

Conditions Affecting the Elderly Primary Health Care in Urban Health Care Centers of Iran

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Abstract: Elderly primary health care in urban health care centers is influenced by many factors. The quality primary health care in urban health care centers is of great importance and complexity and pan dimensionality of the care in these centers requires multiple interpretations that necessitate exploring and describing the perspectives of whom involved in care giving to understand the factors affecting the quality of care. This study was carried out with the aim of exploring and describing the factors involved in quality elderly primary health care in urban health care centers of Isfahan, Iran. Qualitative research was conducted using unstructured interviews, focus group discussion and participant observations. Data revealed that structural factors including micro or inter organizational conditions and macro or ultra organizational conditions have influenced the quality of elderly primary health care. Micro conditions refer to the conditions relating to health care system and included five categories of problems and conditions related to health care planning, human resource related issues, fundamental problems in the health care system, factors related to possibilities and facilities and factors related to access to health care. Macro conditions included social problems and issues, economical problems and issues and cultural problems and issues. Interaction between micro and macro conditions resulted in indifference to health care of health care providers and elderly clients and poor quality of care. Findings were suggestive of correcting and modifying the micro and macro conditions and comprehensive ecological approach in promoting elderly primary health care.

Key words: Elderly health, primary health care, quality primary health care, qualitative research, health care centers, Iran

INTRODUCTION

Worldwide the number of older persons is expected to more than triple over the next 50 years after it had tripled over the last 50 years (United Nations, 2007). Given the scale of the phenomena, it is no wonder that countries have to be concerned with ageing-related issues. In fact the phenomenon has grown into a defining global issue (HelpAge International, 2002) where in concerns regarding policy interventions appropriate for older people, especially those relating to their health care were considered high in the development agenda (Gorman and Heslop, 2002; Barrientos and Lloyd-Sherlock, 2002). Iran is now grappling with the population ageing phenomenon. Given the scenario that while, it has a relatively young population, the proportion of elderly is projected to double in <20 years (Jogataee, 2005). The United Nations statistical projections demonstrate rapid growth of elderly population in Iran. While, the proportion of people in the 60 years and above group in Iran was 5.4% in 1975 it will increase to 10.5% in 2025 and 21.7% in

2050 (United Nations, 2007). While, the total size of population of Iran will fail to double in the next 50 years, the number of elderly aged 65 years and over will experience about a six-fold increase (Mehryar and Ahmadnia, 2004). The Islamic Republic of Iran has to consider ageing issues more seriously now than in the past. The already large number and the projected future of elderly population highlight the need to attend to and plan early for the ageing of the population. It is necessary to ensure that the elderly, who are amongst the most vulnerable groups in the population, are not increasingly left behind. Although, health policy makers develop health systems with the goal of providing affordable and quality health care to the older people, differing sociopolitical, economic and cultural conditions have not made it possible for the older persons to use health care facilities made available to the population. Changing social, cultural and economic factors in developed countries have led to the emergence of facilities such as day care centers, home health care services, skilled nursing care facilities, nursing homes, congregate

housing and hospice care. These serve to provide family-based or community-based health care services to the special care needs of different groups of elders (Stone *et al.*, 1999). In developing countries such as the Islamic Republic of Iran, access to Primary Health Care (PHC) is prioritized in order to provide care that older people need to prevent or delay the onset of chronic, often disabling diseases. It was in response to the urge by the World Health Organization (WHO) Regional Office for the Eastern Mediterranean (EMRO) in the 1980s for countries to develop suitable programs for their growing elderly population. The urgency of developing a most appropriate model has to be founded on the felt needs, expectations and perceptions of the group concerned. While, these are crucial the capability of health care providers is equally vital. The longer these issues are kept in view the more factors will come into play into the process. For example, Adams *et al.* (2002) found that although, primary care for the elderly people is rewarding and enjoyable, it is also complex, difficult and time consuming. Physicians alone cannot meet the wide range of needs these people have in the practice environment and they suggested that changes in practice organization, health policy and medical education are needed if primary care physicians are to care for a larger volume of elderly clients effectively. WHO (2004) reported that despite the critical role that PHC centers play in older persons' health and well-being, older people encounter many barriers to care such as the unavailability or expensive transportation, waiting in long line in uncomfortable settings, becoming discouraged from seeking and continuing treatment and so on. While, bearing in mind that these are important issues when designing methods to improve their health and well-being, the realities of primary health care for older people vary greatly from one society to another.

In recent years, a country program for elderly health in Iran was developed with a survey in elderly health status and the elderly health program was started in the Ministry of Health with a focus on reducing the burden of diseases in the elderly through delivering of primary and secondary prevention services in health care network, which offer health education on healthy lifestyle and screening for early disease detection and treatment that takes place in the PHC setting at the community level. Hence, the PHC centers play the critical role in older persons' health and well-being. In performing this role it is necessary that the primary health care services be able to offer quality care. Furthermore, these centers have to be accessible and be developed according to the realities of older populations' world views. To do so research findings and information about nature of elderly primary

health care in health care settings are needed. The question that needs to be answered immediately is what is the structure of elderly primary health care in the health care centers in Iran? In response to the need for promoting elderly primary health care in Islamic Republic of Iran, the present study used qualitative method to explore and describe the factors involved in quality elderly primary health care in urban health care centers of Isfahan, Iran through exploring and describing the perspectives of whom involved in care.

MATERIALS AND METHODS

To determine conditions affecting the elderly primary health care in urban health care centers we conducted a qualitative study using triangulation of data from heterogeneous samples of the elderly, their families, health care workers and health care managers. Data were collected and analyzed over 13-months of period in 2007-08 in Isfahan, one of the largest cities of the Islamic Republic of Iran. Data collection included a series of individual, in-depth, open-ended, semi-structured interviews (20 interviews), focus group discussions (4 focus groups: 6 and 8 participants in each group) and participants observation. We used purposeful sampling and continued with theoretical sampling according to the codes and categories as they emerged. The participants consisted of 12 elderly women and men over 60 years of age that utilize services of health centers in health care services network in urban level, 5 elderly' families and 8 health care managers and health care workers. This study took place in the real life settings of elderly people in Isfahan province in Islamic Republic of Iran. The initial interviews were done in urban health centers. Two health care centers in different parts of the city were chosen to cover different level of socio economic status of participants. Considering to this matter that in qualitative research phenomena should be studied in natural setting in some cases interviews and observations have done in the elderly homes and focus groups carried out in faculty of health in Isfahan University of Medical sciences. Data collection was carried out by the same interviewer and audio taped. Then, the records were transcribed verbatim and analyzed consecutively. The duration of interviews and focus groups was between 1 and 2 and half hours, over 1-4 sessions. Data were collected and analyzed simultaneously using a grounded theory approach. Data from the interviews, focus groups and observations were analyzed concurrently using the constant comparative method.

After each interview, the data were transcribed and analyzed immediately. Every sentence in the transcript

was analyzed to identify descriptive categories. Coding processes were applied in data analysis (Strauss and Corbin, 1998). The researcher examined the transcripts line by line to label conditions that affected elderly primary health care process in urban health care centers in the process of open coding. The labels of similar events and incidents were grouped to form a higher level of abstraction of categories. The second process of coding, axial coding, was to develop connections between categories. Rigour in qualitative designs can be measured in terms of credibility, dependability, transferability, auditability and confirmability (Streubert and Carpenter, 2002). In this study, credibility was established through the participants' review of transcripts, prolonged engagement with participants and peer check (Streubert and Carpenter, 2002). The participants were contacted after the analysis and were given a full transcript of their coded interviews with a summary of the emergent themes to determine whether the codes and themes were true to their point of view (member check). To establish auditability, a second review was conducted by faculty members. The researcher also documented precisely the steps in the research for other researchers to confirm the findings in future studies. The results were checked with some individuals who did not participate in the research to confirm their fitness (peer check).

Ethical approval was obtained from ethical approval was obtained from the ethical approval committee of the Faculty of Medicine and Health science University Putra Malaysia and ethical approval committee of Faculty of Health, Isfahan University of Medical sciences. Furthermore, ethical issues in this study involved the assurance of confidentiality and autonomy for the participants. All participants were informed of the purpose and design of the study and their voluntary participation. Verbal consent was sought from the participants for the audio taped interviews.

RESULTS

Two main categories were delineated from the data to describe affecting conditions. These two categories were ultra organizational (macro conditions) and inter organizational (micro conditions) factors. Table 1 and 2 show, the major categories, their subcategories and dimensions.

Ultra organizational factors (Macro conditions): Ultra organizational factors identified are the following: social issues and problems, economical issues and problems and cultural issues.

Table 1: The category of macro condition, its sub-categories and dimensions

Social issues and problems	Economical issues and problems	Cultural issues and problems
-----Macro conditions-----		
Growing numbers of the elderly clients	Insufficient financial support and pension	Removing the elderly from focus of attention
Low level of public education about aging issues	Economic problems' effects	Diminished adherence to religion among the youth
Lack of necessary warning sign	Effect of economic problems on health behaviors	Being regards as a value (not stating one's needs and problems)
Simultaneous issues of youth and elderly	Elderly economic challenges	Limited viewpoint about the elderly
Abundance and complexity and of the elderly problems		
Lack of special centers for the elderly		
Lack of supporting system		
Not giving priority to aging issues by senior managers poor inter-sectoral collaboration		
Non-activeness of the elderly health Council		
superficial attention to the elderly		

Table 2: The category of micro conditions, its sub-categories and dimensions

Health care planning related issues	Human resources related issues	Fundamental problems in health care system	Condition related to possibilities and facilities	Access related factors
-----Macro conditions-----				
Not involving the elderly representatives in determine their needs	Insufficient human resources	Limitations for employment of human resources	Unsuitable physical environment	Poor remote access capabilities
Non compiling programs of elderly health care	Lack of suitable and sufficient human resource training programs	Problems related to access to the elderly in the urban environment	Lack of necessary facilities	Poor economic access
Not using of a team in offering services to the elderly	Lack of specialist human resource	Insufficient financial resources		
Incomprehensive elderly health care and supports	Inattention to the issues and problems of elderly health in medical education curricula			
Weak points in the referral system				

Social issues and problems: All of the participants talked about social issues as an important factor that influenced the process of the elderly primary health care. They perceived this influence were direct or either indirect. These factors include growing numbers of the elderly clients, low level of public education about aging issues, lack of the necessary warning signs, simultaneous issues of youth and elderly, abundance and complexity of the elderly problems, lack of supporting system, lack of specific centers for the elderly, not giving priority to aging issues by senior managers, poor Inter-Sectoral collaboration, non-activeness of the elderly health council and superficial attention to the elderly. Below are the descriptions of some of the factors.

Whether, we realize it or not, most applicants of our hospital services and treatments are old people. If they are considered in primary health care service, they will form the clients to the health care centers (Health care provider). Health care workers in the health care system and family members of the elderly are not aware of the elderly health needs (Health care center manager). The real burden of the elderly health issues and problems on the health care system is not clear and we do not have information about it (Health care center manager). When, I see misfortunes of the youth, I forget myself. I swear to you by god, do something for the youth, while my children are unemployed and jobless, there will make no difference for me in what condition I live. I cannot think about my health (elderly woman). In the beautiful city of Isfahan there is no suitable and equipped place, in which we can spend some hours with the coevals. All of the elderly have a sense of hopelessness and depression. They think that they have taken troubles during their lifetime, but what about now? (elderly man). I think most of our managers aren't aware of health issues of the elderly, partly it is related to the fact that they haven't been involved in the problems yet and haven't encountered with it (Health care manager). Considering the capabilities of financial and human resources in the health system, we can do nothing without the help of other organizations. We don't have a good support in the society (health care manager). After several years, we did not see any positive and effective action from the national council of elderly health. Elderly issues at the upper level it was not addressed, then the lower level would be worse (Health care provider). Each year, the first day of October is the world day of old people and honoring of the elderly and retired persons nominally. And every year a series of superfluous ceremonies and meetings are held and the elderly and retired persons are honored, then it is finished. The next day all of them are forgotten, Certainly, they need someone to solve their problems (elderly man).

Economical issues and problems: The second sub-category of ultra organizational factors (macro conditions) comprised of economical issues and problems. Every participant said something on importance role of the economy in relation to elderly health care. Without any direct question during interviews they talked about this aspect as an important motivation for their behavior and health care. Most of the respondents talked on the economic situation and lack of financial support and pension as an important influencing factor on health care behaviors. They believed that this problem not only is an essential fundamental issue, per se, but also it affects other areas and is a cause of other problems.

I can't work and I have no pension. There is no place to help me. How I can follow a healthy nutrition, go for medical routine checkups when I cannot pay their costs? (elderly man). The most serious problem for old women and especially, widows in Iran is the economic one. Most times when I listen to persons complaints, I can see that they have no supporter to help them. They have no insurance and don't receive much support from insurance companies. Their families manage their lives with difficulty (health care provider). In one of educational classes, a woman (health educator) was speaking about which foods are to be eaten in old age in order to be healthier, I started to laugh since I knew all of those. I wanted to ask her from where, we should bring such things. I make something out of necessity and eat (elderly woman).

Cultural issues: The deeply rooted beliefs about the elderly in the Iranian society influence the participants' behaviors about elderly health care. There were four sets of predominant beliefs about the elderly that were constantly mentioned by the participants. They include removing the elderly from focus of attention, diminished adherence to religion among the youth, being regarded as a value (not stating one's needs and problems) and limited viewpoints about the elderly. One of the often repeated points in this set of data that elderly participants talked and complained about it in different ways and was repeated in the statements of families and health care providers most often was the belief that the elderly do not deserve more attention and provision of needs because of age. Scolding the elderly because of being happy, scolding the elderly because of using bright colors, considering elderly complaints as unreal, inattention to elderly complaints, negligence of the elderly in social relations were some of the indicators of this category. This category is exemplified by the participants' remarks:

I was a happy person and laughed most of the times. One day my brother came to my house and told that it's not good for an old woman to laugh so much. They said

that I shouldn't laugh, because I'm old (elderly woman). In one of my classes I told them that why Iranian old people should put on black clothes all the time? Why don't you try on bright colors which are good for your mentality? You can hold periodical meetings and drink afternoon tea with each other in a happy party. One of the women answers that they are old and if they do so, all will laugh at them and say these activities are proper for the youth (Health care provider). These elderly annoy us. There is no one to tell them you are old and have lived your life, why you have so many expectations. I am very busy and I don't like such manners. I think they put on airs and they always nag (elderly family).

Too often, the elderly were complaining that the youth are faithless and do not follow religious and Eastern Iranian culture recommendations about children showing respect for their parents, in particular and to all elderly people in general.

The youth are completely different from us. We had some beliefs and we thought much of God, religion and the Prophet. We helped our parents for God's sake. But, now the children think in a different way. Every one thinks of himself (elderly woman). We are encountering youth attitude' changes regarding old people, we should consider to this matter in health care planning for the elderly (Health care provider). Most of the elderly believed that they should not say anything about their problems. They considered this belief as a value. There are times I have nothing to eat and I just feed myself with a loaf of bread, but I don't say anything. It's not proper to nag all the time. What people would say? (elderly woman). Elderly families and health care providers' viewpoints towards the elderly were negative in most cases. This was true about viewpoints of the elderly concerning themselves too. Not giving a right to oneself, believe in invariability of behaviors in old age, considering education of the elderly as a useless means, sense of neutrality toward the society, sense of inability, putting aside the elderly from social processes were some of the indicators of this category. The following illustrations from data demonstrate this: I have lived my life; all I want is just a room. The society should pay attention to the youth. Old people can't do anything and are not worth to spend something on them (elderly man). I like to see the effect of education when I'm teaching. So, I prefer to teach those who have the ability to use such knowledge. In my opinion, the elderly can't change themselves and whatever I teach them is to carry water in a sieve (health care provider).

Inter-organizational factors (micro conditions):

According to interviews inter organizational factors are those conditions that related to health care system and

include health care planning related issues, human resources related issues, fundamental problems in health care system, conditions related to possibilities and facilities and access related factors.

Health care planning related issues: Elderly participants believed that they were never asked about their problems, needs and demands and their remarks have not been considered in health care planning. Health care providers were complaining about this issue too.

They never ask about our needs, we do not have any representative in province council (elderly man). There is no one to ask the elderly about their problems and needs. This is why they aren't interested in coming to the center most of the time (health care provider). Health care providers believed that lack of programs developed specifically for elderly health care as those programs that they have for other vulnerable groups affected providing health care for the elderly and led to the system's inabilities and disorientation in offering health care services to the elderly. When I'm working in the units of mother and child or family planning, it is exactly defined for me what to do, based on instructions and step by step. It has been defined that which aspects I have to watch for and which issues to register. But, when I have an old client, stages and programs aren't exactly defined for me thus, at last I take some actions and give an instruction arbitrarily (health care provider). Most of the health care providers and managers believed that considering the complexity and diversity of elderly health care problems, providing health care services for them requires team work. They emphasized that health care delivery without taking advantage of team work led to relinquishing the elderly in the process of health care delivery that resulted from weaknesses of health care providers' knowledge and skills. When an old person who has diabetes problem comes here, he/she needs a nurse, a nutrition specialist, a doctor and an educator, to form a group in order to deal with all his/her needs and offer appropriate services. When, a client refers to me, I give him/her a medical examination and test and some medicine. Other services need a special group that is forgotten in the system (health care provider).

Incomprehensive elderly health care and supports was an issue repeated by health care providers and managers too often as an important influencing factor on elderly health care in health care centers. They looked at incomprehensiveness from different perspectives. When an old person comes here, we teach him/her the 4 books of methods of a healthy lifestyle. But thereafter no follow up system exists by which we can understand whether, he/she has understood the education or has applied them. Or if he/she has taken medications for controlling his/her

blood pressure, does he/she use them correctly or not (health care provider). When I educate the elderly, most of the time I feel I should educate their caregivers. Since, some of the elderly are in a condition that a caregiver should give such services to them. I feel that it's necessary to visit families and caregivers and educate them (health care provider). Weakness of the referral system is one of the most important factors that affect elderly health care and caring behaviors, according to health care providers and managers.

Elderly health care related tasks are not defined for higher levels of the health care system and those levels do not address their needs if we refer the elderly to them, because of this, in most cases, we can not offer a quality health care to the elderly (health care provider).

Human resource related issues: Human resources shortage was one of the prominent conditions in the quality of elderly health care and health care providers' caring behaviors. This factor led to a heavy load of work and fatigue for health care providers. I have no time at all, since I have to perform all care services for mothers, children and family planning for clients. It is obvious that by doing all these activities I will get tired and when an old person comes to me I have no energy to deal with him/her (health care provider).

Lack of sufficient educational programs for health care providers, who are employed in the health care system led to their feeling of inability and weakness in providing quality elderly health care. Medical education curricula in Iran also do not include teachings concerning the issues of elderly health and treatment and problems and inabilities of health care providers in the area of elderly health care resulted from this weakness. We are using in the system of offering services to the elderly those who have not been trained for the job and have not gone through educational courses (health care manager). During my course of education as a public health expert, when I had to control a family health unit in these centers, I haven't had any practical and theoretical learning about the elderly (health care provider). Lack of Geriatrics specialist in the health system affected the quality of elderly health care and caring behaviors from health care providers and managers' viewpoint. In this county, where about 8% of the population is old, the number of geriatrics specialists is not >5 and this is one of the major weaknesses (health care manager).

Fundamental problems in health care system: Limitations for employment of human resources, problems related to access to the elderly in the urban environment and insufficient financial resources were also mentioned as

affecting conditions on elderly primary health care quality. It has been told that there is human resource shortage, but, on the other hand, there is no authorization for employment (health care manager). For offering health care to the elderly in urban areas we need to use appropriate strategies. They are different from other groups, we should attract them to the system and this is not a simple thing (health care provider). For elderly health preservations, the minimum task is to perform a medical diagnosis routine examination that is expensive both for the person and the system. Insurance companies don't help in this regard and the health system doesn't have the required facilities to perform such activities (health care manager).

Conditions related to possibilities and facilities: Unsuitable physical environment and lack of necessary facilities affected elderly primary health care, as the elderly participant said: The health center near my house is located on the second floor of a building... I am not able to climb up its stairs, even if I really need it (elderly man). If an old person wants to enter a health center with a wheelchair, he/she can't. There is no ramp for wheelchairs in none of the centers. The visiting room for the elderly is not separate in these centers (health care provider).

Access related factors: Limitation of distance accessibility was one of the barriers of utilizing care provided in health care centers by the elderly. Even despite the existence of services in most cases old people cannot utilize it because of high costs. There is not a health care center near my home, I have to come here by car, it is difficult for me and because of this I cannot come for routine checking (elderly woman). The provided services are not free or cheap in this center, I cannot pay the fees I prefer not to pay attention to my disease and problem (elderly man).

DISCUSSION

To the best of the knowledge, the present study is the first qualitative research designed to increase the understanding of the factors affecting the quality of the elderly primary health care in urban health care centers in Iran to provide in-depth and comprehensive information and sound recommendations to guide efforts to promote elderly primary health care quality. The study's results on the influence of socio economic factors on elderly health care concur with previous researches. Based on structured dependency privileges the contribution of social policy to the structuring of old age both as social category and as lived experience. Peoples'

experience and status in later life is the direct consequences of political and economic policies, wherein older people are forced into a structured dependence as a result of compulsory retirement thus, having to live on a much reduced income and for older people living in their own homes, community care services are laid on without asking clients about their real needs. In several studies, there were evidences to indicate that socio-economic status plays an important role in the health-seeking behaviors of the elderly, health care utilization and realization of health care rights (Khe *et al.*, 2002; Ahmed *et al.*, 2003, 2005; Cardano *et al.*, 2004; Dzakula *et al.*, 2007).

It is estimated that the aging of the population will happen in just 25 years in Iran, although this process has been developing for the past 100 years in western countries Statistical Centre of Iran (2007). Since, the elderly are at high risk for disease and disability, this population aging will place urgent demands on Iran's health care system, which is not prepared for such demands. Participants in this study emphasized on increasing numbers of elderly, who need assistance and weakness of health care system to address their needs as an influence factor on nature of elderly primary health care in health care centers. This finding is consistent with previous research (Kaldi, 2004; Teymoori *et al.*, 2006; Pourreza *et al.*, 2007; Aliabadi *et al.*, 2008).

In order to provide support for caring of elderly policy-makers, the mass media, civil society and the general population need to be made aware of the needs of older people and the measures that can be taken to respond to these needs. The participants in this study emphasized on lowness of educational level about aging issues as conditions that affected elderly primary health care. The results of current study were in line with the literature regarding hindering of effective programs by insufficient knowledge about older people's health needs in decisions about health-seeking behaviors in developing countries (Lloyd-Sherlock, 2004; WHO, 2006).

For any policy for older people to be successful, it must be supported by a strong and a comprehensive perception about elderly status and needs, how these needs can be met in social, economic and cultural contexts in which policies for the elderly are located. This has been closely associated with providing a strong evidence base and surveys need to be undertaken in any country to generate data for providing this evidence base. Several participants of this study reported poor country data base about elderly health and needs as an important condition that affected elderly primary health care in health care centers. Finding of this study had consistency with previous study regarding challenges of developing countries in sufficient data base about elderly health care

and weaknesses in the information management and lack of necessary information about elderly health issues in health care system in Iran (Schieber and Klingen, 1999; Phillips and Chan, 2002; Sadrizadeh, 2004; WHO, 2006; Teymoori *et al.*, 2006; UN, 2007; Wahlin *et al.*, 2008). Iran suffers from a burden of both young and ageing population issues. Participants of this study emphasized on the effect of young population problems at family and country levels on the elderly health care. Most of the elderly, families and health care providers participants gave priority to youth issues and believed that importance of this problem is a powerful force shaping their caring behaviors regarding elderly primary health care. This agrees with other studies (Ensor *et al.*, 2002; Warnes and Corne, 2002).

Although, previous studies concluded that social capital and social support has a positive effect on elderly' physical and mental well-being, health promoting regimens, healthful behaviors and people with more social support tend to be in better health (Rowe and Kahn, 1987; Doeglas *et al.*, 1996; Seeman and Crimmins, 2001; Comman *et al.*, 2003; Satariano, 2006) however, all of the elderly participants complained about lack of welfare centers for the elderly on a daily base as an essential base for social ties. The elderly Participants explained that because of insufficient or having no financial support and insurance they could not refer to health care centers for checking their health status, or follow healthy behaviors that they know is good for remaining healthy. These findings also supported by study that reported Iran have few social welfare programs to which, elderly can turn for support (Siyam, 2001; Kaldi, 2004; Jamshidpoor *et al.*, 2009). Health care providers and managers participating in this study believed that senior managers don't give priority to elderly issues and this matter affect the elderly primary health care process. This is consistence with Lloyd-Sherlock (2000) that reported in countries that population ageing is just beginning, policy makers give priorities to other groups and this historical priorities need to shift towards the elderly. Non-activeness of elderly' health country committee of aging that mentioned by the health care providers participants as one of the social issues that affected elderly primary health care process was supported by the deputy of elderly department in Iran' Behzisti organization that said although Iran's national coordinating committee for the elderly health was formed in 2004 at Ministry of Health to plan and coordinate all issues related to elderly health at country level hence, so far only two sessions have been held. It is considerable that responsibility of this committee has changed and devolved to Iran' Welfare Organization and after these changes, only one other session has been held (Shahbazi, 2006).

Participants of this study believed that poor inter-sectoral collaboration affected the process of elderly primary health care through influence health care system and other necessary social contexts involved in providing primary health care for the elderly. Poor inter-sectoral collaboration in Iran was reported by Sadrizadeh (2004). In this study, negative stereotypes about aging and old people and change in the new generation beliefs about elderly were categorized as cultural issues. Stereotyping older adults and perpetuating false information and negative images and characteristics regarding older adults often arise from negative personal experiences, myths shared throughout the ages and a general lack of current information (Moody, 2009). Scolding the elderly because of being happy, scolding the elderly because of using bright colors, considering elderly complaints as unreal, inattention to elderly complaints, negligence of the elderly in social relations, not talking about problems as values, beliefs in invariability of behaviors in old age, considering education of the elderly as a useless means, sense of neutrality toward the society, sense of inability, putting aside the elderly from social processes were the stereotypes that the participants of this study talked about. These stereotypes could affect the elderly, their family members and health care providers caring behaviors and nature of elderly primary health care. These findings are consistent with Grant (1996), Unger *et al.* (1997), Dulin *et al.* (2001) and Leinonen *et al.* (2002) and Sa'nchez Palacios *et al.* (2008). Participants in this study talked about diminished adherence to religion among the youth and believed that inattention to elderly in terms of care and respect is the result of this matter. They believed that breaking down the family support as a result of new generation's beliefs changes led to their inattention to parents care and respect. This finding was consistent with other studies (Abyad, 1995, 2001, Hegland *et al.*, 2007; Azadarmaki, 2008). Most of the elderly participants believed that they should not say anything about their problems and accepted their situations and consequently this belief may have led to their indifference to health care. Consistent with this finding, most of the elderly women in Sharmin (2005) in Bangladesh could say very little about the real opportunities they have regarding the life they might have. It seems similar cultural issues in some countries have sever influence in elderly health care beliefs and behaviors. Participants emphasized that the elderly needs and demands are not considered for health care planning. Inattention to elderly views and expectations for providing health care led to inability of provided care to address the elderly needs and affected elderly primary

health care quality. These findings is concurrent with AsadiLari *et al.* (2004) that stated Iran's health services are historically based on providers and policy makers' understanding of population health status that does not necessarily reflect the real needs of a population and also studies have been done by WHO (2004a). Health care providers and managers believed that mechanisms for applying primary health care services to the elderly are not defined exactly and it caused difficulties in applying designed programs. These findings were supported by Altenstetter and Bjorkman (1981). They concluded that health planning has changed little in health care system of any country because inadequate attention has been paid to the questions of implementation. Lemieux-Charles and McGuire (2006) emphasized on the effectiveness of team care and the impact of task redesign on care delivery team effectiveness in different areas of care such as elderly care in their review of health care team effectiveness literature. Despite the importance of team works in improvements of care and organizational effectiveness, lack of team work in providing primary health care for the elderly in health care centers were stated by participants of this study. Consistent with this study, not working effectively as a team in provision care for the elderly in primary health care setting was reported in several countries in the studies carried out by WHO (2004a). The participants of this study talked about incomprehensiveness of elderly primary health care provided in health care centers as an important condition that affected process of elderly health care. Findings were consistent with explanations given by literature regarding elderly health care services that stated for the delivery system of a community health care service to be effective, it should be comprehensive, many communities provide some programs, but don not offer a full range of services to more adequately meet the needs of their senior citizens (Foote and Stanners, 2002; WHO 2004b, 2006). The findings from this research are consistent with other studies that stated insufficient support of Urban Health Centers by other levels of health care system has so far hindered implementation of an efficient referral system in Iran (WHO, 2004b). The majority of the health care providers participants in this study emphasized on insufficient human resources and lack of trained health care providers as the influence condition on elderly primary health care. This finding supported by previous studies (El-Jardali *et al.*, 2007; Mahfouz *et al.*, 2004; WHO, 2004a). The results of this study, were also synonymous with Hafezi (2008) and Heydarpoor (2005) in regards to Iran's health care system budget deficits. Despite the importance of effect of physical environment of health care setting on the health

of clients, WHO (2004a) reported that many health centers are not set up for older people in different countries. Lack of facilities and long time spent in the centre and not enough specialty clinics were the leading items of Saudi Arabian elderly' dissatisfaction from PHC centers (Mahfouz *et al.*, 2004). Consistent with the previous research about physical environment and lack of facilities in primary health care settings for the elderly clients were also evident in the study result. The elderly poor access to primary health care centers has been previously reported in the literature in terms of economic and distance access (WHO, 2004a). According to Aghababaeen *et al.* (2009) elderly women in Isfahan province in Iran emphasized on access to health care services as the most important needs. Javadnoori *et al.* (2009) found that the most important elderly' dissatisfaction from primary health care provided in Isfahan health care centers were related to access. Likewise, this finding was also evident in this study's results.

CONCLUSION

The findings of this study revealed important and in-depth information regarding conditions affecting the elderly primary health care quality in urban health care centers. The study highlighted the strong effect of macro and micro conditions in caring behaviors of all of the participants and nature of the elderly primary health care. Based on these results, elderly primary health care promoting activities in health care centers need to be embedded in a comprehensive and ecological approach and to involve elderly, their families, the media, community organizations, government and law enforcement agencies, with focused on fostering change in the socio-economic and cultural environment, health care system as well as elderly self-empowerment.

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