatric surgery	Yes	No	No	No
Stroke units				

^a Information from chief medical officers, ^b Due to decentralisation of 21 regions, ^c numbers are provided where available

The structural integration of geriatric medicine within hospital care also differs between countries. In Denmark and Norway, geriatricians are increasingly integrated into Emergency Departments and sub-acute teams. In recent years, multidisciplinary acute geriatric teams have been introduced in emergency departments in Finland [22]. Swedish geriatric units vary substantially in organisation, and many are located outside acute hospital settings, particularly in the Stockholm region. These units often have more limited access to diagnostics, specialist consultation, and escalation pathways compared with geriatric departments embedded within acute hospitals [23]. To preserve admission capacity, transfers from other hospital wards to geriatric wards are uncommon, limiting the availability of dedicated beds in Sweden for geriatric rehabilitation outside the Stockholm area. Across all countries, geriatric care is delivered through multidisciplinary teams involving primarily nurses, physiotherapists, and occupational therapists.

Workforce Planning and Educational Capacity

All four countries increased the number of practising geriatricians over the past decade, ranging from a 7% increase in Sweden to a 93% increase in Denmark (Table 2). Denmark has implemented a proactive national workforce strategy, with the number of geriatricians projected to increase by 187% by 2045, making it the second-fastest-growing specialty in the country [24]. To support this expansion, national workforce planning has prioritized geriatric training positions. Recruitment has improved in recent years, with more than 60 applicants for 27 positions and no vacancies nationwide in 2025 [25]. Historically, recruitment challenges were most pronounced in hospitals far from university cities. Conversely, Sweden had no national workforce regulation. Norway has established geriatric specialty training positions in most hospitals, with no reported vacancies to date, alongside a 357% increase in the geriatric workforce from 2012 to 2026. Nevertheless, some hospitals still do not have geriatric specialists. Educational advancement has been notably supported in Norway through the European Academy for Medicine of Ageing (EAMA) course, which has seen high participation rates and has strongly influenced the specialty's development there (Figure 1) [8]. EAMA is a two-year postgraduate course consisting of four one-week training sessions. EAMA is aimed at junior faculty members and promising future teachers in geriatric medicine, with the goals of strengthening knowledge and skills, fostering collaboration and networking across Europe, and promoting the development and harmonisation of geriatric care and research [8]. However, to meet Norway's future demands and political goals of geriatricians in all acute hospitals, more training positions are wanted from the professional environment of geriatric medicine [19]. Finland reports approximately 300 geriatricians, which is below projected needs, leaving general practitioners to provide the majority of care for older adults. In Norway, long-term care in nursing homes is generally also covered by general practitioners with special approved competence, not geriatricians.

Survey findings from the COST PROGRAMMING study highlighted educational capacity and perceived workforce shortages as challenges across all countries. Respondents identified barriers to geriatric education situated around three main domains: structural constraints, educational and career-related factors, and cultural perceptions of geriatrics or care for older people. Structural constraints were the most frequently reported and included high clinical workload, limited availability of protected time for training, financial constraints related to course participation, and geographical barriers to accessing educational activities. These findings are consistent with broader challenges related to workforce recruitment and geographical variation in access to healthcare services across the Nordic countries. [1,2]. Respondents described a need for educational support in managing the complexity of caring for older adults, including multimorbidity, interdisciplinary collaboration, and uncertainty in clinical decision-making. Across countries, practice-oriented and interactive educational formats were perceived as more useful than traditional lecture-based teaching.

Within the educational domain, respondents described a need for greater support in managing the clinical complexity of caring for older adults, including multimorbidity, interdisciplinary collaboration, ethical dilemmas, and uncertainty in clinical decision-making. Practice-oriented and interactive educational formats—particularly case-based and clinically integrated learning approaches—were consistently perceived as more useful than traditional lecture-based teaching for addressing these challenges. Finally, cultural perceptions of geriatrics were identified as an additional barrier, with respondents reporting persistent low prestige associated with working with older adults (Figure 2)..

Responses are shown as percentages of valid responses. Three Swedish respondents selected "Don't know" and were excluded from the figure.

Clinical Scope and Academic Development

Modern Nordic geriatric medicine has evolved from long-term care to a focus on acute medicine, multimorbidity, polypharmacy, and frailty. However, the clinical scope and organisational positioning of geriatric practice vary across countries and healthcare settings. Orthogeriatric services are well-established in Denmark, Norway, and Finland, starting as local initiatives, but has evolved into national policy in Norway. Finnish and Swedish geriatricians are also involved in palliative care and geriatric oncology, which may partly relate to the inclusion of palliative medicine in Finnish undergraduate medical education. Subspecialised geriatric services, including geriatric surgery, have been established in selected centres across the region, although availability varies substantially between countries.

Academic infrastructure in geriatrics is well established across the Nordic region, with professorships and academic representation in all four countries (Table 1). Finland and Sweden have contributed substantially to international ageing research, including dementia prevention and longitudinal cohort studies. In Denmark, academic activity in geriatrics has expanded substantially over the past decade, with increasing numbers of PhD students, the establishment of research centres, and growing participation in international collaborative research networks. Similarly, Norway has strengthened its academic profile and maintains geriatric representation across all four medical faculties, contributing to research in orthogeriatrics, delirium, and dementia. Academic collaboration across the Nordic countries is further supported through national geriatric societies and the Nordic Gerontological Federation.

Barriers and Future Needs

Several challenges were identified as barriers to the delivery of geriatric care. Commonly reported barriers in the Nordic countries were general shortages of specialized nurses and geriatricians, limited prestige associated with working with older adults, and structural fragmentation between healthcare sectors. An important shared finding was the presence of regional disparities in access to geriatric expertise, highlighting ongoing geographic inequalities in specialist care for older adults. In Denmark and Sweden, recent healthcare reforms have explicitly identified health inequity as a policy priority and have sought to improve local access to care primarily through strengthening general practice rather than expanding geriatric specialist services in primary care.

Findings from the COST PROGRAMMING study, together with evidence from other sources, help to contextualise differences in national barriers. In Denmark and Norway, educational challenges were closely linked to insufficient prioritisation of geriatrics within training pathways. In Finland and Sweden, challenges mentioned were primarily framed in relation to structural and workforce constraints, i.e., system level capacity. However, respondents emphasised the need for training that supports care delivery under conditions of limited resources, including skills in prioritisation, cross-sectoral coordination, and maintaining care quality despite staffing shortages.

Across countries, respondents identified increasing clinical complexity and demographic pressure as key future challenges for geriatric care. Core geriatric competencies, such as frailty and, to a lesser extent, Comprehensive Geriatric Assessment, were perceived as relevant and relatively well established, whereas educational gaps persisted in more specialized or cross-disciplinary domains, such as onco-geriatrics and gerodontology, ethics, and collaboration across specialties.

National strategic responses to these challenges varied across countries. In Denmark, multiple recent national initiatives have highlighted the need to strengthen geriatric capacity, including workforce projections from the Danish Medical Association,

prioritisation of geriatric training positions in national workforce planning, recommendations from the Danish Health Authority, and the recent healthcare reform, which identifies health inequity and geographical disparities in access to care as key policy concerns [21,24,25]. Finland’s national ageing strategy includes initiatives related to frailty screening and digital innovation, while Norway continues to prioritise the expansion of specialised geriatric and orthogeriatric services [17,20]. In Norway, even though geriatrics is rarely mentioned, Norway’s “Time for Change”-initiative supports better care for older people [26].

Table 2: Trends in number of specialists in geriatric medicine across countries [34-36]

Geriatric specialists ^a	2011	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Sweden	450	537	537	538	502	492	531	546	563	576	b	b
Norway	72 ^c	184	190	197	199	205	223	218	219	222	248	257
Denmark	90	102	110	115	124	130	143	155	166	173	178	197
Finland	240	250	245	252	245	255	270	290	300	310	330	340

^a Below retirement age, ^b Not published yet, ^c Data from 2012

In contrast, Sweden has no national strategy to reinforce geriatric care. Responsibility for geriatric service provision and specialist training remains decentralised across 21 autonomous regions, resulting in substantial regional variation in prioritisation, organisation, and access to geriatric medicine services [18]. In addition, the absence of national workforce oversight limits the ability to monitor training capacity and plan future geriatric workforce needs at a national level.

Discussion

This cross-national comparative analysis highlights significant variation in the organisation, development, and prioritisation of geriatric medicine across the Nordic countries, despite their shared welfare models and demographic challenges. While all four countries recognise geriatrics as a medical specialty, differences in structural integration, workforce planning, and educational support reflect distinct national approaches to addressing the needs of ageing populations. These findings suggest that investment and institutional commitment to geriatric medicine will be essential to manage the complexities of ageing populations in the future.

A central finding was the apparent importance of coordinated national policy and workforce governance. Norway, Finland, and Denmark have prioritised workforce planning and geriatric capacity building and the continuous increase in the number of geriatricians in Finland during the last decade may indicate growing recognition of the need for geriatric expertise within healthcare services [27]. However, without accurate workforce metrics, it is difficult to design targeted policies or allocate resources effectively. In contrast, Denmark and Norway have established more robust systems for monitoring the number of geriatric specialists, enabling more informed planning and reform efforts. However, to meaningfully support workforce planning, such data must be available in near real time; currently, Denmark appears to be the only Nordic country with this level of accessibility [25].

Findings from the COST PROGRAMMING initiative have highlighted that in several European countries, geriatric medicine remains only partially integrated into hospital systems, variably recognised as a specialty, or structurally embedded within other disciplines, limiting both its visibility and institutional influence [6]. In such contexts, geriatric services may be particularly vulnerable during organisational reform and financial constraint, especially when the multidisciplinary and cross-sectoral nature of geriatric care is insufficiently recognised in conventional productivity metrics. These observations suggest that formal specialty recognition alone may be insufficient to secure sustainable specialty development unless accompanied by organisational integration, workforce planning, and institutional support. For geriatric surgery, this is not commonly established, as opposed to e.g., the US, where structured geriatric surgery programmes are increasingly integrated into perioperative care [28].

Educational and academic infrastructure also appeared to play an important role in specialty development. The role of the European Academy for Medicine of Ageing (EAMA) emerges as a cultural and educational cornerstone in the development of geriatrics, particularly in Norway, Finland, and Denmark. In Norway, the substantial increase in the number of geriatricians and expansion in academic activities can be attributed, at least in part, to the Norwegian Geriatrics Society’s investment in sponsoring EAMA

students annually. This initiative has not only expanded the workforce but also strengthened the specialty's visibility and appeal, demonstrating how targeted educational support can drive systemic change. EAMA's influence extends beyond national borders, acting as a banner carrier for geriatric medicine and fostering a shared professional identity across the Nordic region.

Academic development may represent an additional, underexplored driver of specialty growth. Across medical disciplines, research opportunities, academic mentorship, and institutional academic environments have been shown to influence specialty attractiveness and career choice among resident doctors [6, 29]. In this context, the expansion of academic geriatric environments—including research centres, PhD opportunities, and international collaborations—may contribute to workforce growth not only through scientific output, but also by strengthening specialty visibility, academic legitimacy, and perceived career opportunities. Although this relationship cannot be established within the present study, the observed parallel development of academic and workforce expansion in e.g., Denmark and Norway, suggests that academic investment may have broader workforce implications than research productivity alone.

The findings also raise broader questions regarding the future organisation of geriatric care. Across all countries, general practitioners continue to provide a substantial proportion of care for older adults, reflecting the limited number of geriatricians relative to population need. This suggests that expanding the geriatric specialist workforce alone is unlikely to meet future demand. Strengthening geriatric competencies across the wider medical workforce, particularly in primary care and general hospital medicine, may therefore be essential to ensure equitable access to high-quality care for ageing populations. One potential approach could be to strengthen the integration of geriatric medicine and palliative care, as in Finland, within undergraduate medical curricula. At present, geriatric medicine appears to represent only a small proportion (1–2%) of undergraduate medical training in the Nordic countries, and no comprehensive overview or recommendations regarding its curricular extent currently exist [30, 31]. Given demographic ageing and increasing complexity of care for older adults, greater attention to geriatric education is warranted [31].

Following this, newly developed European training requirements in geriatric medicine provide updated recommendations to help developing and unifying specialist training also in the Nordic countries [32]. The introduction of the European Geriatric Medicine Examination presents an interesting development for the field [32]. Even in the Nordic context, the European Geriatric Medicine Examination could serve as a benchmark for competency, promoting greater alignment in educational standards and clinical practice.

The survey findings further highlighted a need for broader competency development in geriatric care beyond the specialist workforce. Respondents across countries consistently emphasised the complexity of caring for older adults with frailty, multimorbidity, and cross-sectoral care needs, while also expressing a clear preference for clinically integrated, case-based, and interactive educational approaches over traditional didactic teaching. These findings suggest that future educational initiatives should prioritise practical, context-embedded and workplace-based learning formats that support clinical reasoning, interdisciplinary collaboration, and decision-making in complex geriatric care. Such findings align closely with the objectives of the COST PROGRAMMING initiative, which aims to develop consensus-based educational recommendations and competency frameworks to support geriatric capacity building across specialties and healthcare professions [33].

A key strength of this narrative review is its multi-source data collection to provide a contextualised overview of geriatric medicine across the Nordic countries. By combining survey findings with workforce, policy, and organisational data, the study offers a broader perspective on specialty development than would be possible from any single data source alone. However, the study has some important limitations. First, the use of heterogeneous national data sources introduces variability in data completeness, definitions, and availability, limiting direct comparability between countries. Second, survey findings may be affected by selection bias, as respondents were primarily recruited through geriatric professional networks and may therefore not reflect broader healthcare workforce perspectives. Also, a small number of respondents from each country compromise the robustness of data. Future research could benefit from larger-scale, systematic comparisons to validate and expand on these insights, particularly in exploring the long-term impact of educational and policy interventions on geriatric care quality and workforce retention.

Conclusions

The Nordic countries demonstrate that demographic ageing alone does not drive the development of geriatric medicine. Rather, specialty growth appears to depend on deliberate political prioritisation, coordinated workforce governance, academic and

educational investment, and structural integration of geriatrics within healthcare systems. Without such support, formal specialty recognition may have limited impact on workforce growth or equitable access to geriatric expertise. Future strategies to meet the needs of ageing populations should therefore combine expansion of specialist geriatric capacity with broader dissemination of geriatric competencies across the healthcare workforce. The Nordic experience provides important lessons for countries seeking to strengthen geriatric medicine in ageing societies.

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Figures

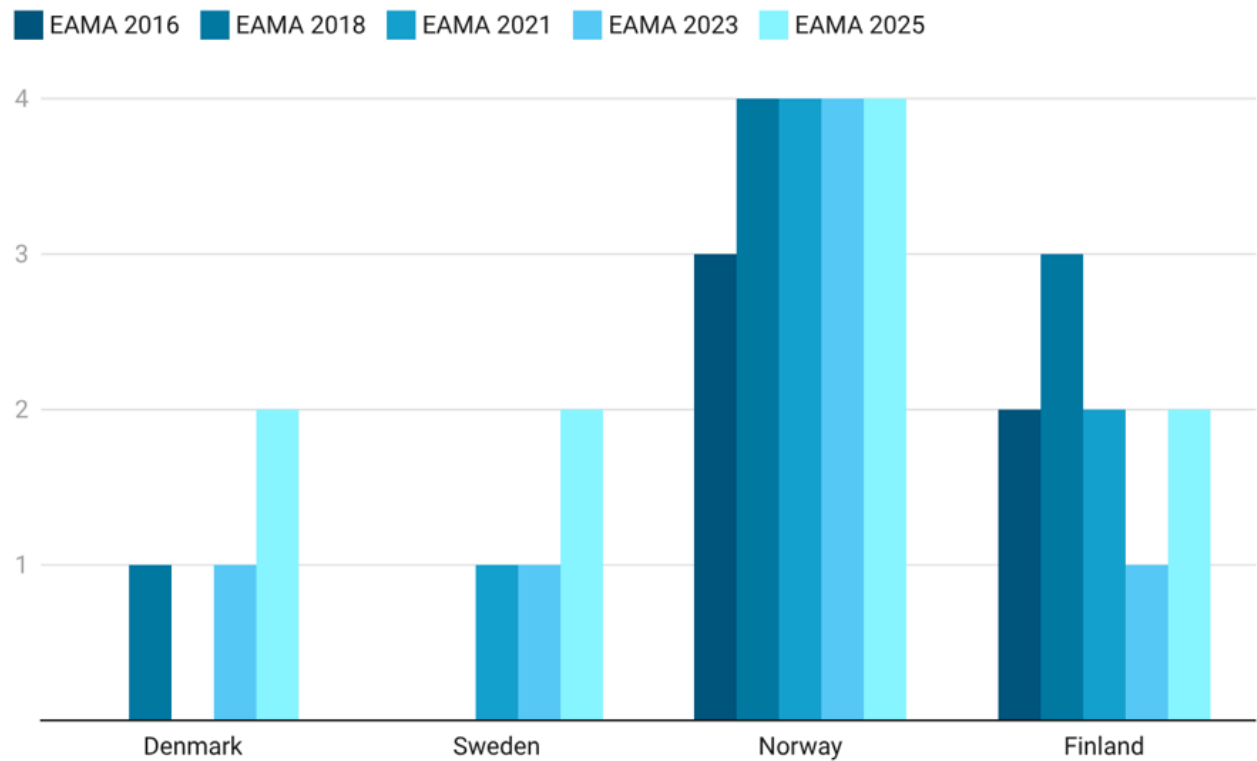


Figure 1

EAMA students from 2016 to 2025 by country

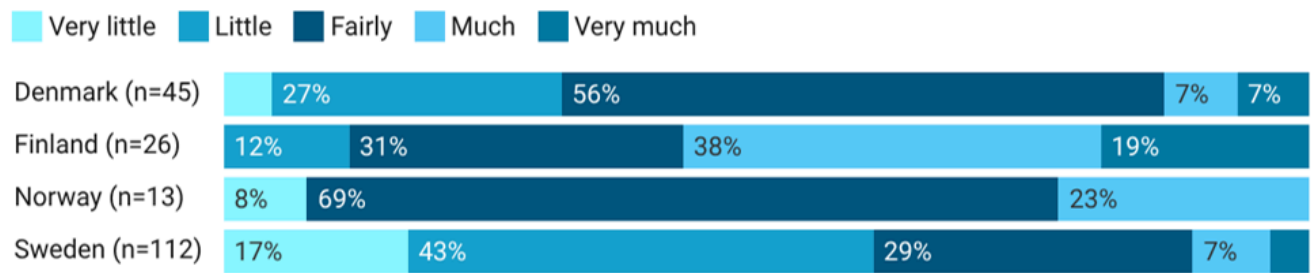


Figure 2

How prestigious is working with older adults by country