



Letter to Editor

The Urban Family Physician Program as a Platform for Integrated Healthy Ageing in Iran

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Population ageing is one of the major health system challenges of the twenty-first century. By 2030, one in six people worldwide will be aged 60 years or older, and this proportion is expected to increase substantially by 2050 (1). Similar to many middle-income countries, Iran is experiencing a rapid demographic transition, with a growing proportion of older adults expected in the coming decades (2). This demographic shift is associated with increasing multimorbidity, functional decline, and complex care needs that require continuous, coordinated, and person-centered care rather than episodic service delivery (2). The World Health Organization has emphasized strong primary health care (PHC) as the foundation of healthy ageing. Therefore, health systems must shift from episodic, acute-care models toward integrated primary care approaches that support long-term management of chronic conditions and preserve functional ability among older adults (3, 4).

Iran has made important progress by developing care service packages for older adults within its PHC system, including preventive services, health promotion, chronic disease management, and routine screening for older adults (5, 6). However, before the implementation of the Urban Family Physician Program in urban areas, care for older adults faced challenges related to fragmentation and limited coordination across levels of care. Although Iran had developed a three-tier referral structure, mechanisms for ensuring continuous geriatric care coordination, referral feedback, and multidisciplinary collaboration had not been fully established (7, 8). Consequently, continuity of care was limited, and follow-up of older adults with multimorbidity by family physician-led teams was inconsistent, communication and referral feedback between levels of care were suboptimal, and multidisciplinary collaboration remained challenging (7, 9). These challenges were not solely related to referral mechanisms but also reflected broader gaps in care coordination, information exchange, geriatric-specific care processes, and implementation capacity across healthcare settings (5, 8). These long-standing gaps limited the effective translation of existing care policies for older adults into coordinated, continuous, and person-centered care. The implementation and further development of the Urban Family Physician Program provide a timely opportunity to address these long-standing gaps by establishing an integrated primary care platform capable of delivering coordinated, continuous, and person-centered care for older adults across the continuum of care. Family medicine represents the operational backbone of PHC in ageing societies by providing first-contact care, ensuring continuity, coordinating services, and supporting comprehensive management of chronic conditions (10). The Urban Family Physician Program has the potential to operationalize these principles by strengthening integrated care for older adults. However, its effectiveness will depend on building on the existing three-tier referral structure by embedding coordinated care pathways supported by standardized geriatric protocols, clearly



defined responsibilities, and effective communication between primary and specialist services (10). These pathways should be developed by the Iran's Ministry of Health and Medical Education, in collaboration with geriatric experts, family physicians, specialist societies, and primary health care managers, drawing on national clinical guidelines and the WHO ICOPE framework (4).

Their integration into the Urban Family Physician Program should be achieved through standardized referral criteria, shared clinical documentation, clearly assigned responsibilities across different levels of care, and structured communication mechanisms between primary and specialist services. Implementation should be monitored by the Ministry of Health and Medical Education and relevant primary healthcare authorities using predefined process, quality, and outcome indicators, with periodic evaluation of care processes, referral patterns, continuity of care, and health outcomes among older adults.

The integration of standardized geriatric care pathways into the existing referral system would help ensure continuity across primary, secondary, tertiary, and social care services. The care service packages for older adults at the secondary care level should be developed as a continuation of and complement to services delivered at the primary care level. Clearly defined roles and responsibilities, shared geriatric clinical protocols, and effective two-way communication between family physicians and specialists are essential to ensure continuity of care and avoid fragmented or duplicated services. Such an integrated approach would enable older adults to receive coordinated, person-centered care throughout the entire continuum of care.

Implementation of the program requires competency-based training for the entire health workforce, including family physicians, specialists, nurses, allied health professionals, and multidisciplinary primary care teams. Particular attention should be given to private-sector providers participating in the Urban Family Physician Program to ensure consistent implementation of standardized geriatric care pathways and equitable quality of care across public and private sectors. Active engagement of private providers in the design, implementation, and continuous evaluation of care services for older adults will be essential for ensuring feasibility, acceptability, sustainability, and consistent standards of care.

Moreover, electronic health record and referral systems supported by shared health information and standardized clinical documentation guidelines should be progressively implemented across all levels of care. Such systems would facilitate continuity of care, strengthen communication between family physicians and specialists, enable longitudinal follow-up of older adults, and support quality improvement through routine monitoring of care processes and outcomes.

Finally, public primary health care centers, private family physician clinics, specialist outpatient clinics, and referral hospitals should progressively adopt age-friendly service standards to improve accessibility, communication, safety, responsiveness, and the overall care experience for older adults. Taken together, these policy actions provide a practical roadmap for strengthening healthy ageing within Iran's evolving Urban Family Physician Program. Achieving healthy ageing will require more than expanding access to

family physicians. It will depend on integrating standardized geriatric care pathways, strengthening collaboration between primary and specialist services, developing workforce capacity, implementing shared health information systems, and progressively adopting age-friendly health services across the health system.

By positioning the Urban Family Physician Program as a platform for integrated, person-centered care for older adults rather than merely a referral mechanism, Iran can bridge the policy-to-practice gap and develop a more responsive primary health care system for its rapidly ageing population. Lessons from this experience may also inform other middle-income countries facing similar demographic transitions, epidemiological changes, and health system challenges.

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