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Title: Rehabilitation for Iran's Aging Population: From Policy Fragmentation to Integrated Primary Care

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Dear Editor-in-Chief,

The demographic signal is unambiguous. According to the World Bank's World Development Indicators, the share of Iran's population aged 65 and above rose from 7.92% in 2023 to 8.58% in 2025, and the absolute number of older adults has been increasing by approximately 5% per year (1). This is not a distant projection; it is the present reality of every rehabilitation clinic, hospital ward, and community health center in the country (2). Yet the service system has not kept pace. A recent qualitative situation analysis concluded bluntly that the integration of rehabilitation services for older adults into Iran's primary healthcare system has not yet been achieved. This is not a marginal gap. It is a structural failure that will define the health trajectory of millions of Iranians unless it is addressed with deliberate, coordinated policy action (3).

The barriers are well documented and mutually reinforcing. In a narrative review using a systematic search strategy, the authors searched MagIran, SID, IranDoc, PubMed, Scopus, ScienceDirect, and Google Scholar for studies published between 2008 and 2024; of 98 retrieved records, 23 studies met the inclusion criteria (15 Iranian and 8 international). Original quantitative or qualitative studies addressing barriers to geriatric rehabilitation were included. This study classified the challenges of geriatric rehabilitation into seven domains: structural factors such as inadequate infrastructure and lack of specialized equipment; behavioral factors such as poor communication and elder mistreatment; educational factors such as insufficient staff training and low health literacy; socio-economic factors such as inadequate insurance coverage and high out-of-pocket costs; functional factors such as ineffective referral systems and poor primary care implementation; governance and leadership factors such as fragmented policies and lack of coordination; and self-care limitations. Financial barriers and process-related obstacles were the most frequently reported, and the study rightly calls for strengthening community-based integrated rehabilitation models, expanding insurance coverage, and addressing governance fragmentation (4). These findings are not abstract. A recent policy brief documented that older adults face limited availability of geriatric services, inadequate physical infrastructure, financial constraints, transportation difficulties, insufficient awareness of available services, and low trust in public health centers. These barriers interact with one another. An older adult who cannot afford transport will not attend a rehabilitation session even if the service is nominally free; a family that does not know that community-based rehabilitation exists will not seek it; and a primary care provider who has never received geriatric rehabilitation training will not refer a patient who could benefit from it (5).

The equity dimension is equally troubling. In a study that examined inequality in access to rehabilitation services, a 2025 analysis revealed that disparities are more pronounced among older

adults relative to younger people, and among uninsured individuals and those with severe impairments. In other words, the older adults who are most in need of rehabilitation, including those with severe functional limitations, those without financial protection, and those living in underserved areas, are precisely the ones least likely to receive it. This is not merely an inefficiency; it is an equity failure that should concern every rehabilitation professional in Iran (6). The human cost extends beyond the older adult. In a qualitative study of 14 family caregivers of older adults with dependency in activities of daily living (11 women and 3 men, recruited purposively from two rehabilitation centres in Alborz Province), 31% of caregivers reported depressive symptoms and nearly 50% reported caregiver burden. These are study-specific findings rather than national estimates, but they illustrate the psychological cost borne by families. In the Iranian context, where family support is a cultural strength but also an unacknowledged care infrastructure, the rehabilitation system's failure to support older adults is silently transferred onto the shoulders of family members, disproportionately women, who are themselves aging and often lack training, respite, or financial recognition (7).

There are, however, genuine opportunities that should not be overlooked. The same situation analysis that documented the system's weaknesses also identified substantial strengths: Iran's primary healthcare system has broad urban and rural coverage, an existing workforce of community health workers, the SIB information infrastructure, and relatively favorable financial access at the primary level. The study highlights the potential for community-based and telerehabilitation services, the Ministry of Health's Office for Older Adults, and the family physician programme as vehicles for integration. It recommends strengthening preventive and community-based rehabilitation, empowering the workforce through modular and interdisciplinary training, expanding telerehabilitation, and systematically integrating rehabilitation into the family physician programme (3). These are not utopian proposals. They build on existing capacities and avoid the costly, hospital-centric solutions that have failed elsewhere.

Telerehabilitation deserves particular attention, but also particular caution. Iranian studies are exploring its potential for older adults, including elderly chemical veterans and those with chronic musculoskeletal conditions. Yet the evidence also shows that insufficient technological infrastructure and limited digital health competencies, especially among older adults with low digital literacy, continue to hinder equitable access. A practical mitigation would be to pair telerehabilitation rollout with a structured digital facilitator role, delivered by trained family caregivers or community health workers, alongside short, older-adult-specific training modules. This would reduce reliance on ad hoc assistance from younger relatives and extend equitable access to older adults without a digitally literate household member. If telerehabilitation is scaled without parallel investment in digital literacy, device

access, and caregiver support, it risks becoming a solution for the urban, educated, and digitally connected, while leaving behind the rural, the poor, and the oldest-old, precisely the populations with the greatest rehabilitation needs (8).

What, then, should be done? Four interconnected priorities for the rehabilitation and gerontology communities in Iran are proposed.

First, rehabilitation for older adults must be explicitly integrated into primary healthcare, not treated as a specialist add-on (9). The family physician programme provides a ready platform, but integration requires more than a policy declaration. It requires standardized referral pathways, shared information systems, and clear role definitions for community health workers, nurses, and rehabilitation professionals. The SIB infrastructure offers a foundation, but it must be used to track functional trajectories, not merely to record encounters.

Second, the rehabilitation workforce must be trained in geriatric competencies (10). The shortage and maldistribution of rehabilitation professionals is a documented threat to integration. But numbers alone are insufficient. Modular, interdisciplinary training in geriatric assessment, fall prevention, cognitive rehabilitation, and caregiver support should be embedded in pre-service and continuing education for nurses, primary care physicians, physiotherapists, occupational therapists, and community health workers. The evidence on fall prevention and balance training in Iranian older adults is growing, and it should inform curricula and practice.

Third, financial protection must be extended to rehabilitation services (11). The current inadequacy of insurance coverage for rehabilitation is a recurring finding across studies. Out-of-pocket costs push rehabilitation into the realm of luxury for many older Iranians, while long-term care costs, including home nursing and specialized rehabilitation, have risen to levels that even middle-class families cannot sustain. Expanding insurance coverage for community-based and home-based rehabilitation is not only a matter of equity; it is a cost-containment strategy, because untreated functional decline leads to avoidable hospitalization and institutionalization.

Fourth, the mental health and caregiver dimensions of rehabilitation must be brought into the mainstream (12). Rehabilitation is not only about physical function. Depression, anxiety, social isolation, and caregiver burnout are integral to the rehabilitation trajectory of older adults. Mobile-based digital cognitive behavioral therapy and family-centered empowerment interventions have shown promise in Iranian older populations, and they should be considered part of the rehabilitation continuum, not a separate domain. Caregivers are co-producers of rehabilitation outcomes; failing to support them is failing the older adult.

A localized implementation model would not require a new vertical programme. It would use the Urban Family Physician Program as the entry point and care-coordination hub, with family physician teams conducting routine functional screening and initiating referral. The SIB infrastructure would be repurposed to track functional trajectories, flag missed referrals, and generate feedback to referring teams. Community health workers, working under physiotherapy and rehabilitation supervision, would deliver home-based exercise and caregiver training modules in both rural and urban catchments. The Ministry of Health's Office for Older Adults would provide governance, set minimum geriatric rehabilitation competencies for pre-service and continuing education, and convene the intersectoral coordination that fragmented policies currently lack. Financing reform would follow the same layered logic: basic insurance coverage for community-based and home-based rehabilitation, with cost-containment justified by avoided hospitalisation and institutionalisation. This model builds on platforms that already exist, which is precisely why it is feasible.

In summary, the rehabilitation needs of Iran's older adults can no longer be treated as a peripheral concern of an aging society. They are a central test of whether the health system can adapt to the demographic reality already unfolding. The four priorities outlined here, namely integration into primary healthcare, geriatric competency in the workforce, financial protection, and attention to mental health and caregivers, offer a practical and interconnected agenda. None of them requires a new system to be built from scratch. Each requires existing capacities to be used more deliberately, more equitably, and more accountably. The rehabilitation and gerontology communities now have an opportunity to move from documenting gaps to shaping solutions. This journal can support that transition by encouraging evidence that links service delivery, workforce development, financing, and technology to the lived needs of older Iranians and their families. The cost of delay is measured not only in functional decline and avoidable hospitalization, but in preventable suffering and deepening inequity.

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