

ACTIVE AGEING MANAGEMENT IN IRAN: DESIGNING A MODEL

Zeinab Gholipour, Mahmood Mahmoodi Majd Abadi Farahani, Leila Riahi, Kamran Hajjabinabi

Department of Health Services Management, Sciences and Research Branch, Islamic Azad University, Tehran, Iran.

Correspondence: Mahmoodim@tums.ac.ir

ABSTRACT

OBJECTIVE

Active ageing constitutes one of the guiding perspectives on policies, but the factors influencing ageing have not received considerable attention. The present study aimed to identify the factors affecting active ageing management in Iran.

DESIGN

Drawing on quantitative data gathered through a questionnaire filled out by 287 participants and an interview with 20 experts.

MAIN OUTCOME MEASURES

The instrument was a questionnaire based on the five-point Likert scale. Questions with $CVR > 0.49$ and with $CVI > 0.7$ were accepted. To assess the reliability of the questionnaire, Cronbach's alpha coefficient was (0.92) used. The adequacy of the sample size was estimated at 0.952, based on the Kaiser-Meyer-Olkin (KMO) index. The collected data were analyzed by SPSS Ver 22. An exploratory factor analysis was used to explore and evaluate the dimensions of the model through a mathematical approach. Also, confirmatory factor analysis was utilized to verify the model, using AMOS 24 software.

RESULTS

Eight factors were identified as effective factors in active ageing management in Iran, which include: Organizational structure (0/83), services (0/80), control (0/74), financing (0/72), government grants (0/71), policy making (0/68), selected area to focus (0/65), members (0/63).

Organizational structure and member components had the most and least significant effects.

CONCLUSIONS

Establishing a High Council with the presence of the President's representative, allocating a specific budget for the elderly, determining the responsibilities of the government and the related organizations, determining the responsibility and providing suitable services can lead to the effective management of active ageing.

KEYWORDS

elderly, active ageing, active ageing management, ageing financing

BACKGROUND

The 20th century has witnessed an unprecedented increase in average human lifespan as well as a rapid decrease in human fertility in many countries of the world. [1] Globally, the share of older people (60 years and older) incremented from 130 million in 1994 to more than 600 million in 2017; that is, it has increased from 4% to 10% during this period which is expected to reach 21% per se by 2050. [2] In Iran, the population of older people (60 years and older) increased from 7/3% in 2006 to 9/3% in 2016, and it is expected to reach 25% by 2050. [3] So, in the near future, we will see an 'aging explosion.' [4] What has been described as the trend of increasing population in the world and in Iran is not important in itself inasmuch as the fact that the economic and social consequences of this population

increment seem to be more crucial.[5] Ageing is a multidimensional phenomenon with political, economic, social, cultural, educational, welfare, physical, mental, and health dimensions that are intertwined as a chain. Therefore, we are mistaken if we rely solely on the health facilities and abilities to address ageing issues. [6]

These findings highlight several questions from both an individual and public perspectives. Who will take care of the current generation as we become older? What types of health and social organizations should we develop to preserve the quality of life of an ageing population and sustain our health care systems over the medium and long term? Supporting Active and Healthy Aging (AHA) is one answer to these questions.

AHA population is a resource that benefits society. Maintaining a healthy ageing population may also lower demands for health care services. In addition, in many cases, older adults in good health conditions are able to support their fellow generation. [10] It is postulated that active ageing is a multidimensional concept affected by several factors, including physical functionality, lifestyle, urban environment, and social inclusion. [7] Active ageing is a process of optimizing opportunities for health, participation, and security in order to enhance quality of life as people age [8] and healthy ageing is process of developing and maintaining the functional ability that enables well-being in older age. [9]

Older people contribute to society in many ways – whether it is within their family, to their local community or to society more broadly. [9] Therefore, policies should ensure that older people can continue participating in economic and community activities as they grow older, and that they can take care of themselves as long as possible, and this is the essence of an Active and Healthy Aging (AHA) approach [11] Most of developing countries in the world have perceived socioeconomic and health related complexities resulting from population transition called 'ageing nations', however, given the progressive growth of the elderly population, their problems also have increased so that a satisfactory solution has not been found yet for them. [12]

There are critically important issues related to the ageing society, such as future intergenerational relations and tensions, socioeconomic disparities and inequalities and its capacity to serve the traditional safety-net role, the impact of technology, and the critical importance of adaptation of core societal institutions, including education, work and

retirement, housing and even the design of the built environment. [13] There are five main reasons for policymakers to pursue the concept of active ageing with interest. These reasons include the ageing of the workforce, an increase in the early exit of labor, the need for social protection system sustainability, changing business needs, and political pressure to provide equal treatment and care. [14]

A comprehensive concept of active ageing can provide a framework for the development of global, national, and local strategies relating to population ageing. It has the potential to unify the interest of all the key stakeholders: citizens, non-governmental organizations, business interests, and policymakers. [15] The use of the experiences of advanced and successful countries in the management of the ageing population can be a guide and a suitable model for the relevant authorities. (1) Over the past two decades, 'active ageing' has emerged in Europe as the foremost policy response to the challenges of population ageing. [17] It is only in the last one and half decades that countries in Asia are facing a steady growth of the elderly, as a result of the decline in fertility and mortality, better medical and health care and improvements in the overall quality of life of people. [18] A review of the laws and regulations of the country of Iran shows that only 1% of laws passed are for the elderly, 62% of which are economic, 22% social, and 16% health and well-being. [2]

The status of hospitals and health care facilities in providing services to the elderly is severely weak in terms of staff, physicians, nurses trained to interact with the elderly, home visits and preventive measures. Existing policies on the health of the elderly have failed to achieve their goals; elderly policymaking has taken place regardless of the important underlying factors (such as human resources), community conditions and stakeholders. [3] And the elderly in Iran are not covered by any insurance organization as "elderly" unless they are insured as employed, retired, needy, disabled, and rural. [21]

OBJECTIVES

Resolving elderly problems is not the sole responsibility of an entity or organization and requires the combination of capabilities and involvement of all sectors, so establishing a coordinated body to plan elderly related activities as a strategic measure can be a strategy for improving elderly

support services. Consequently, the aim of this study was to identify the factors affecting active ageing management.

METHOD

This descriptive quantitative study was carried out in six phases in 2018. In the first phase, factors influencing active ageing management were identified and extracted through a literature search. In the second phase, a comparative study was conducted on the experience of the selected countries in active ageing management. A narrative review was used in databases of Pub Med, Science direct, Scopus, and Web of Science. In order to find more reports and documents, various databases such as the WHO, the World Bank, and the Google search engine were also examined. To this end, the relevant studies were checked using the key words "active ageing, elderly policy making financing, control, organizational structure, active ageing management, and ageing services. The study population was selected from countries with high aged population and available references. These countries included Norway, the United Kingdom (UK), Japan, Malaysia, Turkey, and Iran. The data obtained from this stage (literature review and comparative study) were classified using an information form, and duplicate data were removed. The important variables affecting active ageing management were classified into eight dimensions consisting of policy making, organizational structure, members' component, control, financing, governance grants, services, and selected area to focus which led to the development of a proposed model.

In third phase, an interview was conducted with 20 experts in the field of the ageing management. The inclusion criterion for experts was a minimum experience of 10 years in ageing management positions. The interviews continued until reaching data saturation, and analysis of the collected data from the interviews was carried out by content analysis.

In fourth phase, a researcher-made questionnaire with 41 items in eight dimensions, rated on a five-point Likert scale (from very low = 1 to very high = 5) was used to confirm the validity of the proposed model by a large number of experts. The face validity and content validity of the questionnaire was confirmed by 20 experts. Questions with $CVR > 0.49$ (Content Validity Ratio) and with $CVI > 0.7$ (Content Validity Index) were accepted. Furthermore, to

assess the reliability of the questionnaire, Cronbach's alpha coefficient was (0.92) used. In fifth phase, validation of the model was made by the stakeholders. The questionnaire was distributed among 287 samples, including experts of ageing management in the organizations related to the provision of active aging services such as ministry of health and medical education, ministry of cooperatives labor and social welfare (state welfare organization of Iran, insurance companies) and universities of medical science with 10 years of experience in the field of ageing. The sample size was determined using the Cochran formula, and sampling was carried out using cluster sampling method. The adequacy of the sample size was estimated at 0.952, based on the Kaiser-Meyer-Olkin (KMO) Kaiser Mayer Olkin index. The collected data were analyzed by SPSS 22 software. An exploratory factor analysis was used to explore and evaluate the dimensions of the model through a mathematical approach. The internal consistency of dimensions was estimated through Cronbach's alpha. In the last step, confirmatory factor analysis was utilized to verify the model, using AMOS 24 software.

RESULTS

According to the literature review, five countries were selected, including Norway, the United Kingdom (UK), Japan, Malaysia, and Turkey, and seven factors were identified including policy making, organizational structure, control, financing, governance grants, services, and members component. Table 1 provides an overview of the key characteristics of active ageing management in the selected countries. After comparative study, one more factor was added to the name of selected area to focus. In exploratory factor analysis, to categorize the items among the factors, based on their factor load, the rotated component matrix results were used.

Table 2 shows the correlation matrix between items and factors rotation, in which the correlation value varies from -1 to +1. Based on this table, the researcher, based on the largest factor load of each item, classified them according to the degree of correlation with each other. Classification of variables (items) in factors is usually based on the first variable of the factors and its implicit meaning. The Eigen values of the first and eight factors were 14.225 and 7.225, respectively. Besides, these eight factors could explain approximately 73.25% of the variance in the variables.

TABLE1- THE RESULTS OF LITERATURE REVIEW ON ACTIVE AGING MANAGEMENT IN SELECTED COUNTRIES

		FINANCING	MEMBER COMPONENT	SERVICES	GOVERNANCE	ORGANIZATIONAL STRUCTURE	CONTROL	POLICY MAKING	COUNTRIES	NO.
		*		*			*		The United Kingdom (UK),	1
		*	*			*	*		Norway	2
		*	*	*	*	*	*	*	Japan	3
		*	*	*	*	*	*	*	Malaysia	4
		*			*	*		*	Turkey	5

TABLE2- ROTATIONAL CORRELATION MATRIX AMONG ITEMS, ENGINE VALUES AND TOTAL VARIANCE EXPLAINED BY EACH FACTOR

ITEM	FACTOR 1	ITEM	FACTOR 2	ITEM	FACTOR 3	ITEM	FACTOR 4	ITEM	FACTOR 5	ITEM	FACTOR 6	ITEM	FACTOR 7	ITEM	FACTOR 8
q 3	0.821	q 5	0.715	q 10	0.660	q 14	0.632	q 19	0.697	q 21	0.547	q 25	0.536	q 32	0.497
q 1	0.814	q 7	0.713	q 11	0.653	q 15	0.600	q 17	0.634	q 22	0.542	q 24	0.532	q 37	0.492
q 4	0.803	q 9	0.702	q 12	0.620	q 16	0.584	q 20	0.612	q 23	0.540	q 26	0.530	q 33	0.487
q 2	0.792	q 6	0.690	q 13	0.619			q 18	0.604			q 27	0.527	q 36	0.471
		q 8	0.681									q 30	0.522	q 34	0.462
												q 28	0.517	q 35	0.450
												q 29	0.515	q 39	0.448
												q 31	0.502	q 38	0.431
														q 40	0.420
														q 41	0.409
total	14.225		14.036		13/125		12.136		11.096		10.174		6.854		7.226
% variance	14.902		12.851		11.236		10.337		9.897		8.574		7.365		6.251
%cumulative	14.902		16.262		28.842		32.230		38.147		54.415		67.321		73.025

As it can be seen in Table 3, the items and factors of the research are categorized into eight factors and 41 items. Confirmatory factor analysis in AMOS24 software was used to confirm the final model. The findings related to fitting indices (Chi-square/df (χ^2/df), Goodness of fit index (GFI), Adjusted Goodness of Fit Index (AGFI), Normed fit index (NFI), comparative fit index (CFI), Parsimony comparative fit index (PCFI), and Root mean square error of approximation (RMSEA)), were all optimal and approved the model with five dimensions for the hospital holding

governance. Table 3 demonstrates the fitting indices of the model.

Figure 1 and Table 4; represent the active aging management model with eight factors. The dimensions of policy making, organizational structure, control, financing, governance grants, services, members component, and selected area to focus consisted of four, four, five, four three, three, eight, and 10 items, respectively.

TABLE3- FITTING OF MODEL ON ACTIVE AGING MANAGEMENT

	STATUS OF INDEX	ESTIMATED VALUE	OPTIMAL VALUE	STATISTICS
	√	4.163	Between 2 and 5	χ^2/df
	√	0.028	<0.08	RMSEA
	√	0.906	0.9>	GFI
	√	0.915	0.9>	AGFI
	√	0.927	0.9>	CFI
	√	0.945	0.9>	NFI
	√	0.661	0.6>	PCFI

In this model, there was a significant direct relationship between all factors and active aging management. Also, the highest and lowest standard coefficients were

attributed to financing and decision rights, with factor loadings of 0.83 and 0.44, respectively.

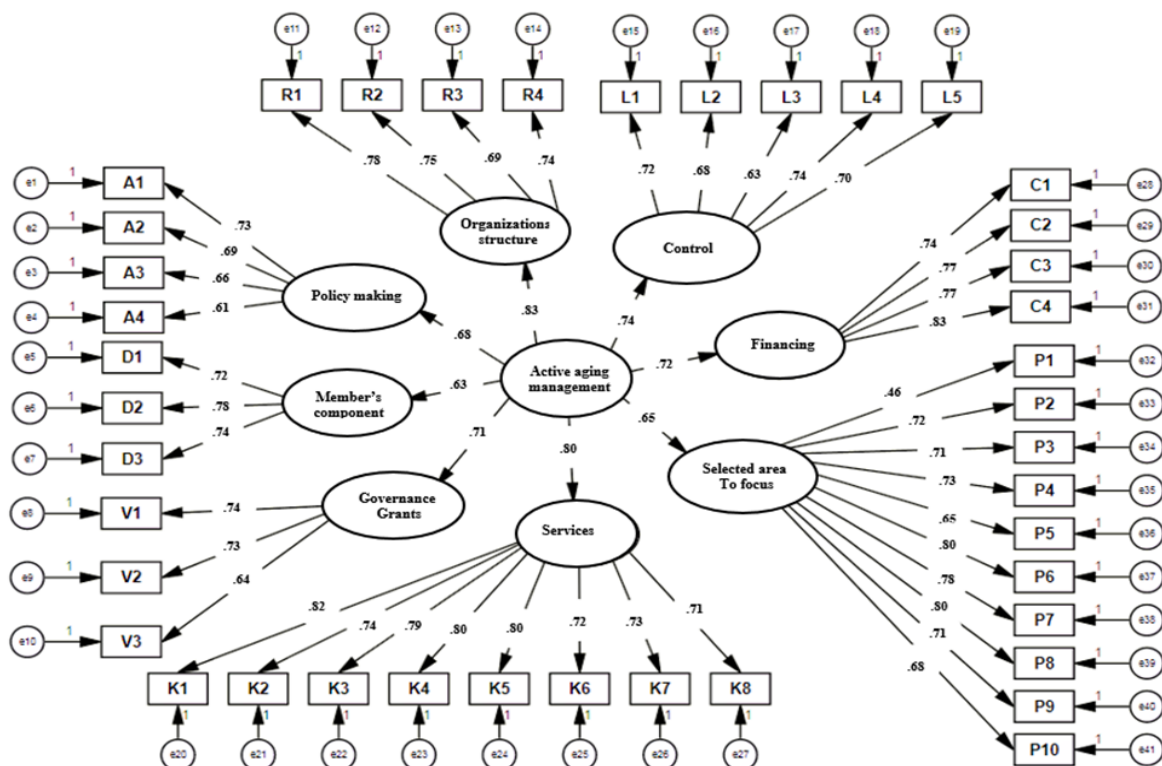
TABLE 4- FACTORS AND SUB-FACTORS OF ACTIVE AGING MANAGEMENT

STATUS	STANDARD COEFFICIENT	SUB- FACTORS	ITEMS	STANDARD COEFFICIENT	FACTORS
√	0.73	Formation of the High Council on Aging	A1	0.684	Policy making
√	0.69	Ministry of Health and Medical Education	A2		
√	0.66	Ministry of Cooperatives, Labor and Social Welfare	A3		
√	0.61	Ministry of Education	A4		
√	0.72	National Strategic Plan of the Elderly	L1	0.742	control
√	0.68	Developing an Active Aging Law	L2		

√	0.63	Developing Active Aging Regulations (Proposed at Ministries Level)	L3		
√	0.74	National Strategic Plan of the health and welfare of the Elderly	L4		
√	0.70	Develop national policies and operational plans based on valid needs assessment	L5		
√	0.78	Decentralized Organizational Structure: Establishing Secretariat of the National Council on Aging at the Capital Level and Establishing General Offices in Welfare Offices in the Provinces	R1	0.832	Organizational structure
√	750/	Council consisting of Ministries of Health and Medical Education and Ministries of Cooperatives, Labor and Social Welfare	R2		
√	0.69	Forming a council consisting of relevant ministries at the state level and delegating to municipalities at the local level	R3		
√	0.74	Formation of the National Council of State and formation of secretariats at the level of deputy governor	R4		
√	0.72	The current composition of the Iranian National Council on Aging,	D1	0.633	members component
√	0.78	The formation of an aging council chaired by the first vice president and all members of the cabinet	D2		
√	0.74	Forming a policy council chaired by the Minister of Health, Health and Medical Education plus the Ministers of Co-operation, Labor and Social Welfare and the Ministers of Education	D3		
√	0.74	Allocate sufficient funds to the Ministries of Health and Medical Education and Cooperatives, Labor and Social Welfare the Ministries of	C1	0.715	financing
√	0.77	Financing from municipalities	C2		
√	0.88	Allocate Social Security Resources plus Pension Funds	C3		
√	0.83	Creating a special insurance plan with the participation of citizens over 40years old	C4		
√	0.74	Subsidies for people over 60	V1	0.707	governance grants
√	0.73	Payment of insurance and tax quotas from the state budget to social security	V2		
√	0.64	Paying elderly health insurance	V3		
√	0.82	Non-participation pension payment to the elderly	K1	0.800	services

√	0.74	Discount Cards for Transportation	K2		
√	0.79	Discount cards for recreational and sports centers	K3		
√	0.80	Perform free health check-ups and outpatient services	K4		
√	0.80	Establishment of hospitals and clinics for the elderly	K5		
√	0.72	Providing long-term care insurance to the elderly	K6		
√	0.73	Creating mobile care services	K7		
√	0.71	Creating a college education plan	K8		
√	0.46	Lifelong Learning	P1		
√	0.72	"Health literacy	P2		
√	0.71	Housing	P3		
√	0.73	Urbanization and Adaptation of Spaces	P4		
√	0.65	Leisure planning	P5		
√	0.80	Nutrition	P6		
√	0.78	mental health	P7		
√	0.80	Employment	P8		
√	0.71	Income security	P9		
√	0.68	Community attitude	P10		

FIGURE 1: MODEL OF ACTIVE AGING MANAGEMENT FOR IRAN



DISCUSSION

This study provides a framework for identifying the factors affecting the management of active ageing. The results showed that the model of the active ageing management had eight factors, including policy making, organizational structure, members component, control, financing, governance grants, services, and selected area to focus. The organizational structure, with a factor loading of 0.83, was the most important factor affecting active aging management, followed by services with a factor loading of 0.80. The factors of control, financing, governance grants, policy making, selected area to focus, and members component with factor loadings of 0.74, 0.71, 0.70, 0.68, 0.65 and 0.63 were in the third, fourth, fifth, sixth, seventh, and eight places, respectively.

The finding of the study indicated the importance of policy making on active ageing management. In a study conducted by Haghshenas [22], evaluation in policymaking in the field of senior management as the main perspectives of the relevant institutions has been emphasized and in the present study the above factor is also mentioned. In this regard, from Ahmadi Teimorloo's [20] point of view, at present, the issue of stewardship is neglected in the health of the elderly and is not one of the priorities of the country which is in line with this study. The government, as the country's executive and policymaker, by forming and attending the High Commission on Ageing, has an important role to play in active ageing management.

The finding of the study showed the importance of control on active ageing management. Ahmadi Teimorloo's [20] study adopted national laws and regulations to control elderly health issues which included 11 policies that did not pay much attention to the necessary dimensions and components of the policy content, which give credence to the results of the present study. According to Zeinalhajju et al. [4] organizing elderly affairs have no legal support and the creation of laws and regulations are proposed for the protection of the elderly by related organization. Also, according to the Riahi's [6] study, a review of the laws and regulations on aging is needed to improve their economic and social position. It is not enough just to adopt laws and policies, but implementation of them is more important, and the government must adopt long-term planning, laws, policies.

In the result of this study establishing coordinated organization to plan and direct activities, related to elderly as a strategic measure to improve elderly support services is necessary, and it is in line with results of the present study. In a study conducted by Palombo [23], collaboration between organizations and the establishment of formal organizations is a key pillar of advocacy for the elderly.

The finding of the study showed the importance of member component on active ageing management. Some studies such as Vogeli and Haghshenas [22,24], in developing countries, there is a need for the involvement of various public and private organizations, but in the present study, non-governmental organizations have not been involved at least in macro policy-making.

The findings of this study indicated the importance of financing on active ageing management.[25]. Ahmadi Teimorloo [20] and Alizadeh et al. [26] proposed insurance policy and service financing. Boyle et al. [27] study, establishing financial stability for the elderly is one of the top priorities of efforts to support the elderly. Jhala and Christian (4)'s study, stated that the financial needs of the elderly must be included in the policies and plans for the elderly. Therefore, sufficient financial support with no concern about daily expenses and future medical expenses is a prerequisite for a good old age. Based on the results of study, government grants on active ageing management is very important. [29] Studies by Jacobs et al. [30] have emphasized the need for preventive measures by government for the whole population (including the elderly) that could lead to a decline in chronic disease. They have proposed the implementation of essential measures in the area of provision of insurance services and free treatment of the elderly by the responsible authorities. One of the executive policies of the government to fund the elderly is the use of targeted subsidies, which is mentioned in the national elderly document.

The finding of the study indicated the importance of providing services on active ageing management. Considering Mohammadi et al.'s [29] research, the formulation of formal and informal policies by the government to establish welfare structures and health-based services for the elderly can lead to the improvement of family quality.

So we can say older people's health plans should focus on meeting the needs of the elderly with a balanced approach which are consistent with the present study. According to previous studies, measures for the elderly in Iran are not adequate and appropriate, and not taking into account the priorities and needs based on the experiences of advanced countries in the near future will lead the country to economic, social and health crisis. The findings of the present study showed alignment with those of Jaleh and Christian [28], who believe that ageing policies and programs should focus on health protection, the labor market, employment, lifelong education, and social support.

CONCLUSION

The results of this study showed those factors, including policy making, organizational structure, members' component, control, financing, governance grants, services, and selected area to focus had an influence on the active ageing management. Therefore, based on the proposed research model, the first step should be to form a High Council of Ageing with the presence of the President's representative and to set policy, plans, and policy priorities in accordance with surveys and need assessment of the elderly. Then, in the second step, the specific funding for the elderly, purely as the elderly (not as retired, needy, disabled, rural or...) as well as the duties of the government and related organizations at each specified level should be determined with responsibility and the scope of their activity and should be precisely defined to ensure implementing decisions. In the final step, which is the implementation phase, with the help of government agencies and other relevant agencies, the elderly are exposed to a variety of services and supports in various individual, economic, and social areas. The results of the present study can be used in countries that are economically, socially, and culturally similar to Iranian conditions and in other countries, due to the impact of these variables, must be done based on the specific need assessment of the communities.

ACKNOWLEDGEMENTS

This article has been obtained from the PhD thesis of Zeinab Gholipour. We thank Department of Health Services Management, Science and Research Branch, Islamic Azad University.

FUNDING

No cases reported

CONFLICT OF INTEREST STATEMENT

The authors confirm that this article content has no conflict of interest.

References

1. Sander M, Oxlund B, Jespersen A, Krasnik A, Mortensen EL, Westendorp RGJ, et al. The challenges of human population ageing. *Age and ageing*. 2014;44(2):185-7.
2. Ogura S, Jakovljevic MM. Global Population Aging-Health Care, Social and Economic Consequences. *Frontiers in public health*. 2018; 6:335.
3. Tehrani H, Vahedian Shahroodi M, Fadayevatan R, Abusalehi A, Esmaeili H. Mental Health Status and its Related Factors in Elderly People Residing in Nursing Homes of Mashhad, Iran. *Journal of Health and Development*. 2017;6(3):171-81.
4. Zeinalhajlu AA, Amini A, Tabrizi J-S. Consequences of population aging in Iran with emphasis on its increasing challenges on the health system (literature review). *Depiction of Health*. 2015;6(1):8.
5. Kiani S, Bayanzadeh M. The Iranian population is graying: are we ready? *Archives of Iranian medicine*. 2010;13(4):333.
6. Riahi ME. A Comparative Study on the Status of Elderly in the Traditional and Modern Societies. *Iranian Journal of Ageing*. 2008;3(3):10-21.
7. Illario M, Vollenbroek-Hutten M, Molloy DW, Menditto E, Iaccarino G, Eklund P. Active and healthy ageing and independent living. *Journal of aging research*. 2015;2015.
8. Organization WH. *Active ageing: A policy framework*.: Geneva: World Health Organization; 2002.
9. Organization WH. *World report on ageing and health*: World Health Organization; 2015.
10. Liotta G, Canhao H, Cenko F, Cutini R, Vellone E, Illario M, et al. Active ageing in Europe: adding healthy life to years. *Frontiers in medicine*. 2018; 5:123.
11. Nations GU. *Introducing the active aging index: Policy brief*. European Commission and the United Nations Economic Commission for Europe (UNECE). 2013.

12. Lunenfeld B. The ageing male: demographics and challenges. *World journal of urology*. 2002;20(1):11-6.
13. Mendoza-Ruvalcaba NM, Fernández-Ballesteros R. Effectiveness of the Vital Aging program to promote active aging in Mexican older adults. *Clinical interventions in aging*. 2016; 11:1631.
14. Walker A. Active ageing in employment: Its meaning and potential. *Asia-Pacific Review*. 2006;13(1):78-93.
15. Foster L, Walker A. Gender and active ageing in Europe. *European Journal of Ageing*. 2013;10(1):3-10.
16. Shoaei F, Nejati V. Elderly-caring service pattern in USA comparing with IRAN. *Iranian Journal of Ageing*. 2008;3(1):68-77.
17. Foster L, Walker A. Active and successful aging: A European policy perspective. *The Gerontologist*. 2014;55(1):83-90.
18. Singh B, Kiran U. Recreational activities for senior citizens. *IOSR J Human Soc Sci*. 2014;19(4):24-30.
19. Raju M. Population Ageing and the Elderly. *Indian journal of psychiatry*. 2018;60(Suppl 3): S295.
20. A AT. Analyzing the health policies of the elderly in the country and providing a model (Phd) 2013.
21. Reisi M, Javadzade SH, Mostafavi F, Sharifirad G, Radjati F, Hasanzade A. Relationship between health literacy, health status, and healthy behaviors among older adults in Isfahan, Iran. *Journal of education and health promotion*. 2012;1(1):31.
22. Haghshenas N. Assessing the sociodemographic policies of active aging and challenges ahead in Iran. *Marifat Frhangi Ejtemaii Journal*. 2013;4(1):101-20.
23. Palombo R, Alongi J, Goldman A, Greene R, Lambert T, Smith S. Opportunities for collaboration: linking public health and aging services networks. *Generations*. 2005;29(2):48-53.
24. Vogeli C, Shields AE, Lee TA, Gibson TB, Marder WD, Weiss KB, et al. Multiple chronic conditions: prevalence, health consequences, and implications for quality, care management, and costs. *Journal of general internal medicine*. 2007;22(3):391-5.
25. MacLeod S, Musich S, Hawkins K, Armstrong DG. The growing need for resources to help older adults manage their financial and healthcare choices. *BMC geriatrics*. 2017;17(1):84.
26. Alizadeh M, fakhrzadeh H, Sharifi F, Mohamadiazar M, Nazari N. Analytical performance of administrations in charge of ageing program in Iran. *Iranian Journal of Diabetes and Lipid Disorders*. 2013;13(1):74-81.
27. Boyle PA, Yu L, Wilson RS, Segawa E, Buchman AS, Bennett DA. Cognitive decline impairs financial and health literacy among community-based older persons without dementia. *Psychology and aging*. 2013;28(3):614.
28. Jhala N, Christian A. Active aging. *International Journal of Humanities and Social Science Invention (IJHSSI)*. 2013;2(1):1-4.
29. mohammadi f, dabbaghi f, Nikravesh M. Facilitator and Barriers Factors in Family Caregiving Process of Iranian Frail Elderly: Qualitative study. *Iran Journal of Nursing*. 2008;21(55):55-65.
30. Jacobs B, Hill P, Bigdeli M, Men C. Managing non-communicable diseases at health district level in Cambodia: a systems analysis and suggestions for improvement. *BMC health services research*. 2015;16(1):32.