WILEY | Hindawi

Research Article

Experiences regarding Home Care for Older Adults from the Viewpoint of Family, Paid Caregivers, Nurses, and Experts: A Qualitative Study

Khorshid Mobasseri [ID],[1] **Hamid Allahverdipour** [ID],[2] **Hossein Matlabi** [ID],[1,3]
and Ahmad Kousha [ID][2]

[1]*Department of Geriatric Health, Faculty of Health Sciences, Tabriz University of Medical Sciences, Tabriz, Iran*
[2]*Department of Health Education and Promotion, Faculty of Health Sciences, Tabriz University of Medical Sciences, Tabriz, Iran*
[3]*Research Center for Integrative Medicine in Aging, Aging Research Institute, Tabriz University of Medical Sciences, Tabriz, Iran*

Correspondence should be addressed to Ahmad Kousha; amkousha@gmail.com

Home care (HC) is recommended for older adults who want to live at home as long as possible despite life-limiting conditions. It is more convenient and cost-effective than institutionalization and hospitalization. However, HC for older adults in Iran faces many challenges. The purpose of this study was to explore the perspectives of different stakeholders involved in HC for older adults about their experiences and suggestions for HC improvement. This qualitative study was conducted based on the explorative content analysis approach between 2021 and 2022 in Tabriz, Iran. The participants were selected using the purposeful sampling method, and the data were collected through in-depth semistructured personal interviews. A total of 27 individuals who participated in individual interviews were family members, HC workers (including nurses and unqualified paid caregivers), heads of counseling and nursing care at home centers, and experts who had clinical or research experience in the field of geriatric care. Collected data were categorized into three main themes: defects in home care governance, concern about the efficiency of home care, and caregivers' job security concerns. These themes reflected the problems of HC, such as conflicts between multiple trustees, lack of evaluation and monitoring, inadequate competence and financial barriers of families and caregivers, and poor integration and coordination of services. Therefore, it is recommended to develop a national model for HC for Iranian older adults and allocation of different financial resources for HC, implementing quality improvement and evaluation tools, enhancing the training of caregivers, providing them with adequate compensation and benefits, and ensuring the safety and quality of services. These findings can inform the policymakers and planners of care services about the needs and challenges of this population and facilitate the collaboration among different stakeholders to provide better HC for older adults.

1. Introduction

The growth of the aging population resulted in more prevalence of chronic diseases, progressive functional decline, and the need for receiving help from others for taking care [1]. Care may be provided in hospitals, long-term care facilities, or at home by either family caregivers or qualified workforce such as nurses or trained caregivers [2].

The World Health Organization focuses on reforming long-term care systems to support healthy aging and meet older adults' current and future needs [3]. HC can lead to enhanced social and emotional well-being for older adults, as it allows them to maintain their autonomy in their familiar environment [4]. According to a survey, older adults prefer to live in their homes as long as possible [5]. In addition, HC can help older adults maintain their dignity

and self-esteem, as they do not have to rely on strangers or institutional rules. They can choose the type, frequency, and duration of care they want and adjust it as their situation changes [6].

HC care means delivering medical necessities and/or clinical services to patients in their homes or other community settings [7]. This type of care can include health, personal, and support services to help older people stay at home and live as independently as possible [8]. The WHO has developed the Integrated Care for Older People (ICOPE) guidelines, which offer scientific advice for healthcare workers on how to help older people maintain or improve their physical and mental abilities. The guidelines also stress the importance of respecting the wishes and needs of older people and of working together across different sectors and levels of care [9]. HC is an integral part of the ICOPE approach. In line with the goals of ICOPE, HC can promote healthy aging, adopt a person-centered and integrated approach, and empower older people and their caregivers to participate in decision-making and self-management of their health and well-being [10].

The policy approach for social welfare services for older adults in most countries, such as England and Ireland, is to provide HC [11]. Despite the benefits, this system also presents challenges. One of these challenges is the threat faced by caregivers, such as physical and mental distress and insufficient skills in HC [12]. Financial unsustainability and unacceptable quality of care are additional problems [13]. Another study found that HC faced many difficulties and obstacles, such as excessive workload, transportation issues, unfamiliarity with the family culture, insecurity of employment, low pay, shortage of equipment, and lack of qualified staff among the workforce [14]. A scoping review synthesized the existing Canadian literature on these factors and suggested some potential solutions to improve HC delivery, such as continuity and coordination of care; the adequacy and appropriateness of staffing mix and levels; the ongoing professional development and support of the HCNs; the quality and safety of practice environments; intraprofessional, interprofessional, and intersectoral collaboration among different stakeholders; the enhancement of the scope of practice and roles of the HCNs; and the appropriate use of technology to facilitate and improve care [15].

Currently, the age structure of Iran is considered youthful, but the population of older people in Iran is also steadily increasing. Iran is among the Asian countries experiencing aging faster than high-income countries [16]. The three main factors of decreasing fertility and mortality rates and increasing life expectancy have changed the demographic situation of Iran [17]. In 1986, only 5.43% of the total population of Iran were 60 years and over. The proportion of this age group reached 7.27% in 2006 and 8.2% in 2011. According to the latest census of population in 2016, the number of the older people in Iran was more than 7 million and accounted for 9.3% of the total population [18]. According to estimates, the percentage of the population over 60, 65, and 80 in Iran is predicted to reach 29.4%, 22%, and 3% in 2050, respectively [19]. Another critical change in

aging demographics will be the feminization of aging in Iran, urbanization, delayed marriage and interest in higher education among women, an increase in single and widowed women, and their rising need for care [20]. The increasing older population, their social and healthcare, and welfare issues have become a debate among health policymakers [21]. There is no long-term care system adapted to the care needs. Older people refer to general hospitals to use healthcare services whether their illness is severe or mild. Complicated procedures and delayed treatment increases prolonged hospitalization rates and costs [22]. Accurate planning should be done before these issues become a crisis in Iran. Planning to meet health needs by using all involved stakeholders in geriatric care and the experiences of prosperous countries prevents future challenges [23, 24].

In Iran, there are policies to support older adults and caregivers. For example, the Fifth Five-Year Development Plan of the Islamic Republic of Iran emphasized the importance of providing social security insurance to vulnerable people [25]. Likewise, the strategic planning of Iran's National Document for the Elderly mentioned skill training for older adults and their caregivers, providing HC, and conducting relevant research [26]. General population policies in Iran have been announced by Supreme Leader before the decrease in the birth rate in past years. It emphasized a respect for older adults and creating the infrastructure to ensure care for older adults in their own homes [27]. Despite these formulated policies, the current health infrastructure is still focused on caring for young people, and there is no formal structured system of HC in Iran, and institutions providing HC are inadequate and inappropriate [21]. A study showed that providing care at home is an inevitable necessity [28]. HC in Iran is mainly provided by informal caregivers, such as family members or friends, who receive little or no support from formal healthcare providers [29]. There are several barriers to providing HC services in Iran, such as a lack of policies, standards, and regulations; inadequate training and supervision of caregivers; insufficient financial resources and insurance coverage; and cultural and religious factors [30].

According to Article 29 of the Constitution of Iran, health is the right of all people [31]. Five ministries and organizations are responsible for policymaking and providing specialized healthcare services for older adults: the Ministry of Health and Medical Education, the Ministry of Cooperatives, Labour and Social Welfare, the Red Crescent Society, the Martyr Foundation, and the Social Security Organization. The Ministry of Health and Medical Education is in charge of developing and implementing health and medical policies and programs. In each geographical area, one of the medical universities is responsible for policymaking and providing healthcare services in that area. The Ministry of Health and Medical Education is also responsible for providing primary and secondary care to all citizens in primary healthcare (PHC) centers across the country. Patients may be referred by PHC to a local hospital, as the second level, where some secondary care is provided. Another center that is under the supervision of the Ministry of Health is the counseling and nursing care at home centers.

The center provides clinical services and care at home and is established to provide clinical and health services [32].

Coordinating HC for this population is complex and difficult, as it involves multiple stakeholders, such as the family, paid caregivers, nurses, and experts who have clinical or research experience in the field of geriatric care, in the Iranian context [33]. No study has explored the experiences of providing HC for older adults from the perspectives of different involved stakeholders, including the family, paid caregivers, nurses, and experts who had clinical or research experience in the field of geriatric care, in the Iranian context. To achieve an in-depth understanding of these issues and challenges, interviewing stakeholders could be a method to gain more insights. Therefore, the present study aimed to fill this knowledge gap and explore the answers to these questions from different stakeholders' viewpoints: what services are provided for older people in their home, what are the challenges in providing HC, and what is the best way to improve HC for older adults?

2. Materials and Methods

2.1. Study Design. An exploratory qualitative approach was used for this study to achieve a more precise and comprehensive insight and understanding of participants' experiences [34]. In Iran, any centers related to older adults' health requires licensure under some regulations. The Ministry of Health announces the rules, standards, workforce, tariffs, and quality-monitoring checklists. The vice-chancellor for treatment is responsible for quality monitoring of facilities. One of these centers is the counseling and nursing care at home centers that provides supportive and nursing care at home which we assessed [35]. In Iran, there are no counseling and nursing care services at home centers in rural areas; therefore, this study was conducted in the urban area of Tabriz. The qualitative interviews were completed with stakeholders, who were asked to express their experiences about the current situation and existing challenges.

2.2. Recruitment of Participants. We explored the perspectives of 27 individuals, including five groups of participants, to ensure a diverse representation of perspectives. The participants were selected through a purposive, a snowball, and a maximum variation sampling method. Purposive sampling is generally used in qualitative studies and provides the selection of information-rich participants [36].

The first group consisted of family members closest to the older person who appointed a caregiver to care for their father or mother. The criteria for entering this group were a family member who spent the most time in care and the caregiver of the older person. Other criteria were the participants who were caregivers of older adults with a diagnosis of a chronic condition or disability that required HC, such as dementia, stroke, or arthritis, and who were able to provide informed consent to participate in the study and were available and willing to participate in the interview or focus group at the scheduled time and place.

The second group comprised nonqualified paid caregivers with at least five years of experience in domestic care, including (instrumental) activities of daily living.

The third group consisted of nurses with at least five years of experience in geriatric care and home-based nursing.

The fourth group included the heads of counseling and nursing care at home centers who were responsible for hiring nurses and caregivers for HC and had at least 5 years of work experience.

The participants were recruited from counseling and nursing care at home centers in Tabriz. After searching online for these centers, we contacted and visited them to coordinate interviews. We interviewed interested heads of centers, HC workers, and recipients. Specifically, we obtained the contact information of service recipients, caregivers, and nurses from the counseling center and contacted them directly. If they were willing and met the inclusion criteria, we arranged interview times and locations. We approached a total of 21 potential participants, but three of them declined to participate due to personal reasons, lack of availability, or both. We also obtained the telephone number of the HC recipients from the managers of the counseling and nursing care at home centers in order to interview them, but none of the 10 older people could participate in the interviews because their severe cognitive and physical problems prevented them from doing so. Therefore, our sample of the first four groups consisted of 18 participants who agreed to participate and completed the interview.

For healthcare experts, recruitment was conducted through the personal contacts of the research team members and snowball sampling. The fifth group comprised experts working at the treatment vice-chancellor of the Tabriz University of Medical Sciences or as faculty members with at least two years of experience in geriatrics within the geographical area of Tabriz city.

To attract stakeholders' contribution, the purpose, process, and benefits of the research were explained, and informed consent was obtained. Incentives such as gifts or feedback reports were provided to encourage participation. The exclusion criteria included language barriers and location outside the geographical area of the study. Table 1 shows interviewees' characteristics.

2.3. Data Collection. Data were collected through semi-structured interviews between 2021 and 2022. Semi-structured interviews are interviews that have a general plan for what to ask, but the questions do not have to follow a specific phrasing or order. They are often open-ended, allowing for flexibility, but follow a predetermined thematic framework, giving a sense of order [37]. We reviewed the literature related to the research topic, which were the experiences of older adults or their families, nurses, and caregivers about HC. Each interview guide consisted of several main questions tailored to each group of participants. All research members and four additional experts in the geriatrics field reviewed and assessed validity of the

TABLE 1: Characteristics of interviewees.

P	Gender		Age				Job	Academic discipline	Level of education	Work experience			
	Female	Male	20–29	30–39	40–49	50–60				5–9	10–14	15–19	20–25
1	*					*	Housewife		Under diploma				
2	*					*	Teacher		Under diploma				
3		*				*	Retired		BS				
4		*				*	Retired		PhD				
5	*						Head of nursing care at home center	Nursing	BS	*			
6	*						Head of nursing care at home center	Nursing	BS	*			
7		*					Head of nursing care at home center	Nursing	BS	*			
8		*					Head of nursing care at home center	Nursing	PhD	*			
9		*					Head of nursing care at home center	Nursing	PhD			*	
10	*			*			Nonqualified paid caregiver	Persian language and literature	BS	*			
11	*			*			Nonqualified paid caregiver	—	Under diploma	*			
12	*					*	Nonqualified paid caregiver	—	Under diploma	*			
13	*					*	Nonqualified paid caregiver	—	Under diploma	*			
14		*				*	Nonqualified paid caregiver	—	Under diploma				*
15		*		*			Nurse	Nursing	BS		*		
16		*		*			Nurse	Nursing	BS		*		
17		*		*			Nurse	Nursing	BS		*		
18		*			*		Nurse	Nursing	PhD				*
19	*			*			Health Vice President of the University	Nursing	BS				*
20	*			*			Health Vice President of the University	Health Management Services	PhD			*	
21	*			*			Faculty member	Nursing	PhD			*	
22	*				*		Faculty member	Nursing	PhD		*		
23	*				*		Physician	Infectious diseases	Specialist physician				*
24	*				*		Faculty member	Gerontology	PhD			*	
25		*				*	Faculty member	Gerontology	PhD		*		
26		*				*	Faculty member	Nursing	PhD		*		
27		*				*	Faculty member	Health Management Services	PhD	*			

P, participant; BS, Bachelor of Science; PhD, Doctor of Philosophy. The asterisks in the table indicate the presence or absence of a certain characteristic for each interviewee.

preliminary interview guides. We also listened to the audio recordings of the pilot interviews and transcribed them verbatim. We made notes of any interesting or relevant points that emerged from the data. The interview guides were revised following pilot interviews with two experts and three caregivers (Table 2). Any experiences with issues and challenges around HC were among the core questions. Due to the COVID-19 pandemic, this study was conducted following all health protocols during interviews. Before starting the interview, participants were provided with a brief explanation of the aim, data collecting process, and role of researchers and participants in the study. After obtaining their written consent, the interview began and continued by establishing contact and gaining participant's confidence. Each interview lasted between 40 and 90 minutes and was conducted in a preferred place for participants. We determined the number of interviews based on data saturation, which means that no new information or themes are observed in the data. Data saturation is a common criterion for determining the adequacy of qualitative data collection [38]. To assess data saturation, we conducted a preliminary analysis of the data after each interview using an inductive approach. We found that after the 22nd interview, no new themes or information were emerging from the data, indicating that data saturation was reached. To ensure the validity and reliability of our findings, however, we conducted five additional interviews to confirm that no further data were needed. The conversations were digitally recorded and transcribed verbatim after each session.

Most of the participants preferred to speak in their native Turkish language. Therefore, one of the research team members (KHM) conducted the interviews and also translated the transcripts into our national Persian language. To check the accuracy of the translations, we used the member-checking method. Therefore, we contacted the participants who agreed to review the translated transcripts and asked them to confirm or correct the accuracy and meaning of the translations. We also asked them if they wanted to add or delete anything from the transcripts. Another member of the research team (AK) listened to the audios and rechecked the transcribed audios to ensure the validity and reliability of the data and to avoid any misinterpretation or distortion of the participants' views and experiences.

2.4. Data Analysis. We used an inductive content analysis approach to analyze transcribed verbatim interviews to identify key concepts. This method is appropriate for research with limited or no prior studies related to the research question [39]. It involves categorizing verbal data and extracting themes from the raw data [40]. Data analysis was conducted concurrently with data collection. Two researchers (KHM and AK) read the transcriptions several times to obtain a general understanding of the participants' statements in line with the study objectives. They also checked the field notes, which led to the extraction of meaning units or initial codes. Field notes are written

records of the observations, interactions, and experiences of the researcher in the field [41]. They provide rich contextual information that can enhance the analysis and interpretation of the data (Patton 2015). Field notes can also help the researcher to reflect on their own role and positionality in the research process [42]. They deleted the redundant codes and merged the remaining codes into eleven subthemes based on similarities and differences. Then, all members of the research team rechecked the subthemes and their relationships with each other in order to reach a consensus regarding the unified themes emerging from the data. They finalized the themes and concepts according to the suggestions of their research team members. They used MAXQDA 12, a qualitative data analysis software, to index references and annotate in the margin beside the text.

2.5. Trustworthiness. Qualitative research uses trustworthiness criteria to evaluate its quality. Trustworthiness is a concept that encompasses four aspects: credibility, transferability, dependability, and confirmability [43]. These aspects reflect the extent to which the research findings are believable, applicable, consistent, and neutral. One of the researchers (KH) had prolonged engagement in the field or research site and used good interviewing technique to increase confirmability and credibility of the study. Confirmability refers to the degree of objectivity and transparency in the research process, while credibility refers to the degree of confidence and validity in the research findings. A good qualitative interview involves preparing an interview guide, choosing a suitable location and time, building rapport and trust, asking nonleading and nonjudgmental questions, listening actively and empathetically, summarizing or paraphrasing occasionally, ending the interview politely and respectfully, and recording and transcribing the data confidentially [44, 45]. For example, the interviewer asked questions such as "What are the challenges of home care?" instead of "Do you like home care?" or "Is home care better than institutional care?" to elicit rich and nuanced responses from the participants. In addition, the engagement of different stakeholders with sufficient experience in the geriatric field and gaining their trust raised the credibility of the findings. To gain the trust of interviewees, the interviewer communicated clearly and respectfully, showed interest and empathy, asked open-ended and nonjudgmental questions, listened actively and attentively, ensured confidentiality and anonymity, and invited feedback. For instance, the interviewer thanked the participants for their time and participation, assured them that their identities would be protected, and asked them if they had any questions or comments at the end of the interview. The purposive sampling and extensive description of the processes of this research, including data collection, study context, data analysis, and the accurate report of the results, made it possible to ensure the transferability of this qualitative inquiry. Transferability refers to the degree of generalizability and applicability of the research findings to other settings or populations. By providing detailed

Table 2: Interview guide.

Group	Topics
Family members	(i) Why do you use home care services? (ii) How did you access home care services? What challenges have you had in this field? (iii) What challenges do you have in paying for care? (iv) What are your expectations regarding home care for older adults? How can the care system be improved?
Nonqualified caregivers and nurses	(i) What are the reasons that have made you care for the elderly at home? (ii) What training have you seen in this field? Do you have a suggestion to improve the education of caregivers? (iii) What challenges, problems and issues do you have in providing care to the elderly? (iv) How do you think these challenges can be dealt with? (v) What is the expected outcome of care for you, the elderly, and his family? What suggestions do you have for achieving ideal home care for the elderly? (vi) Are you satisfied with your job? What are your expectations for your career advancement?
Heads of counseling and nursing care at home centers	(i) Why do you work in the field of home care for older adults? (ii) How is staff training done in your center? Do you have any suggestions in this regard? (iii) How is the competence of caregivers determined in this center? Do you have any suggestions to improve this? (iv) What challenges, problems, and issues do you have in providing care to the elderly? How to overcome these challenges? (v) How do you pay the caregiver? What is your suggested solution to deal with financial challenges? (vi) How do you measure the quality of care? How can the quality of care be improved?
Experts	(i) How would you describe the current home care system for the elderly? (ii) Do you think it is possible to establish a home care system in Iran formally? Mention the reasons (iii) What are the obstacles in this path? (iv) If we consider home care for the elderly as a system, what components does this system include? (v) What are the solutions for financing the context of Iran? How to cover the cost of long-term care? (vi) What can support be done for the workforce?

information about the research design, methods, participants, and context, the researchers enabled the readers to judge the relevance and suitability of the findings to their own situations. Analyzing data separately and comparing the results by two researchers, coding the same data twice by giving one-month intervals after each coding, peer examination, and receiving comments from participants and research team members raised the dependability and stability of the findings. Dependability refers to the degree of consistency and reliability of the research findings over time and across researchers. By using multiple strategies to check and verify the data analysis and interpretation, the researchers enhanced the dependability of the findings and reduced the potential biases or errors.

3. Results

Considering the interview questions, the findings are summarized under three themes and eleven subthemes. Figure 1 shows the theme tree that emerged from the coding.

3.1. Theme 1: Defects in Home Care Governance. Many participants pointed to major deficiencies in home care governance, including the following four subthemes: conflicts between multiple trustees, lack of transparency in policies, lack of seriousness in evaluation and monitoring, and lack of integration of financial resources.

3.1.1. Subtheme 1: Conflicts between Multiple Trustees. Most experts believed that there are many trustees in the affairs of older adults, whose parallel work causes the loss of existing financial resources and a lack of effectiveness. The trustees are the Ministry of Health, Imam Khomeini Relief Committee, and Social Security Organization. They suggested that there should be a single trustee for geriatric health.

"We always see that the Department of Aging of the Ministry of Health is in conflict with the Welfare Organization. As long as there is no single trustee for the geriatric affairs, this situation will continue." (Participant 27, faculty member).

3.1.2. Subtheme 2: Lack of Transparency in Policies. Participants emphasized that in the existing laws and policies, there are generalizations about various protections for the older adults and there is no mention of how to support them. They believed that one of the consequences of the lack of transparency in some policies is that the older people's access to HC is overshadowed.

"In the country, we have five-year development plans, a poverty reduction document, a law on targeted subsidies and similar policies. Which one of these seriously covers the needs of the older adults?" (Participant 27, a faculty member).

"In Iran, policies are either not transparent or not logical. When the tariffs approved by the Ministry of Health are not transparent and reasonable, each care center imposes its own tariffs, and older adults do not use the services due to the high cost." (Participant 23, Specialist physician).

3.1.3. Subtheme 3: Lack of Seriousness in Evaluation and Monitoring. Most of the participants stated that a lack of careful monitoring of geriatric care reduces the quality of care and the satisfaction of the older adults and their families.

"There are many nursing consultation centers in Tabriz where the staff operate without a formal license from the Ministry of Health." (Participant 19, an employee of the vice-chancellor).

"The quality of HC depends not only on the skills and knowledge of the caregivers, but also on the monitoring and evaluation of the service provision. In Iran, HC is still a new and developing concept, and lack of regular monitoring can result in inefficiency, inconsistency, and inequality in the delivery of care." (Participant 26, a faculty member).

3.1.4. Subtheme 4: Lack of Integration of Financial Resources. According to the participants, many financial resources exist for older adults in Iran, but they are not managed appropriately.

"Many funds are allocated to organizations such as Social Security, the Imam Khomeini Relief Committee, the Welfare Organization, and the Ministry of Health, but these funds are not integrated and are not used effectively" (Participant 20, an employee of vice-chancellor of the university).

According to experts, a combined funding system is the best financing option, which has been successful in the world.

"The best way is to have public funding, that is, a combination of government funding, insurance contributions, taxes, and charitable contributions." (Participant 23, a faculty member).

3.2. Theme 2: Concern about the Efficiency of Home Care. Because of some problems and issues with HC, many stakeholders are skeptical about its effectiveness. The interviews revealed four subthemes: lack of HC workforce, lack of HC equipment, lack of trust in caregivers, and the high cost of HC.

3.2.1. Subtheme 1: Home Care Workforce Shortage. One of the challenges that the participants mentioned was the lack of nurses and caregivers to care for the elderly at home. They had to use different methods to solve this problem.
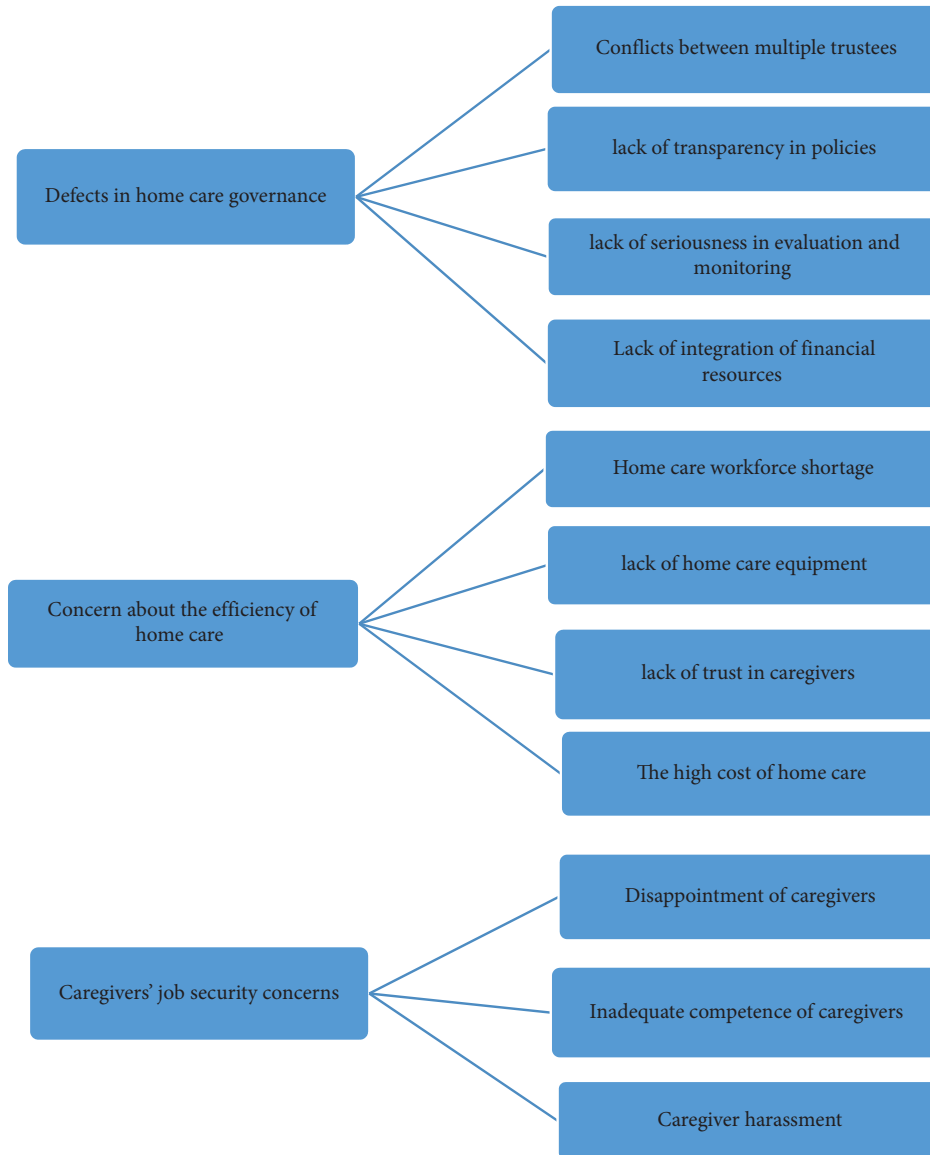
FIGURE 1: The theme tree emerged from the coding.

"A few years ago, the Ministry of Health planned to hold one-year courses and issue care certificates to people without nursing education. However, this was prevented by excessive protests by nurses. In my opinion, this was the biggest harm to the country's elderly community. The consequences were also seen in coronavirus pandemic. When coronavirus pandemic started, there was no labor force at all. Families called and begged with tears to send caregivers to their parents. Even the nurses did not agree to go home" (participant 5, a head of a counseling and nursing care at home center).

"I often face a shortage of labor, and I go to the houses myself when that happens. I have the skills to do injections, dressings, stitches, and many other things related to care." (Participant 9, a head of a counseling and nursing care at home center).

3.2.2. Subtheme 2: Lack of Home Care Equipment. One of the challenges mentioned by different stakeholders that caused them concern was the lack of equipment needed for HC. They pointed out that what should be there is not in the home, and for organized care, the home of the elderly under care should be equipped like a hospital.

The lack of equipment needed for HC was a challenge that different stakeholders were concerned about. They stated that the home of older adults under care did not have the equipment that was necessary, and that it should be as

well-equipped as a hospital. "Our system lacks infrastructure. We don't have enough equipment. What should we do if we want to take care of an older person who needs to be connected to the ventilator at home? We are not prepared for this. We can't work anywhere without enough equipment. We will not succeed." (Participant 15, home care nurse).

3.2.3. Subtheme 3: Lack of Trust in Caregivers.

Some families mentioned that some caregivers have physical, psychological, and financial problems and do not perform their duties well.

"One of the caregivers stole all my mother's jewelry after gaining our trust, and another caregiver was an old woman and illiterate, and we could not trust her." (Participant 2, a family member).

"We would like our father to be cared for at home, but there are many problems that prevent this. One of these problems is the lack of security and trust in caregivers. We cannot share our family's personal and private information with them. We always worry about the abuse and neglect of our mother. We want HC to be of high quality and professional. We want our parents to feel appreciated and respected." (Participant 4, a family member).

Most of the participants emphasized that laws should be passed or revised to support older adults and caregivers:

"The security of older adults and caregivers should be included in the legislation. Medical ethics for HC have not been proposed." (Participant 23, a faculty member).

3.2.4. Subtheme 4: The High Cost of Home Care.

Most of the participants and especially the families complained about the high costs of home care.

"We call the nurse every two weeks to change my father's catheter. The cost of changing the catheter is very high and it is difficult for us to pay for it. We prefer to do it ourselves, but we do not have the necessary training. We don't know how to prevent infection. We feel like the health system has left us alone, forcing us to choose between health and finances." (Participant 3, a family member).

"At least when you go to a public hospital, the insurance covers the costs. We pay all the costs out of our pocket. I feel that HC should be accessible for all patients, not a luxury service that is only possible for those who can afford it." (Participant 3, a family member).

3.3. Theme 3: Caregivers' Job Security Concerns.

Many problems and gaps in the work system of caregivers are related and cause them to feel insecure in their jobs. Disappointment of caregivers is one of the subthemes, which is based on the many problems that have been mentioned. Inadequate competence of caregivers and caregiver harassment were among the other reasons that we found in this study.

3.3.1. Subtheme 1: Disappointment of Caregivers.

Caregivers mentioned many problems that ultimately make them despair. They pointed out that caring for the elderly threatens their health in many ways.

"I am caring 24 hours a day for a heavy older person who cannot move. Because I have to move him alone, I got disc herniation and neck arthritis." (Participant 10, an unqualified caregiver).

Most of the caregivers also stated that, according to their expectations, they would not receive any job support, but they hoped to be regarded as professional treatment staff and earn fair salaries according to the labor law.

I work continuously every day from 7 am to 7 pm without visiting my family or having at least one day off a month. Therefore, if this is defined as a job, I need to go on leave at least one or two days a month and leave my work to another caregiver or an elderly family member. This is because I have two children and they also expect me to be with them. (Participant 11, an unqualified caregiver).

Some caregivers considered caring for the older adults, who have complex medical conditions, to be a source of mental exhaustion and despair. One of them said:

"How can you take care of an older person, who is on a ventilator for a long time, who has a low level of consciousness? An elderly person, who has no connection to the environment." (Participant 18, a home care nurse).

3.3.2. Subtheme 2: Inadequate Competence of Caregivers.

The analysis of interviews showed that the training program is not implemented. Nurses take care of older adults based on their previous experiences. Unqualified caregivers are also amateurs unless they learn procedures from the Internet. Experts believed that quality is achieved through determined standards, periodic monitoring, assessing satisfaction, and using a trained workforce. For instance:

"I was taking care of an Alzheimer's patient who pulled a colostomy bag and removed it. I did not know what to do, so I quickly called the emergency room." (Participant 12, an unqualified caregiver).

3.3.3. Subtheme 3: Caregiver Harassment.

Caregivers stated that the family has expectations other than caring for the older adult, making them feel unsafe. For example:

"The older person's son called our office and requested a young and beautiful caretaker for his father."

(Participant 17, a head of a counseling and nursing care at home center).

Another caregiver said:

"I go home as a caregiver for the elderly, and nothing else. Unfortunately, the daughter of the family wanted me to clean their house and wash their carpets." (Participant 12, an unqualified caregiver).

4. Discussion

We categorized essential issues and challenges of delivering home care for older adults in three themes: defects in home care governance, concern about the efficiency of home care, and caregivers' job security concerns. According to the results, the existing policies are either not transparent or not implemented properly, and they should be modified to suit the needs of older adults. The World Health Organization asserts that policies should be designed according to the needs of older adults to provide them with integrated and person-centered services [46]. Also, policymaking should follow a home care approach with a skilled, multidisciplinary team and collaboration across sectors [47]. Goharinezhad reported that Iran lacks the infrastructure and resources to care for older adults, and the care system is primarily treatment-oriented and neglects prevention, which should be the essence of care [21]. A similar study in China recommended that the policymakers should provide a mixed service for clients, build an information system to facilitate evidence-based policymaking, establish a quality-monitoring system, and train a specialist workforce for long-term care [48].

The lack of unique governance and the conflicts between multiple trustees in home care were another important finding, which were also mentioned in another study [49]. These issues can affect the quality of care and the satisfaction of the older adults and their families, as well as the efficiency and effectiveness of the health system. Therefore, it is essential to establish a coherent governance structure for home care, with well-defined roles and responsibilities for the different stakeholders involved. Moreover, it is important to foster collaboration and coordination among the various trustees, such as the Ministry of Health, the Social Security Organization, the Welfare Organization, and the private sector, to ensure the delivery of integrated and comprehensive care for the older population [30].

Another problem in home care governance is the poor and inconsistent supervision of services. Bahador et al. [50] argued that monitoring the services should be one of the most important aspects of managing health services for older people in Iran. The participants in this study also talked about the inappropriate management of financial resources. The World Health Organization [51] recommended that, due to the high cost of care for older adults, financing should be guaranteed and sustainable combined sources for financing should be used. Mosadeghrad et al. [52] referred to strengthening public-private cooperation, determining fair tariffs, and fixed payment methods as sustainable financing solutions, which are in line with our results, in a scoping review study.

Many countries, including Iran, the United Kingdom [53], the United States [54], and Canada [55], face the problem of a home care workforce shortage. This is a global challenge that affects the quality and availability of health and social care services for older people, as stated by Hussein and Manthorpe [56]. To address this issue, it is important to learn from the experiences and best practices of other countries and regions, and to improve the working conditions and compensation of home care workers, such as offering more autonomy, flexibility, recognition, training, and career advancement opportunities, as suggested by Stepick and Tran [57].

The interviews uncovered a shortage of equipment and devices for home care, which may be attributed to their high cost and complexity of use. The devices should be able to self-calibrate whenever possible. The maintenance should generally be limited to only the most basic, routine functions, such as simple cleaning and battery replacement [58].

Another challenge of HC explored in this study is the lack of trust in caregivers in HC, which is a complex and multifaceted issue that affects the quality and effectiveness of care delivery and the satisfaction of both caregivers and care recipients [59]. One of the factors that contribute to this issue can be due to the high levels of stress, burden, and emotional distress that caregivers may encounter, which can adversely affect their physical and mental health as well as their competence to provide quality care [60]. Similarly, another study also explored that HC workers face physical, mental, and financial pressures and insufficient job support, which ultimately causes high caregiver turnover [61]. Specifically, for caregivers of older adults with dementia, the older person's problematic behaviors can lead to a perceived caregiving burden [62]. The primary basis of caring for older person is the nurse and caregiver; therefore, meeting the needs of caregivers can increase their commitment and responsiveness to the demands of the clients and improve the quality of care [63]. To address these barriers, it is important to improve the recruitment, retention, and development of HC workers and to provide them with adequate compensation, and recognition. Moreover, it is essential to ensure the safety and quality of HC services and to support the integration and coordination of HC workers with other healthcare providers [64, 65]. Providing needed information, stress reduction programs, generous leave policies, benefits, and financial counseling are among the measures to support caregivers [66]. One of the essential factors affecting quality of care is the composition of staff [67], which is disproportionate in home care (HC), and people are employed for social care without considering the necessary qualifications. Caregivers in this study stated that they did not receive any formal training. They considered the need for emergency training essential. Other studies have also pointed out the challenges of knowledge in the care field, such as pressure ulcer care, airway maintenance, and communication skills [68, 69]. Experts claimed that for client-centered care, comprehensive care should be delivered based on quality standards of care. Formal training and providing care by qualified caregivers in the multidisciplinary team will lead to quality care [70, 71]. After the

necessary policies in the HC field are implemented, informing older adults about the available services should be provided so that everyone has equal access to the services [72]. Many older adults refuse to receive services due to the fear of losing their independence, high costs, and not trusting strangers [73].

Lack of insurance coverage was another vital issue that participants identified as a reason for inequitable access to HC services. High costs and unfair pricing prevent access to HC services, which the elderly try to cope with by limiting other expenses and relying on financial assistance from their children. In contrast, those individuals who are more financially secure buy services privately, and people with low incomes do not have access to these services [74]. Similar to the results of this study, universal coverage of long-term care insurance can solve the needs of older adults with chronic conditions in the community [75]. According to various pieces of literature, quality care should cover dimensions such as a competent workforce, patient satisfaction, person-centered care, patient involvement in decision-making, and compliance with care standards [76, 77]. In leading countries in HC, such as Germany and Japan, issues such as long-term care insurance, benefits, rights, and ethics in care are among the passed laws [78, 79].

5. Strength and Limitation

One of the main weaknesses of this study was the non-participation of older adults. This is because older adults receiving HC either had severe cognitive impairment or were bedridden and had no desire to participate in the interview. Therefore, we attempted to interview family caregivers who were the closest person to the clients. Another limitation was that we did not interview key stakeholders at upstream levels due to lack of access to them. This may have affected the comprehensiveness and validity of our findings, as we could not capture the perspectives and experiences of those who are involved in the policymaking and implementation processes of HC. Future research could address this limitation by using alternative methods to access the key stakeholders at upstream levels, such as conducting online surveys, focus groups, or document analysis, or by establishing partnerships with relevant organizations or networks that can facilitate the access. Despite the limitations, this study has significant strengths, one of which is that we tried to meet all four criteria to assess trustworthiness in qualitative research, including transferability, credibility, confirmability, and dependability, and this caused this study to last more than one year. This study is the only study that explores HC in Iran from all dimensions using a qualitative approach. Exploring the experiences of all stakeholders involved in care is another strength of this study. In addition, this study provides information to policymakers to develop a comprehensive HC plan with an evidence-based approach.

6. Conclusion

The findings have several implications for the HC practice of older adults. They can inform the policymakers and planners of HC services by raising the awareness and advocacy of the needs and challenges of this population. They can also facilitate the collaboration among different stakeholders, such as the government, the healthcare system, the HC providers, the care recipients, and their families, to improve the quality and accessibility of HC. Moreover, they can enhance the responsiveness and adaptability of HC to the diverse and changing needs of older adults by providing a framework for monitoring and evaluating the performance and outcomes of HC services and for identifying and implementing best practices and innovations in HC. Furthermore, they can empower and support the caregivers and the care recipients in home care by improving their well-being and satisfaction, providing a platform for sharing and learning from their experiences and perspectives, and for fostering a trusting and respectful relationship between them. Based on these implications, some possible strategies are recommended, such as developing a national model for HC, improving the coordination and integration of services, increasing the investment and allocation of resources for HC, implementing quality improvement and evaluation tools, enhancing the training and education of caregivers, promoting the use of technology and innovation in HC, improving the recruitment, retention, and development of caregivers, providing them with adequate compensation, benefits, and recognition, and ensuring the safety and quality of HC services.

This research also proposes some possible directions for future research on HC for older adults, such as exploring the experiences and needs of different cultural groups, comparing the outcomes and costs of different models and types of HC, investigating the impact of technology and innovation on HC, evaluating the effectiveness and feasibility of quality improvement and evaluation tools, developing and testing interventions and strategies to improve the well-being and satisfaction of caregivers and care recipients, and examining the factors and challenges that affect the recruitment, retention, and development of caregivers. This research contributes to the existing knowledge and literature on HC for older adults and provides valuable insights and suggestions for enhancing the quality of life and care of this population and their caregivers.

Data Availability

The data used to support the findings of this study are available from the corresponding author, Dr. Kousha (amkousha@gmail.com), upon reasonable request. The data are not publicly available due to privacy and confidentiality restrictions. The data include interview transcripts and extracted codes in MAXQDA.

Additional Points

What Is Known about This Topic? (i) HC is a necessity in Iran. (ii) There are many policies, regulations, and upstream documents in the field of health and care of the older adults. (iii) Until now, Iranian studies have explored the challenges of HC from the nurses' viewpoint. *What This Paper Adds?* (i) This study explores the perspectives of most of the

stakeholders involved in HC for the older adults in Iran. (ii) Determining the experiences for HC for the older adults can help in designing an organized home care system in Iran. (iii) Iran has some home care policies, but they are not effectively implemented or monitored. (iv) There is insufficient monitoring of the provided HC services. (v) There are complex challenges in providing home care, such as lack of evaluation and monitoring, inadequate competence, and financial barriers of families and caregivers. (vi) Meeting the training and financial needs of the caregivers is necessary to improve the quality of care.

Ethical Approval

This study protocol was approved by the Ethics Committee of Tabriz University of Medical Sciences (code number: IR.TBZMED.REC.1400.934). All participants were informed of the objective and design of the study and the confidentiality of their personal information.

Consent

Written consent was received from all participants, and they were free to leave the study whenever they wish.

Disclosure

The funders have no role in the design and conduct of the study, collection, management, decision to publish, or preparation of the manuscript.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Authors' Contributions

All authors contributed to the design of the study. KH.M., H.A., and A.K. contributed to conducting interviews, performed analysis, and interpreted the findings of this study. K.M. and H.M. drafted the manuscript. A.K., H.M., and H.A. contributed in making critical revisions to different versions of the manuscript. All authors have read and approved the final version of this manuscript.

Acknowledgments

References

[1] J. H. Fong, "Disability incidence and functional decline among older adults with major chronic diseases," *SSRN Electronic Journal*, vol. 19, no. 1, pp. 1–9, 2019.

[2] L. S. Noelker and D. M. Bass, "Home care for elderly persons: linkages between formal and informal caregivers," *Journal of Gerontology*, vol. 44, no. 2, pp. S63–S70, 1989.

[3] J. Amuthavalli Thiyagarajan, C. Mikton, R. H. Harwood et al., "The UN Decade of healthy ageing: strengthening measurement for monitoring health and wellbeing of older people," *Age and Ageing*, vol. 51, no. 7, p. afac147, 2022.

[4] N. Stall, M. Nowaczynski, and S. K. Sinha, "Systematic review of outcomes from home-based primary care programs for homebound older adults," *Journal of the American Geriatrics Society*, vol. 62, no. 12, pp. 2243–2251, 2014.

[5] J. L. Wiles, A. Leibing, N. Guberman, J. Reeve, and R. E. Allen, "The meaning of "aging in place" to older people," *The Gerontologist*, vol. 52, no. 3, pp. 357–366, 2012.

[6] C. Blazquez, M. J. Forjaz, M. E. Prieto, F. Rojo, G. Fernandez, and P. Martinez, "Health status and well-being of older adults living in the community and in residential care settings: are differences influenced by age?" *Aging and Mental Health*, vol. 16, no. 7, pp. 884–891, 2012.

[7] J. Asbridge and M. Davies, "Clinical care in the home and population health management: improving the care of patients with long-term health conditions," *European Journal for Person Centered Healthcare*, vol. 5, no. 1, pp. 148–153, 2017.

[8] World Health Organization, "The growing need for home health care for the elderly: home health care for the elderly as an integral part of primary health care services," 2015, https://applications.emro.who.int/dsaf/EMROPUB_2015_EN_1901.pdf?ua=1.

[9] A. Banerjee and R. Sadana, "Integrated care for older people (ICOPE): from guidelines to demonstrating feasibility," *The Journal of Frailty and Aging*, vol. 10, pp. 1-2, 2020.

[10] G. Sum, L. K. Lau, K. A. Jabbar et al., "The world health organization (WHO) integrated care for older people (ICOPE) framework: a narrative review on its adoption worldwide and lessons learnt," *International Journal of Environmental Research and Public Health*, vol. 20, no. 1, p. 154, 2022.

[11] K. Davies, E. Dalgarno, S. Davies et al., "The challenges of commissioning home care for older people in England: commissioners' perspectives," *Ageing and Society*, vol. 41, no. 8, pp. 1858–1877, 2021.

[12] J. O. Faronbi, G. O. Faronbi, S. J. Ayamolowo, and A. A. Olaogun, "Caring for the seniors with chronic illness: the lived experience of caregivers of older adults," *Archives of Gerontology and Geriatrics*, vol. 82, pp. 8–14, 2019.

[13] S. Spasova, R. Baeten, and B. Vanhercke, "Challenges in long-term care in Europe," *Eurohealth*, vol. 24, no. 4, pp. 7–12, 2018, https://apps.who.int/iris/bitstream/handle/10665/332533/Eurohealth-24-4-7-12-eng.pdf?sequence=1&isAllowed=y.

[14] P. Markkanen, M. Quinn, C. Galligan, S. Chalupka, L. Davis, and A. Laramie, "There's no place like home: a qualitative study of the working conditions of home health care providers," *Journal of Occupational and Environmental Medicine*, vol. 49, no. 3, pp. 327–337, 2007.

[15] R. Ganann, A. Weeres, A. Lam, H. Chung, and R. Valaitis, "Optimization of home care nurses in Canada: a scoping review," *Health and Social Care in the Community*, vol. 27, no. 5, pp. e604–e621, 2019.

[16] N. Mehri, M. Messkoub, and S. Kunkel, "Trends, determinants and the implications of population aging in Iran," *Ageing International*, vol. 45, no. 4, pp. 327–343, 2020.

[17] N. Ebrahimi, P. Mehdipour, F. Mohebi, A. Ghanbari, M. Azmin, and F. Farzadfar, "Improved population health in Iran from 1979 to 2019; Decreasing mortality rates and increasing life expectancy," *Archives of Iranian Medicine*, vol. 23, no. 2, pp. 61–68, 2020.

[18] Statistical Center of Iran, "Population and housing censuses. statistical centre of iran," 2016, https://www.amar.org.ir/english/Population-and-Housing-Censuses.

[19] S. Manoochehry and H. R. Rasouli, "Iranian population policy and aging: new health concerns," *International Journal of Travel Medicine and Global Health*, vol. 5, no. 2, pp. 70-71, 2017.

[20] A. Khosravi, M. Alizadeh, M. Torkashvand, and N. Aghaei, "Population ageing in ir iran," 2014, https://catalog.ihsn.org/citations/56631.

[21] S. Goharinezhad, M. Maleki, H. R. Baradaran, and H. Ravaghi, "A qualitative study of the current situation of elderly care in Iran: what can we do for the future?" *Global Health Action*, vol. 9, no. 1, Article ID 32156, 2016.

[22] R. Amini, K. H. Chee, K. Sen, and S. R. Ingman, "Elder care in Iran: a case with a unique demographic profile. Journal of Aging and Social Policy," *Journal of Aging and Social Policy*, vol. 33, no. 6, pp. 611–625, 2021.

[23] J. R. Beard and D. E. Bloom, "Towards a comprehensive public health response to population ageing," *The Lancet*, vol. 385, no. 9968, pp. 658–661, 2015.

[24] N. D. Nayeri, F. Abazari, and B. Pouraboli, "Challenges in caring for the elderly in Iran: a systematic review," *Ethiopian Medical Journal*, vol. 56, no. 2, 2018, https://www.emjema.org/index.php/EMJ/article/view/717.

[25] Z. Abbasi Dolatabadi, H. Seyedin, and A. Aryankhesal, "Policies on protecting vulnerable people during disasters in Iran: a document analysis," *Trauma Monthly*, vol. 21, no. 3, Article ID e31341, 2016.

[26] National Council for the Elderly, "Iran's national document for the elderly," 2004, https://www.tehrantimes.com/news/471921/National-Document-for-the-Elderly-to-take-effect-next-year.

[27] The Office of the Supreme Leader, "Population policies," 2012, https://www.leader.ir/en.

[28] A. Nikbakht-Nasrabadi and M. Shabany-Hamedan, "Providing healthcare services at home-a necessity in Iran: a narrative review article," *Iranian Journal of Public Health*, vol. 45, no. 7, pp. 867–874, 2016.

[29] H. Heydari, H. Shahsavari, and A. Hazini, "Exploring the barriers of home care services in Iran: a qualitative study," *Scientifica*, vol. 10, 2016.

[30] L. Doshmangir, P. Doshmangir, K. Mobasseri, R. Khodayari-Zarnaq, A. Ahmadi Teymourlouy, and V. Sergeevich Gordeev, "Factors affecting health policies for older people in Iran," *Journal of Aging and Social Policy*, vol. 35, no. 6, pp. 859–881, 2023.

[31] S. Rostami, A. Jafari, and S. Rostami, "The concept and status of the right to health in Iran and internationally (with emphasis on citizenship rights and covid 19)," *Medical Law Journal*, vol. 15, no. 56, pp. 57–73, 2021.

[32] J. Bahmaei, R. Ravangard, M. A. Bahrami, A. Asadollahi, and P. Bastani, "Policy requirements in promoting older people health care in Iran: a qualitative study," *Journal of Education and Health Promotion*, vol. 12, no. 1, p. 159, 2023, https://www.jehp.net//text.asp?2023/12/1/159/377849.

[33] G. J. Norman, A. J. Wade, A. M. Morris, and J. C. Slaboda, "Home and community-based services coordination for homebound older adults in home-based primary care," *BMC Geriatrics*, vol. 18, pp. 241–249, 2018.

[34] B. Hollstein, *Qualitative Approaches*, The SAGE handbook of social network analysis, Washington, DC, USA, 2011.

[35] S. Barasteh, M. Rassouli, M. R. Karimirad, and A. Ebadi, "Future challenges of nursing in health system of Iran," *Frontiers in Public Health*, vol. 1052, 2021.

[36] I. Etikan, S. A. Musa, and R. S. Alkassim, "Comparison of convenience sampling and purposive sampling," *American Journal of Theoretical and Applied Statistics*, vol. 5, no. 1, pp. 1–4, 2016.

[37] H. Kallio, A. M. Pietilä, M. Johnson, and M. Kangasniemi, "Systematic methodological review: developing a framework for a qualitative semi-structured interview guide," *Journal of Advanced Nursing*, vol. 72, no. 12, pp. 2954–2965, 2016.

[38] G. Guest, A. Bunce, and L. Johnson, "How many interviews are enough? An experiment with data saturation and variability," *Field Methods*, vol. 18, no. 1, pp. 59–82, 2006.

[39] D. R. Thomas, "A general inductive approach for analyzing qualitative evaluation data," *American Journal of Evaluation*, vol. 27, no. 2, pp. 237–246, 2006.

[40] S. Stemler, "An overview of content analysis," *Practical Assessment, Research and Evaluation*, vol. 7, no. 1, p. 17, 2000.

[41] R. Emerson, R. Fretz, and L. Shaw, "Field notes in ethnographic research," in *Writing Ethnographic Field Notes*, pp. 1–16, University of Chicago Press, Chicago, IL, USA, 2011.

[42] J. Phillippi and J. Lauderdale, "A guide to field notes for qualitative research: context and conversation," *Qualitative Health Research*, vol. 28, no. 3, pp. 381–388, 2018.

[43] Y. S. Lincoln and E. G. Guba, "But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation," *New Directions for Program Evaluation*, vol. 1986, no. 30, pp. 73–84, 1986.

[44] F. A. Kalu, "What makes qualitative research good research? An exploratory analysis of critical elements," *International Journal of Social Science Research*, vol. 5, no. 2, pp. 43–56, 2017.

[45] J. W. Creswell and V. L. P. Clark, *Principles of Qualitative Research: Designing a Qualitative Study*, Office of Qualitative and Mixed Methods Research, University of Nebraska, Lincoln, NE, USA, 2004, https://community.csusm.edu/pluginfile.php/21112/mod_resource/content/1/CresswellJWAndPlanoClarkVLPrinciples_of_QualitativeResearchDesigningQualitativeStudyPPT.pdf.

[46] K. Viktoria Stein, E. S. Barbazza, J. Tello, and H. Kluge, "Towards people-centred health services delivery: a framework for action for the world health organisation (WHO) European region," *International Journal of Integrated Care*, vol. 13, no. 4, 2013.

[47] H. Shahsavari, A. N. Nasrabadi, M. Almasian, H. Heydari, and A. Hazini, "Exploration of the administrative aspects of the delivery of home health care services: a qualitative study," *Asia Pacific Family Medicine*, vol. 17, no. 1, pp. 1–7, 2018.

[48] Z. Feng, C. Liu, X. Guan, and V. Mor, "China's rapidly aging population creates policy challenges in shaping a viable long-term care system," *Health Affairs*, vol. 31, no. 12, pp. 2764–2773, 2012.

[49] R. Safdari, F. Sadeghi, and M. Mohammadiazar, "Aged care and services programs in Iran: looking at the performance of relevant organizations," *Payavard Salamat*, vol. 10, no. 2, pp. 155–166, 2016.

[50] F. Bahador, S. Mahfoozpour, I. M. Asl, and S. Vahdat, "Identifying the dimensions of management in providing preventive services of the first type of health in the elderly in Iran," *Iranian Journal of Ageing*, vol. 40, 2021.

[51] World Health Organization, "Research and development to meet health needs in developing countries: strengthening global financing and coordination: report of the consultative expert working group on research and development: financing and coordination," 2012, https://www.who.int/publications-detail-redirect/9789241503457.

[52] A. M. Mosadeghrad, R. Khodayari, M. Abbasi, and F. Karimi, "Sustainable financing strategies for the Iranian health system: a scoping review," *Journal of School of Public Health and Institute of Public Health Research*, vol. 19, no. 2, pp. 137–156, 2021.

[53] M. Attree, M. Flinkman, B. Howley, R. L. Lakanmaa, M. Lima-Basto, and L. Uhrenfeldt, "A review of nursing workforce policies in five European countries: Denmark, Finland, Ireland, Portugal and United Kingdom∗/England," *Journal of Nursing Management*, vol. 19, no. 6, pp. 786–802, 2011.

[54] American Geriatrics Society, "American Geriatrics Society policy brief: COVID-19 and nursing homes," *Journal of the American Geriatrics Society*, vol. 68, no. 5, pp. 908–911, 2020.

[55] I. U. Zeytinoglu, M. Denton, S. Davies, and J. M. Plenderleith, "Casualized employment and turnover intention: home care workers in Ontario, Canada," *Health Policy*, vol. 91, no. 3, pp. 258–268, 2009.

[56] S. Hussein and J. Manthorpe, "An international review of the long-term care workforce: policies and shortages," *Journal of Aging and Social Policy*, vol. 17, no. 4, pp. 75–94, 2005.

[57] L. Stepick and B. A. Tran, "The rapidly growing home care sector and labor force participation," *Federal Reserve Bank of San Francisco, Community Development Research Brief Series*, vol. 2022, no. 2, pp. 1–22, 2022.

[58] G. Saini, V. Budhwar, and M. Choudhary, "Review on people's trust on home use medical devices during COVID-19 pandemic in India," *Health Technology*, vol. 12, no. 2, pp. 527–546, 2022.

[59] S. Rasiah, S. Jaafar, S. Yusof, G. Ponnudurai, K. P. Y. Chung, and S. D. Amirthalingam, "A study of the nature and level of trust between patients and healthcare providers, its dimensions and determinants: a scoping review protocol," *BMJ Open*, vol. 10, no. 1, Article ID e028061, 2020.

[60] M. Lee, J. H. Ryoo, C. Campbell, P. J. Hollen, and I. C. Williams, "Exploring the challenges of medical/nursing tasks in home care experienced by caregivers of older adults with dementia: an integrative review," *Journal of Clinical Nursing*, vol. 28, no. 23-24, pp. 4177–4189, 2019.

[61] B.-M. Wälivaara, S. Sävenstedt, and K. Axelsson, "Encounters in home-based nursing care-registered nurses' experiences," *The Open Nursing Journal*, vol. 7, pp. 73–81, 2013.

[62] H. E. Ainamani, P. E. Alele, G. Z. Rukundo et al., "Caring for people with dementia in rural Uganda: qualitative study of caregiving burden experienced by informal and formal caregivers," *Journal of global health reports*, vol. 4, Article ID e2020038, 2020.

[63] L. E. Weeks, G. McInnis-Perry, C. MacQuarrie, and S. Jovanovic, "Insights into roles for health-care professionals in meeting the needs of older adults and unpaid caregivers during health-care transitions," *Canadian Journal of Nursing Research*, vol. 48, no. 3-4, pp. 70–79, 2016.

[64] S. A. Chapman, L. Greiman, T. Bates et al., "Personal care aides: assessing self-care needs and worker shortages in rural areas: study examines self care needs for people with disabilities and worker shortages in rural areas," *Health Affairs*, vol. 41, no. 10, pp. 1403–1412, 2022.

[65] H. Hartmann and J. Hayes, "The growing need for home care workers: Improving a low-paid, female-dominated occupation and the conditions of its immigrant workers," *Public Policy and Aging Report*, vol. 27, no. 3, pp. 88–95, 2011.

[66] W. Gao, T. Zhang, H. Wang, S. Wang, Y. Liu, and X. Pang, "Supporting caregivers of people with dementia: a systematic review of guidelines," *Health and Social Care in the Community*, vol. 30, no. 2, pp. e305–e324, 2022.

[67] R. Wittenberg, Long term care reforms in OECD countries, C. Gori, J. L. Fernandez, and R. Wittenberg, Eds., 2016, https://books.google.com/books?hl=fa&lr=&id=6UEhCwAAQBAJ&oi=fnd&pg=PR7&dq=Wittenberg,+R.+Long+Term+Care+reforms+in+OECD+countries.+Long-term+care+reforms+in+OECD+countries.+Ed.+by+C.+Gori,+JL+Fernandez+and+R.+Wittenberg.+Policy+Press.+Chap.+Demand+for+care+and.

[68] C. L. Graham, S. L. Ivey, and L. Neuhauser, "From hospital to home: assessing the transitional care needs of vulnerable seniors," *The Gerontologist*, vol. 49, no. 1, pp. 23–33, 2009.

[69] R. Samuriwo, E. Laws, K. Webb, and A. Bullock, "I didn't realise they had such a key role Impact of medical education curriculum change on medical student interactions with nurses: a qualitative exploratory study of student perceptions," *Advances in Health Sciences Education*, vol. 25, no. 1, pp. 75–93, 2020.

[70] I. C. C. Alvarez, M. B. Ong, and F. Abocejo, "Learning needs and quality care among family caregivers and elderly patients of Guadalupe, Cebu City, Central Philippines," *European Scientific Journal, ESJ*, vol. 13, no. 24, pp. 356–376, 2017.

[71] N. Lotfi Fatemi, H. Karimi Moonaghi, and A. Heydari, "Exploration of nurses' perception about professionalism in home care nursing in Iran: a qualitative study," *Electronic Physician*, vol. 10, no. 5, pp. 6803–6811, 2018.

[72] T. Bovaird, "Beyond engagement and participation: user and community coproduction of public services," *Public Administration Review*, vol. 67, no. 5, pp. 846–860, 2007.

[73] J. Dupraz, Y. Henchoz, and B. Santos-Eggimann, "Formal home care use by older adults: trajectories and determinants in the Lc65+ cohort," *BMC Health Services Research*, vol. 20, no. 1, pp. 1–12, 2020.

[74] R. T. Goins, K. A. Williams, M. W. Carter, S. M. Spencer, and T. Solovieva, "Perceived barriers to health care access among rural older adults: a qualitative study," *The Journal of Rural Health*, vol. 21, no. 3, pp. 206–213, 2005.

[75] A. Kazemi Karyani, A. Rashidian, A. Akbari Sari, and S. Emamgholipour Sefiddashti, "Developing attributes and levels for a discrete choice experiment on basic health insurance in Iran," *Medical Journal of the Islamic Republic of Iran*, vol. 32, p. 26, 2018.

[76] A. Stavropoulou, M. Rovithis, M. Kelesi et al., "What quality of care means? Exploring clinical nurses' perceptions on the concept of quality care: a qualitative study," *Clinical Practice*, vol. 12, no. 4, pp. 468–481, 2022.

[77] K. Mobasseri, H. Matlabi, H. Allahverdipour, F. Pashazadeh, and A. Kousha, "Structure and organization of home-based care for older adults in different countries: a scoping review," *Health Scope*, vol. 12, no. 3, Article ID e136546, 2023.

[78] T. Goergen, "Prevention of elder abuse in Germany," in *International Handbook of Elder Abuse and Mistreatment*, pp. 279–293, Springer, Singapore, 2020.

[79] N. Tsukada, "Japan's 10-year legislative experience, current status and future challenges in preventing elder abuse," in *International Handbook of Elder Abuse and Mistreatment*, pp. 461–483, Springer, Singapore, 2020.