THE GLOBAL PULSE OF HEALTHCARE · FAMILY MEDICINE & PRIMARY CARE INSIGHT REPORT

Healthy Aging in Primary Care: When Routine Visits Cannot Fit Everything

Responses from family physicians and general practitioners on healthy aging in adults aged 65+: how routine visits absorb medication review, cognition, mobility, screening, vaccination, functional decline, and the growing need for workflow support that preserves independence without overloading the consultation.

Context → Signal → Judgement → Action

413 Survey records	**6** Countries represented USA · UK · Canada · Italy · France · Germany	**74.8%** Completion rate

WHY THIS REPORT

The older-adult visit is not short on priorities. It is short on room to hold them all.

Healthy aging in primary care is inherently multi-domain. A single visit can surface medication burden, gait change, cognitive concern, vaccination gaps, nutrition, chronic disease follow-up, caregiver strain, and a patient's wish to remain independent at home. The clinical challenge is therefore not simply knowing what matters. It is deciding what must happen now, what can happen before the visit, what can be delegated, and what needs a wider care network.

Current international frameworks make that breadth explicit. WHO's 2025 Integrated Care for Older People guidance describes person-centred primary-care pathways that assess declines in intrinsic capacity, social and support needs, and personalised care planning. The Age-Friendly Health Systems 4Ms framework similarly organizes care around What Matters, Medication, Mentation, and Mobility. These are useful ideals, but real-world implementation still lands in an appointment with finite time and finite staff.

The MDForLives survey captures how FP/GPs navigate that gap. The findings show strong attention to medication risk, persistent difficulty fitting cognition into the routine visit, a tendency for early decline to appear through functional complexity, and a preference for technology that reduces burden rather than creating another monitoring stream.

Methodology and data note. Audience: family physicians and general practitioners caring for adults aged 65+. Survey ID 8946574. The source export contains 413 survey records, 309 complete responses, 104 partial responses, a 74.8% completion rate, and respondents across the USA, UK, Canada, Italy, France, and Germany. Core question response counts range from 311 to 322. The country metadata item contains 386 responses. The practice-setting/panel-size item is grouped in the source export and does not expose the underlying option split, so it is not interpreted as a clinical finding. Administrative tracking fields, required-text fields, after-question fields, and the honeypot field are excluded.

EXECUTIVE SUMMARY

Six signals that define the healthy-aging capacity gap in primary care

INSIGHT 01
Time pressure concentrates around cognition
48.3% identify insufficient consultation time as the primary barrier to routine cognitive screening.

INSIGHT 02
Cognition is the hardest domain to fit
39.0% say cognitive screening and dementia evaluation are the most difficult healthy-aging area to address adequately.

INSIGHT 03
Medication risk is the top single priority
36.3% prioritize polypharmacy and deprescribing above mobility, cognition, immunization, nutrition, and frailty.

INSIGHT 04
Functional decline hides in everyday complexity
33.7% say new difficulty with medication management, finances, or other complex tasks most often goes unnoticed by patients and families.

INSIGHT 05
Deprescribing works best as a shared decision
37.5% select patient/caregiver shared decision-making as the most effective strategy for reducing high-risk polypharmacy.

INSIGHT 06
Digital value is measured in workflow relief
30.4% put EHR-integrated decision support first, narrowly ahead of ambient clinical scribes.

01 · VISIT CAPACITY

More than 20 minutes can still feel too short when the agenda spans the whole person

34.8% allocate more than 20 minutes to routine wellness or chronic-care visits for patients aged 65+.

CONTEXT

Age-friendly care expands the clinical agenda beyond disease control. Medication review, mobility, cognition, prevention, nutrition, social support, chronic disease follow-up, and the patient's own goals can all be relevant in the same encounter. WHO's ICOPE framework treats this breadth as a feature of person-centred older-adult care, not an exception.

WHAT THE DATA SHOWS

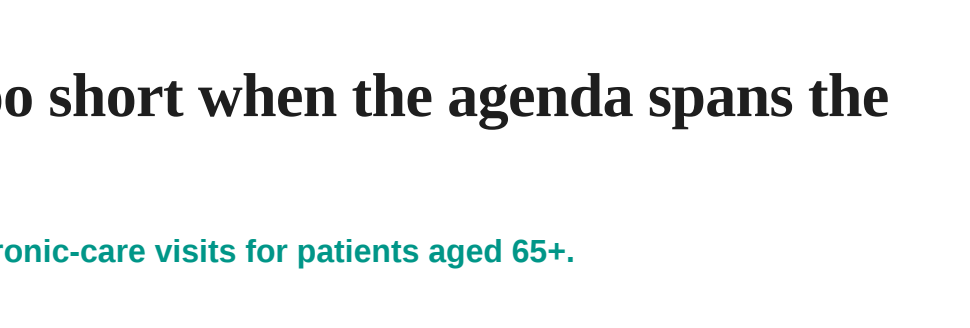
The largest single group, 34.8%, reports more than 20 minutes. Another 32.3% report 16–20 minutes, 29.2% report 10–15 minutes, and 3.7% report less than 10 minutes. The time distribution therefore does not describe uniformly brief visits.

THE INSIGHT

The critical signal appears when this finding is read against the later cognitive-screening result. Even with a substantial share of longer visits, time remains the dominant operational barrier to cognitive assessment. The capacity problem is created by competing tasks, not only by the absolute length of the slot.

WHY IT MATTERS

For FP/GPs, adding minutes without redesigning workflow may produce diminishing returns. A more durable model moves data collection, screening preparation, and routine prevention work outside the highest-value physician minutes, so the consultation can focus on interpretation, prioritization, and decisions that require clinical judgement.



02 · CLINICAL PRIORITY

Polypharmacy and deprescribing sit at the top of the routine older-adult priority list

36.3% choose medication reconciliation and risk reduction as the single highest priority.

CONTEXT

Older adults often live with multimorbidity, long medication lists, changing renal function, fall risk, cognitive vulnerability, and shifting goals of care. Medication decisions therefore interact with almost every other healthy-aging domain. The AGS Beers Criteria is one widely used tool for identifying potentially inappropriate medicines in adults aged 65+, while emphasizing that such criteria should support rather than replace individualized shared decision-making.

WHAT THE DATA SHOWS

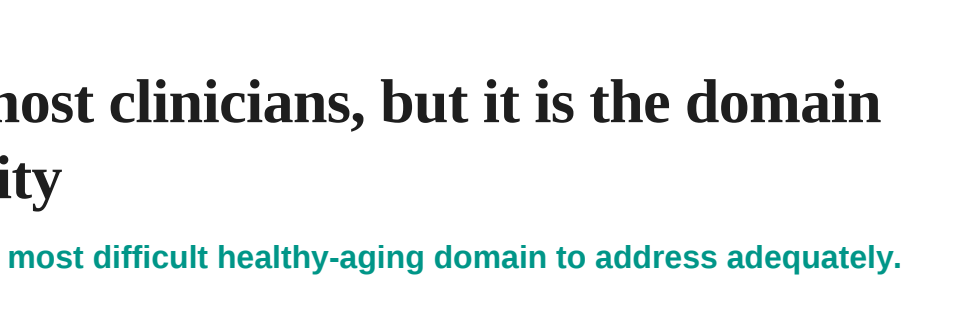
Polypharmacy and deprescribing lead at 36.3%. Mobility and fall risk follow at 22.7%. Cognitive health is 13.9%, preventive immunization 12.0%, nutritional and metabolic health 7.9%, and frailty/sarcopenia 7.3%. The question forces a single priority, so the ranking reflects what clinicians choose when several needs compete.

THE INSIGHT

Medication risk wins because it is both common and actionable. A prescription list can reveal immediate opportunities to reduce adverse effects, interactions, duplication, sedation, dizziness, or treatment burden. It is also one of the few domains in which a single decision during the visit can alter risk across cognition, mobility, falls, and daily function.

WHY IT MATTERS

The finding argues for making medication review a structural part of older-adult care rather than an occasional clean-up exercise. It also raises a workflow question: if medication safety already absorbs the top priority slot, other domains need a reliable route into the visit or they will depend on whichever concern becomes most visible that day.



03 · THE DIFFICULT DOMAIN

Cognition is not the top priority for most clinicians, but it is the domain most likely to exceed the visit's capacity

39.0% say cognitive screening and dementia evaluation are the most difficult healthy-aging domain to address adequately.

CONTEXT

Cognitive concerns rarely behave like a single-item checklist. They may require history from family, review of medication effects, mood and sensory assessment, attention to function, and a plan for what happens after concern is identified. That makes cognition a high-complexity task even before formal testing is considered.

WHAT THE DATA SHOWS

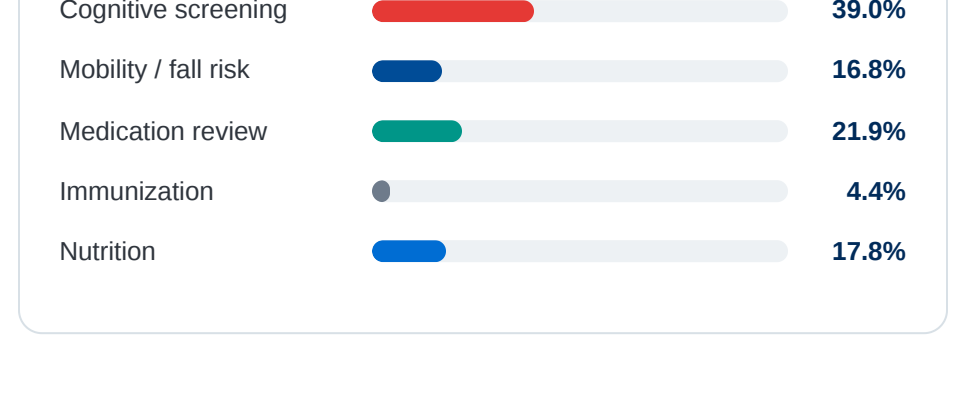
Cognitive screening and dementia evaluation lead the difficulty ranking at 39.0%. Comprehensive medication review and deprescribing are second at 21.9%, nutritional assessment and dietary counseling 17.8%, mobility and fall-risk screening 16.8%, and adult immunization review and administration 4.4%.

THE INSIGHT

The contrast with the priority ranking is revealing. Cognition is selected as the highest single priority by only 13.9%, yet it becomes the hardest domain to address by a wide margin. In practice, difficulty can become a form of deprioritization even when clinicians understand the importance of the issue.

WHY IT MATTERS

The survey suggests that cognitive assessment needs its own workflow rather than being expected to fit opportunistically into the residual minutes of a busy visit. Team-administered tools, informant history before the appointment, scheduled follow-up, and clear referral pathways can protect the quality of assessment without forcing every element into one encounter.



04 · COGNITIVE WORKFLOW

The main barrier to cognitive screening is consultation time, not the absence of a tool

48.3% identify insufficient consultation time as the primary operational barrier.

CONTEXT

Screening recommendations for asymptomatic adults are not uniform across settings. In the United States, the USPSTF currently concludes that evidence is insufficient to recommend for or against universal screening in asymptomatic community-dwelling adults aged 65+, while advising clinicians to remain alert to signs and symptoms and evaluate when appropriate. Local guidance may differ.

WHAT THE DATA SHOWS

Insufficient consultation time leads at 48.3%. Patient or family anxiety or resistance is 17.5%. Limited access to secondary specialists is 12.7%, lack of concise validated primary-care tools 12.4%, and concern about absence of actionable disease-modifying intervention after early diagnosis 9.2%.

THE INSIGHT

The result shifts attention from instrument selection to pathway design. A shorter tool may help, but it does not solve the time needed to establish baseline function, discuss implications, obtain collateral history, explain uncertainty, or decide what happens after an abnormal result.

WHY IT MATTERS

Practices that want more consistent cognitive assessment may need to separate signal detection from full evaluation. Pre-visit history, team-based screening, scheduled diagnostic follow-up, and referral criteria can reduce the chance that a legitimate concern is deferred because the current visit has already been consumed by other priorities.

05 · EARLY DECLINE

Loss of functional complexity may be the signal families notice last

33.7% say new difficulty with complex daily tasks such as medication management or finances most often goes unnoticed.

CONTEXT

Healthy aging is fundamentally about functional ability. WHO's current healthy-ageing approach emphasizes intrinsic capacity and the environment in which an older person lives, making changes in what a person can do clinically meaningful even when no single disease has declared itself.

WHAT THE DATA SHOWS

New difficulty with complex daily tasks leads at 33.7%. Mild loss of muscle mass or grip strength is 24.4%, subtle slowing of gait or balance 21.0%, unexplained fatigue or reduced social engagement 13.0%, and unintentional weight loss or reduced appetite 7.9%.

THE INSIGHT

The leading signal is not a classic symptom. It is a change in the ability to manage complexity. Difficulty organizing medicines, handling finances, or completing multi-step tasks can sit at the intersection of cognition, executive function, vision, dexterity, mood, and social support. That makes it easy to normalize until consequences accumulate.

WHY IT MATTERS

A routine question about what has become harder since the last visit can complement disease-based review. Changes in instrumental daily activities, gait, grip, nutrition, and social engagement may help the care team identify emerging vulnerability before a crisis, fall, medication error, or loss of independence forces the issue.

06 · SCREENING ARCHITECTURE

Older-adult screening is split between physician ownership and team pre-screening

34.3% conduct routine geriatric screenings entirely during the physician consultation; 31.7% pre-screen through medical assistants or nurses.

CONTEXT

CDC's STEADI model for fall prevention in outpatient care is one example of how screening, assessment, and intervention can be organized as a repeatable primary-care workflow rather than an isolated physician task. The broader healthy-aging challenge is similar: decide which signals can be collected reliably before the final clinical decision.

WHAT THE DATA SHOWS

Physician-only screening is the largest group at 34.3%, closely followed by medical assistant or nurse pre-screening at 31.7%. Patient self-assessment accounts for 10.6%, referral to specialized or community services 8.3%, and 15.1% say routine screening is not conducted unless acute symptoms are present.

THE INSIGHT

The near tie between physician-only and team pre-screening shows that practices are already experimenting with two different operating models. One concentrates assessment inside the consultation; the other creates a funnel in which the physician enters after some information has already been collected.

WHY IT MATTERS

For practices struggling with cognition, mobility, vaccination, and medication review, the second model offers a route to more reliable coverage. The key is not delegation for its own sake. It is deciding what the team can gather accurately and what still requires physician synthesis, patient preference, and clinical judgement.

07 · POLYPHARMACY

The most effective deprescribing strategy is not a checklist. It is a conversation.

37.5% say engaging patients or caregivers in shared decision-making is the most effective strategy for reducing high-risk polypharmacy.

CONTEXT

Deprescribing is clinically simple only on paper. A medicine may be potentially inappropriate yet still feel essential to the patient because it represents symptom relief, reassurance, or a long-standing treatment routine. Criteria and pharmacist review can identify risk, but the final decision sits inside goals, trade-offs, and willingness to change.

WHAT THE DATA SHOWS

Shared decision-making leads at 37.5%. Dedicated one-on-one medication review visits are 28.5%, collaborative review with clinical pharmacists 23.1%, and structured deprescribing tools such as Beers Criteria or STOPP/START 10.9%.

THE INSIGHT

The ranking does not diminish the value of tools. It locates their best use. Structured criteria can identify a possible problem; dedicated time or pharmacist input can clarify options; shared decision-making determines whether a change can be implemented and sustained without damaging trust or creating confusion.

WHY IT MATTERS

The finding supports a layered medication-safety pathway: screen the list efficiently, create protected review time for complexity, use pharmacy collaboration where available, and make the final plan with the patient or caregiver. That model treats deprescribing as a behaviour and goals conversation, not merely an alert response.

08 · DIGITAL SUPPORT

Primary care wants technology that closes the gap between knowing and doing

30.4% choose EHR-integrated clinical decision support as the digital or AI tool with the greatest potential over the next two to three years.

CONTEXT

Digital health can either reduce workload or create another inbox. For older-adult care, the distinction is especially important because clinicians already manage multiple preventive and chronic-care tasks. A useful tool must fit the care pathway, not simply generate more observations.

WHAT THE DATA SHOWS

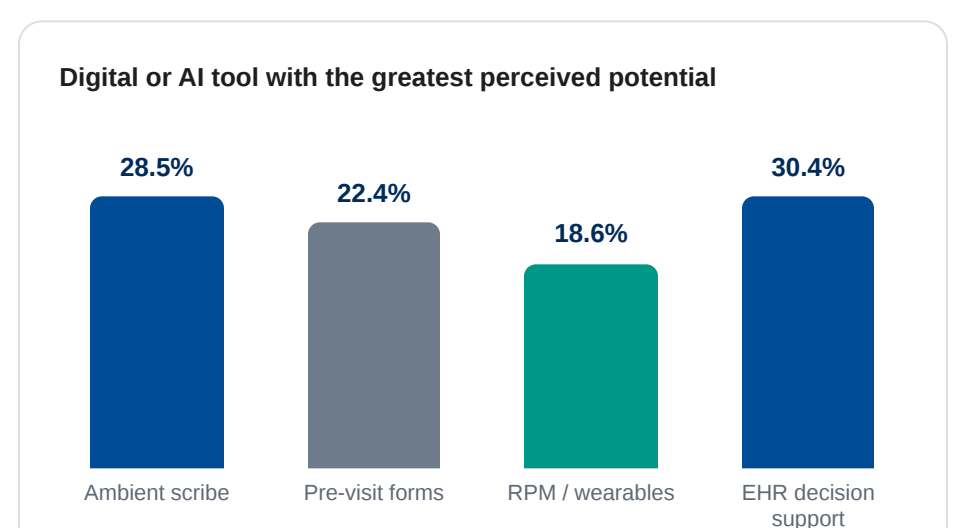
EHR-integrated decision support leads at 30.4%, ambient clinical scribes follow closely at 28.5%, automated pre-visit questionnaires are 22.4%, and remote monitoring or wearable sensors for fall detection are 18.6%.

THE INSIGHT

The two leading choices share a workflow characteristic: they act inside the consultation or documentation environment. Decision support can surface screening or deprescribing opportunities at the point of care. Ambient scribes can return attention by reducing documentation burden. Both aim to create usable capacity.

WHY IT MATTERS

The result suggests that technology adoption in healthy-aging care should be judged by workflow economics as much as technical novelty. A remote signal has limited value if nobody owns the response. A good tool clarifies responsibility, reduces repeated work, and gives clinicians more room for the conversations that cannot be automated.



09 · PREVENTIVE IMMUNIZATION

Vaccination may be supported by systems, but the clinician's recommendation still carries the strongest signal

38.3% select a strong proactive recommendation during the physician consultation as the most effective approach to improving older-adult immunization rates.

CONTEXT

Adult vaccination schedules differ across countries and change as evidence and policy evolve. In the United States, current CDC guidance includes age- and risk-based recommendations relevant to older adults for vaccines such as influenza, pneumococcal, zoster, COVID-19, and RSV. International readers should follow their local schedule and eligibility criteria.

WHAT THE DATA SHOWS

A strong proactive physician recommendation leads at 38.3%. EHR-driven clinical decision alerts are 24.4%. Standing orders for nursing staff and dedicated immunization clinics or seasonal co-administration are each 18.6%.

THE INSIGHT

Prevention appears to need both infrastructure and persuasion. Alerts and standing orders can make the opportunity visible and executable, but the largest group still sees the clinician's recommendation as the intervention most likely to move the patient from eligibility to acceptance.

WHY IT MATTERS

The practical model is layered: identify eligibility reliably, make vaccination easy to deliver, and preserve a clear recommendation from a trusted clinician. That combination reduces missed opportunities without assuming that a digital prompt or standing order will automatically resolve hesitancy, competing priorities, or uncertainty.

OPEN-ENDED PERSPECTIVE

What FP/GPs say would help older adults maintain independence

The open-ended question asked respondents for the single most important change primary care delivery needs to help older adults maintain functional independence as they age. The source export displays 20 responses. The responses are short and varied, so they are interpreted as qualitative themes rather than coded percentages.

More time, not simply more tasks
Several respondents ask for longer consultations, more dedicated time, or longer appointment slots. The theme aligns directly with the quantitative finding that time is the leading barrier to cognitive screening.

Care that reaches the home and community
House calls, home visits, home-support funding, social work, community programmes, and the ability to remain safely at home appear repeatedly. Independence is framed as something that must be supported outside the clinic as well as inside it.

Multidisciplinary and geriatric access
Respondents mention more clinicians, geriatric specialists, occupational therapy, physiotherapy, social work, and faster referral pathways. The desired model distributes older-adult care across disciplines rather than asking the FP/GP to carry every domain alone.

Proactive function, mobility, and participation
Routine geriatric screening, falls-strengthening classes, walking, and social participation appear as practical ways to preserve function before decline becomes crisis-driven. These comments broaden healthy aging from disease control to day-to-day capability.

What the qualitative responses add: clinicians are not asking for a single new screening tool. They are asking for capacity, community connection, team support, and earlier attention to function. The desired endpoint is not merely detecting more problems; it is helping older adults keep doing the things that sustain independence.

FP / GP HEALTHY AGING PRACTICE LENS

What a more workable healthy-aging pathway could look like

The survey does not prescribe a single model of care. It does, however, show where workflow design could reduce friction while preserving clinical judgement.

Front-load routine information
Use team pre-screening or pre-visit tools for medication lists, vaccination status, mobility concerns, and functional change so physician time begins with a clearer signal.

Protect cognition from residual-time medicine
When cognitive concern is present, create a pathway for history, assessment, and follow-up rather than expecting a complex evaluation to fit into the last minutes of an unrelated visit.

Make medication review both structured and relational
Use criteria, pharmacy input, or EHR support to identify risk, but make deprescribing decisions through patient and caregiver discussion about goals, burden, and trade-offs.

Connect function to community support
When gait, strength, daily tasks, or social participation begin to change, link clinical assessment with rehabilitation, home support, social work, and community resources where available.

PEOPLE ALSO ASK

Frequently asked questions about healthy aging in primary care

What does healthy aging mean in primary care?
Healthy aging focuses on maintaining the functional ability that supports well-being and independence as people age. In primary care, that usually means looking beyond single diseases to medication safety, cognition, mobility, nutrition, prevention, social needs, and what matters most to the older adult.

What should primary care assess during visits with older adults?
The exact assessment depends on the patient and local guidance, but common priorities include medication review, mobility and fall risk, cognition when concerns arise, vaccination status, nutrition, functional ability, mood, sensory problems, and social support.

How should cognitive concerns be assessed in older adults?
Clinicians should evaluate cognitive concerns when symptoms, family observations, functional change, or other clinical signals raise concern. Recommendations on routine screening of asymptomatic adults vary by country; in the United States, the USPSTF currently states that evidence is insufficient to recommend for or against universal screening.

What is deprescribing in older adults?
Deprescribing is a structured, supervised process of reducing or stopping medicines when potential harms, burden, duplication, or limited benefit outweigh the expected value. It should be individualized and supported by shared decision-making rather than treated as an automatic medication cut.

How can primary care reduce fall risk in older adults?
A practical approach is to identify fall risk, assess modifiable contributors, and intervene. Depending on the patient, this may include strength and balance work, medication review, vision and footwear assessment, home-safety measures, and management of conditions that affect gait or blood pressure.

Which vaccinations are important for older adults?
Vaccination recommendations vary by country, age, medical history, and risk. Common older-adult schedules may include influenza, pneumococcal, shingles, COVID-19, and RSV vaccination for eligible groups. Clinicians should use the current schedule for their country and the individual patient.

CLOSING PERSPECTIVE

The next step in healthy aging is not adding another priority. It is designing a visit that can hold the priorities already there.

The survey describes primary care at a familiar point of tension. Clinicians know that medication safety, cognition, mobility, vaccination, nutrition, function, and independence are connected. Yet the operating environment still asks many of those domains to compete for the same minutes, the same clinician attention, and the same follow-up capacity.

Medication risk emerges as the most common top priority because it is frequent, consequential, and actionable. Cognition emerges as the hardest domain because it demands more than a quick screen. Functional decline appears in the complexity of daily life before it necessarily looks like a classic geriatric syndrome. Screening workflows are split between physician ownership and team pre-screening. Deprescribing works best when patients and caregivers are part of the decision. Digital tools are valued when they reduce friction inside the workflow. Vaccination remains strongly influenced by a proactive clinician recommendation.

The qualitative responses make the system-level implication clearer. More consultation time matters, but so do home visits, community support, social work, rehabilitation, geriatric access, and team-based care. Healthy aging becomes more achievable when primary care is not treated as the only place where independence is protected.

The practical challenge ahead is therefore integration. The highest-value model is likely to identify signals before the visit, use the wider team to collect and act on routine information, protect clinician time for complex judgement, and connect the practice to resources that operate where older adults actually live. Technology can support that model, but only if it reduces work or makes responsibility clearer.

1 · Identify function before crisis
Ask what has become harder, not only what symptoms are present.

2 · Shift appropriate screening upstream
Use pre-visit tools and team workflows so the clinician does not start every older-adult assessment from zero.

3 · Protect cognitive assessment time
Create a follow-up pathway when concern is present rather than squeezing a complex evaluation into residual minutes.

4 · Make medication review shared
Combine structured risk detection with patient and caregiver decisions about burden, benefit, and goals.

5 · Use technology to return attention
Prioritize tools that reduce documentation, surface decisions, and clarify next steps instead of creating another data stream.

6 · Link clinic care to independence
Use rehabilitation, social work, home support, community activity, and geriatric resources where they are available and appropriate.

Sources used for this report

1. **MDForLives FP/GP Insight Survey_Aug, SGID 8946574.** Source survey report: 413 records, 309 complete responses, 104 partial responses, 74.8% completion rate; country distribution and healthy-aging questions extracted from the supplied PDF. The open-ended independence responses were interpreted qualitatively without percentage coding. Administrative and validation fields were excluded.
2. **World Health Organization.** Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care, 2nd edition. Published September 22, 2025. https://www.who.int/publications/i/item/9789240103726
3. **Institute for Healthcare Improvement.** Age-Friendly Health Systems and the 4Ms framework: What Matters, Medication, Mentation, and Mobility. https://www.ihi.org/partner/initiatives/age-friendly-health-systems
4. **U.S. Preventive Services Task Force.** Cognitive Impairment in Older Adults: Screening. Current recommendation page notes an update is in progress; the existing statement finds insufficient evidence to recommend for or against universal screening in asymptomatic community-dwelling adults aged 65+. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cognitive-impairment-in-older-adults-screening
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7. **Centers for Disease Control and Prevention.** Vaccines for Adults: RSV. Updated February 20, 2026, plus the current adult immunization schedule. https://www.cdc.gov/rsv/vaccines/adults.html

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