ORIGINAL ARTICLE

Explaining the Model of Integrated Elderly Care Program in Khuzestan

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ABSTRACT

Introduction: The present research aims to explain the model of integrated elderly care program in Khuzestan province based on the existing challenges and policies.
Method: This research is a qualitative study. The sample includes 12 elderly health experts and 5 old people using the integrated healthcare services in Khuzestan province. Data collection was done by a semi-structured interview. Data analysis was done by Corbin and Strauss (2014) method.
Findings: According to the findings, the challenges of the integrated elderly care program include the poor participation of the elderly, lack of human force and laboratory facilities, poor education and skills of health care providers, limitation of the provided services, and low occupational motivation of the healthcare providers. Also, it was found that the main policies of this program include the integration of the elderly healthcare services, promotion of the service quality, and improvement of the physical and mental health in the elderly population.
Conclusion: Based on the findings, this research has proposed a model to resolve the challenges of integrated elderly care program using the viewpoints of elderly health experts. This model can be useful in planning and developing the policies of integrated elderly care program.
Keywords: integrated elderly care, challenges, policies, Khuzestan, Iran

INTRODUCTION

The elderly population is growing in all the countries including Iran; so that, the population growth and population health diagrams of the world are rapidly changing. This transformation is an effective factor in the social and economic systems of the communities. Particularly, the life expectancy is increasing and the fertility rate is decreasing (1). In 2015-2050, the transforming population growth reaches the highest level in a rapidly aging population, and the ratio of above 65-year-old population will increase by twice in the world. Although the increased life expectancy can be considered a valuable ideal, the elderly do not necessarily experience functional abilities while aging i.e. healthy aging (2).

An increasing ratio of the world's diseases is currently related to the physical, sensory, and cognitive disorders which increase the disability load in the elderly, especially in the low-income and medium-income regions. Furthermore, the elderly usually experience several diseases at the same time, particularly those who have an unfavorable socioeconomic situation (3-5). Population aging is a demographic consequence that mainly results from health promotion; because fertility and death rates decline in this situation. In other words, decrease of death rate especially in the mothers, infants, and children, the fundamental and continuous decline in fertility rate, and increased life expectancy and social welfare that change the age structure result in this phenomenon (6). Rapid population aging besides the increasing growth of the elderly population with their lost abilities and their long-term complex conditions has created significant challenges for the health systems that have been planned to provide healthcare and treatment services (7, 8). This historical approach to healthcare is not anymore consistent with the current and future population needs. WHO reports support the global strategy and operational programs about aging and health and expanded modifications in healthcare systems to promote healthy aging (2). Such modifications are necessary to achieve the goals of sustainable development planned by the UN, especially the third goal of healthcare and welfare sustainable development that is based on the global health coverage. This organization suggests that the social and healthcare services should be planned to manage aging and prevent the loss of functional abilities in the elderly rather than supporting a limited and disintegrated approach to management of the elderly health (7).

In general, the reports suggest the growing increase of the elderly population in the world which results from the scientific, medical, and technological transformations. The increased ratio of the elderly population in the societies raises new issues and the need to planning for economic, social, medical, and healthcare areas; because aging leads to an increased use of healthcare and medical services. It is said that population aging is the result of development. Although this phenomenon is considered as a positive result of development, if we are not prepared to cope with that in a developed world, it will lead to negative consequences. For example, the higher speed of the elderly population growth than the total population growth leads to a relative decline in the economically productive population. In the case of negligence in taking the necessary measures, this situation can create an obstacle to economic development. So, it is so important to confront the challenges created by this phenomenon and adopt

appropriate policies to improve the physical, mental, and social conditions of the elderly population. Therefore, this issue has been considered as a priority in the international community. Regarding the decreased support of the elderly in the families, some of the problems of the elderly population include their loneliness, not attending the elderly care courses, lack of access to periodic para-clinical tests for the elderly, lack of human force to care for the elderly, lack of insurance for the whole elderly population, not referring to public treatment centers despite being covered by different insurance, and improper collaboration of the private sector. According to the 2016 census of the Statistical Center of Iran, Iran has a 7-million elderly population that constitutes 9.28% of the total population. It is expected that this population increases to 30% of the total population of the country by 1430. This is an alarm suggesting the start of the population aging crisis in Iran (9). Although the increased elderly population indicates the success of health promotion programs in the country, it should be noted that it is a major challenge involving the whole social and economic resources of the country in achieving the maximum health and functional capacity, participation, and security for the elderly (10).

On the other hand, according to the available statistics and studies performed in Khuzestan province, operation of the provided service packs is far from the optimal level (11). It suggests that the elderly have not completely used the service packs provided in public centers. This situation can cause unfavorable consequences in this population. Regarding the importance of this issue, this condition is considered a major challenge in the country's health system. Moreover, no study has investigated this issue in Khuzestan province. Therefore, the present research aims to investigate the challenges and propose appropriate policies to develop an optimal model for provision of integrated elderly healthcare services in Khuzestan province.

After several years of operation of the integrated elderly health care in Iran, this program has not been evaluated yet. So, the healthcare decision makers have received no feedback in this area. In other words, no pathological study has been done to evaluate this program; furthermore, the operational solutions based on the criticism of service integration, operational policies, and its challenges have not been studied carefully. The present research can provide a clearer image of the current realities, and it tries to propose a solution proportional to the current situation. This research is developed in several sections. The first section discusses the research method, and the findings are included in the following, Finally, discussion of the findings and the research conclusion are explained in the last section.

METHOD

This research is a qualitative case study. The sample includes 12 elderly health experts and 5 old people using the integrated healthcare services in Khuzestan province. Data collection was done by a semi-structured interview. The interviews continued until theoretical saturation. Finally, data analysis was done by coding.

In the qualitative phase, the reliability and validity of the study were evaluated by Lincoln and Guba method (12) which is equivalent to the reliability and validity measures in quantitative studies. The criteria of the reliability and validity were credibility, transferability, dependability, and confirmability. In this research, trustability was achieved by the combination of three approaches in data collection. These three approaches included the review of literature, interview, and finally, filling the questionnaire. Moreover, the Delphi panel members were the health experts who were scientifically or practically involved in the management process and the integrated elderly healthcare program. To make sure of the transferability of the findings, the researchers consulted with three experts who did not participate in the research. In all the stages, the details and notes were recorded to create trustability. In order to achieve confirmability and avoid researcher bias, the opinions were revised and modified by Delphi method.

Findings

Section one: Identifying the challenges in the integrated elderly care program

Data analysis was done by Corbin and Strauss method (13). In this stage, all the interviews were studied and coded to extract the relevant propositions. Each of the interviews and propositions was assigned a specific code from A to L. After extracting the basic themes, they were classified in more general themes referred to as the organizer themes. The organizer themes were divided into two classes including the challenges of the integrated elderly care program and the causes creating these challenges. Table 1 presents the organizer themes.

As seen in the above table, the challenges of integrated elderly care program were classified in 5 organizer themes, including the poor participation of the elderly, lack of human force and laboratory facilities, poor education and skills of health care providers, limitation of the provided services, and low occupational motivation of the healthcare providers, and 26 basic themes.

Table1. Cumulative table of the challenges of integrated elderly care program

The organizer themes	The basic themes	Documents
Poor participation of the elderly	Poor participation of the elderly	A1-I3-L1
	Poor cooperation of the elderly with the healthcare providers	B9-G4-I12-K16-L11
	Lack of support by the families of the elderly	B11-D6-G11-H4-I3-K16-L11
	Low literacy in the elderly	A10-C6-D14-E9-F10-H9-J1-K4
	The elderly referring to the health centers alone	F12-I2
	Lack of access to health centers due to the distance	H1-I4
	The elderly's inability to refer to the health centers	A8-D1-F6-G3-H3-I4-K2
	lack of interest in the elderly to receive education	A12-D16-F9-H15-I9-J3-L7
	Lack of access to communication tools for the elderly	D17-E10-I7-J2-K17-L9
	Low information about the healthcare service in the elderly	A2-C1-D3-E2-F3-G6-J1-K5
	Lack of awareness about the healthcare service the families of the elderly	A11-D15-E11-F5-G11-K6

Lack of human force and medical facilities	The absence of doctors in health centers	A4-A6-B1-C2-D4-E4-F4-G2-H2-J9-K3-L3
	Lack of laboratory and para-clinical facilities	A5-A13-B2-C2-D8-E5-F8-H8-J4-K13-L4
	Lack of specialist human force	D5-F7-H11-J5-K1
	Lack of a medical information system	F1-K11
Poor education and skills of healthcare providers	Poor skills of the healthcare providers	A7-B3-C5-F11-G10-H5-L6
	Poor communication skills in the healthcare providers	B4-C7-H12
	Lack of evaluation of the healthcare providers' skills	D10-G5-H10-H13
	Lack of training courses for healthcare providers	B12-D11-E6-G12-H5-H10-J11-K10-L8
	Lack of attention to the elderly	I1-I11-L2
Limited services of the health centers	Provision of more various services by other insurance companies	A9-C4-D9-D13-E8-H7-H14-J6-K14-L1
	Lack of free medicines	D7-G7-I6-J4-L5
	Poor service and lack of treatment services	D2-E1-G8-H6-I10-K9
Low occupational motivation of the healthcare providers	Mass of workload	G1-H11-I8
	Lack of occupational motivation	C3-G1-I13-J10-K15
	Lack of job security	G9-K8

Section two: Identifying the current policies of the integrated elderly care program

Table2. Cumulative table of the current situations of integrated elderly care program

The organizer themes	The basic themes	Documents
Integration of the elderly health services	Integration of the elderly services	A14-G14
	Creation of a comprehensive elderly service system	B15-C9-G15
	Creation of healthcare services for the elderly	L13
Improvement of the physical and mental health in the elderly	Promotion of physical and mental health in the elderly	A15-E12-H17-J12-K18
	Paying attention to health in rural regions	B14-E13
	Participation of the elderly in development programs	D18-I15
	Supporting the elderly from the middle and lower classes	F15-I14
	Promotion of the quality of life for the elderly	L12

As seen in the above table, the current policies of the integrated elderly care program were classified into 2 organizer themes, including: 1. Integration of the elderly healthcare services, and 2. Improvement of the physical and mental health in the elderly population, and 8 basic themes.

Section three: Determining optimal solutions for resolving the current challenges and policies: In this section, Delphi method has been used to determine optimal solutions for resolving the current challenges and developing the current policies and finally, for scientific validation of the proposed model.

Delphi method was used for identifying and determining the optimal solutions for resolving the challenges and developing the current policies in three stages. In each round, the items with the condition of M≥6 (mean) were included in the subsequent round, and the items with a mean value of less than 6 were omitted from the questionnaire in the subsequent round.

After the second and third stages of Delphi method, the difference between the respondents' opinions in the second and third rounds was studied by Kendall correlation test. The results of this test are presented in the following table.

Table3. The results of Kendall test for studying the commonality of the experts' opinion

1	The sample size	12
2	Kendall coefficient	0/761
3	Chi-square	395/509
4	Degree of freedom	10
5	Sig	0/0000

The Kendall concordance coefficients in the third round were reported as Kendall W=0.761χ^2 =395/509 ، that were significant (P≤0.001). The number of members in the third round Delphi (12 people) indicated an almost optimal level of concordance. Since the Kendall concordance coefficient did not have any significant change in the third round (at the significance level of 0.05), the Delphi round was stopped.

Section four: The proposed model: In the last stage of the research, the final model was developed based on the obtained data and the findings resulted from identifying the challenges and policies and also determining the optimal solutions for resolving the challenges based on the experts' opinions. This model is presented in the following.

The challenges and policies of the integrated elderly care program

The policies the integrated elderly care program		**The challenges of the integrated elderly care program**				
Improvement of the physical and mental health in the elderly 1. Promotion of physical and mental health in the elderly 2. Paying attention to health in rural regions 3. Participation of the elderly in development programs 4. Supporting the elderly from the middle and lower classes 5. Promotion of the quality of life for the elderly	Integration of the elderly health services 1. Integration of the elderly services 2. Creation of a comprehensive elderly service system 3. Creation of healthcare services for the elderly	Low occupational motivation of the healthcare providers 1. Mass of workload 2. Lack of occupational motivation 3. Lack of job security	Limited services of the health centers 1. Provision of more various services by other insurance companies 2. Lack of free medicine 3. Poor service and lack of treatment services	Poor education and skills of healthcare providers 1. Poor skills of the healthcare providers 2. Poor communication skills in the healthcare providers 3. Lack of evaluation of the healthcare providers' skills 4. Lack of training courses for healthcare providers 5. Lack of attention to the elderly	Lack of human force and medical facilities 1. The absence of doctors in health centers 2. Lack of laboratory and para-clinical facilities 3. Lack of specialist human force 4. Lack of a medical information system	Poor participation of the elderly 1. Poor attendance of the elderly 2. Poor cooperation of the elderly with the healthcare providers 3. Lack of support by the families of the elderly 4. Low literacy in the elderly 5. The elderly referring to the health centers alone 6. Lack of access to health centers due to the distance 7. The elderly's inability to refer to the health centers 8. lack of interest in the elderly to receive education 9. Lack of access to communication tools for the elderly 10. Low information about the healthcare service in the elderly 11. Lack of awareness about the healthcare service the families of the elderly

Determining the solutions and developing the policies

Developing the policies	**S[illegible]ions for resolving the challenges**				
	Low occupational motivation of the healthcare providers	Limited services of the health centers	Poor education and skills of healthcare providers	Lack of human force and medical facilities	Poor participation of the elderly
	solutions	solutions	solutions	solutions	solutions
1. Creation of information bases to be used for decision making based on the evidence to provide comprehensive elderly care in the country 2. Continuous assessment and updating the national policies of this program	1. Increasing the healthcare providers' salaries proportional to their job difficulty 2. Supplying	1. Increasing the free para-clinical services (providing free drugs, etc.) 2. increasing	1. need assessment for holding training courses for the healthcare providers	1. presence of doctors in health centers at least for 3 days a week 2. increasing	1. Promoting the role of health ambassadors 2. Explaining the importance of referring to health

3. Creating a multi-dimensional national and regional network among the organizations, academic institutes, and the people interested in elderly health issues. 4. Providing the elderly with the necessary knowledge and self-care skills and promoting the health of the elderly, their families, and the society. 5. Supporting education and research works in the area of elderly and social cares.	appropriate facilities and equipment to create a safe workplace for the healthcare providers 3. Providing the necessary conditions for promotion of the healthcare providers' position 4. On-time payment of the healthcare providers' salaries 5. Supplying job security for healthcare providers 6. Providing the conditions for higher education of healthcare providers 7. Resolving the problems and meeting the financial needs of healthcare providers 8. Promoting the healthcare providers' religious belief to strengthen their conscience	the new healthcare services for the elderly	2. holding special courses and workshops for the elderly services 3. providing skill promotion courses for healthcare providers 4. evaluation of the effectiveness of the training course 5. continuous and regular evaluation of the healthcare providers' performance 6. avoiding to hold repetitive and useless courses 7. including the specialized elderly care contents in the university students' chart	the number of specialist human force in health centers 3. allocating the charity funds to healthcare services 4. providing rehabilitation equipment such as glasses, hearing aid, cane, wheelchair, etc. for the poor elderly	centers by media promotion, etc. 3. Going to religious places (such as mosques) to provide elderly health educations 4. Creating communication infrastructures in deprived regions 5. Creating road infrastructures in deprived regions 6. Holding literacy education courses in deprived regions with low-literate people 7. Identifying the patient elderly and going to their home 8. Creating health centers in rural regions
Output					
Promotion and improvement of service quality in the integrated elderly care program					

DISCUSSION

According to the findings, the first identified challenge was the poor participation of the elderly in the program. The regular and continuous referring to the health centers by the elderly is one of the main factors in the integrated elderly care program. So, the elderly population is considered as the target class of the integrated elderly care program, and they should actively participate in this program. In this regards, various factors have led to their poor participation in the integrated elderly care program. These factors include the low literacy of the elderly, their limited access to the health centers due to the distance, lack of support by the families of the elderly, and lack of access to communication infrastructures.

The second major challenge identified in the integrated elderly care program was lack of human force and medical facilities, and especially lack of continuous presence of a doctor in health centers. Most of the elderly refer to the health centers during the treatment stages and they expect to be examined by a doctor; but it is impossible due to the lack of continuous presence of a doctor in health centers. One of the common problems of the integrated elderly care program that was mentioned by most of the experts was the absence of a doctor in health centers. The other problem was the lack of laboratory equipment and para-clinical services. These deficiencies were observed in the form of lack of a laboratory in health centers, lack of drugstore, and para-clinical services in some of the health centers.

The third challenge recognized in this program was the poor education and skills of healthcare providers. Since the needs of the societies are continuously changing and the scientific advances have decreased the half-time of the scientific findings to six months, human force training is an important issue which is not necessary due to the sensitivity of the public health issue. In the county's health system, healthcare providers work in the frontier line of providing healthcare services in the villages. They are employed in their hometown after passing a two-year course and theoretical and practical training. On the other hand, nowadays, the inadequate attraction of efficient human force to work as healthcare providers and lack of attention to their in-service education has led to the improper performance of some of the healthcare providers due to their low literacy. Also, the Islamic Council of the villages sometimes approves the volunteers of this job carelessly. So, as a result of the lack of human force in healthcare programs, some of the healthcare providers working in health centers cannot provide efficient services for the referring people. This situation finally leads to the referring patients' dissatisfaction.

The fourth challenge recognized in this program was provision of limited services by health centers. The elderly referring to the health centers expect to receive services such as supplying free drugs and medical tests, etc. as the other health insurance services. However, since these centers do not have such resources and facilities, they cannot meet the therapeutic needs of the elderly. It has

been always one of the causes of dissatisfaction in the elderly.

The fifth challenge recognized in this program was the low occupational motivation of the healthcare providers. In the integrated elderly service program, some of the healthcare providers should simultaneously cover several health centers and provide service for the people residing in these regions by inspecting the health centers. Sometimes, due to their high workload, healthcare providers become tired and unmotivated. On the other hand, due to the occupational problems existing in the Ministry of Health such as the low salaries, lack of promotion system, lack of job security, etc., healthcare providers are concerned about their position and it finally leads to their decreased occupational motivation. Their low occupational motivation makes them careless in providing service for the elderly. This situation decreases the quality of the services provided for the elderly in health centers.

The findings showed that the healthcare and treatment authorities have adopted two major policies in the integrated elderly care program of Khuzestan province. The first effective policy in the area of elderly health was integration of elderly services. In some of the low-income and medium-income countries, healthcare services are organized focusing on a specific health problem. Since the individuals need to refer to several clinics depending on their problem, this situation can cause dispersion. A solution for this problem is to integrate the healthcare services or strengthen the link between these services. The goal of integrating the services is to improve their coordination and provide the services in an integrated manner. For example, the mothers and children services are provided in a same health center. It is believed that service integration guarantees the management of service provision to provide more efficient and high-quality services. The other belief is that integration of healthcare services provides a higher level of public access and fair distribution of the services among people from different economic and social classes. Also, it leads to the availability of more convenient and satisfactory health services, and consequently, a higher level of health in the society.

The elderly health is one of the most important economic, social, and healthcare challenges in the 21th century. The global growth of the elderly population is considered a challenge for both the healthcare providers and also the family and society members. As a developing country, Iran has gone through similar changes in its population structure and prevalent diseases. The elderly population of Iran will increase by more than 10% by the year 2025 and about 21.7% by the year 2050. According to the latest statistics resulted from the general census of population and housing, the elderly population constitutes about 9% of the total population. According to the UN definition (the countries where the elderly population constitutes more than 7% of its total population is considered an aging country), Iran can be considered an aging country. So, the second policy of the integrated elderly care program is improvement of the physical and mental health in the elderly population and consequently, promotion of the quality of life and life expectancy in this population.

CONCLUSION

In general, it is concluded that the variety of organizations providing elderly healthcare services in the country has led to the creation of similar services, confusion of the elderly, and failure to meet all the needs of the elderly. Accordingly, the integrated elderly care program was executed in health centers to promote the quality of elderly healthcare services. As suggested by the findings, this program has been faced with different challenges. The most important challenges recognized in this research include the poor participation of the elderly, lack of human force and laboratory facilities, poor education and skills of health care providers, limitation of the provided services, and low occupational motivation of the healthcare providers. On the other hand, it was found that the main policies of this program include the integration of elderly healthcare services, promotion of the service quality, and improvement of the physical and mental health in the elderly population. The findings of the present study are consistent with some of the results reported by Sadeghi Moghadam et al. (14), Rezaei (15), Safdari et al. (16), Sahebalzamani et al. (15), Sadeghi et al. (14), Heydari et al. (16), and Ahmadnia et al. (17). Based on the findings, this research has proposed a model to resolve the challenges of the integrated elderly care program by a process-based approach and using the strengths of the previous studies and viewpoints of the elderly health experts and authorities. This model can provide the opportunity of the future studies and development of the policies of the integrated elderly care program. For future studies, it is suggested for the researchers to propose a model to explain the social determinants of healthy behavior in the Iranian elderly who are above 60 years old. The limitations of this research included the lack of full access to the research literature and the probability of bias in analyzing the challenges and policies of the integrated elderly care program in Iran.

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