



## INCLUSIVE CARE MODELS ELDERLY HEALTHCARE: A SYSTEMATIC LITERATURE REVIEW

### MODEL PELAYANAN KESEHATAN LANSIA YANG INKLUSIF: TINJAUAN LITERATUR SISTEMATIS

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#### Abstract

This study applied a Systematic Literature Review (SLR) to identify, appraise, and synthesize open-access empirical evidence on inclusive care models in elderly healthcare. The review followed PRISMA 2020 and searched PubMed, Scopus, Web of Science, DOAJ, and Google Scholar for studies published between 2015 and 2025. Eligible articles were original research (quantitative, qualitative, or mixed methods) focusing on service delivery or care models for older adults and explicitly addressing inclusivity, integration, person-centeredness, or collaborative care, with full-text availability in English or Indonesian. From 1,280 records, 1,010 unique articles were screened, 80 full texts were assessed, and 10 studies were included in the final synthesis. Across studies, inclusive elderly care was most consistently implemented through integrated, person-centred, team-based delivery combining comprehensive assessment, individualized care planning, coordinated follow-up, and cross-sector collaboration. Stronger benefits were typically observed among frail older adults when care intensity was aligned with complex needs by risk stratification and case management. Mental health integration emerged as a critical component for community-dwelling older adults, supporting the integration of psychological care into routine elderly healthcare pathways rather than parallel programs. Evidence from institutional settings indicated that partnership-based models involving nurses, caregivers, and older adults can improve functional outcomes. Overall, the findings support scaling integrated community and institutional partnership approaches, while future research should strengthen reporting on implementation fidelity, equity impacts, and cost-effectiveness to guide sustainable adoption of inclusive, gerontic-friendly care models.

**Keywords :** Elderly Healthcare, Inclusive Care, Systematic Literature Review.

#### Abstrak

Penelitian ini menerapkan Systematic Literature Review (SLR) untuk mengidentifikasi, menilai, dan mensintesis bukti empiris open-access mengenai model perawatan inklusif dalam layanan kesehatan lansia. Tinjauan ini mengikuti pedoman PRISMA 2020 dan menelusuri PubMed, Scopus, Web of Science, DOAJ, serta Google Scholar untuk studi yang dipublikasikan antara tahun 2015 hingga 2025.



Artikel yang memenuhi kriteria adalah penelitian original (kuantitatif, kualitatif, atau mixed methods) yang berfokus pada penyelenggaraan layanan atau model perawatan bagi orang dewasa lanjut usia serta secara eksplisit membahas inklusivitas, integrasi, person-centeredness, atau perawatan kolaboratif, dengan ketersediaan teks lengkap dalam bahasa Inggris atau Indonesia. Dari 1.280 rekaman, 1.010 artikel unik disaring, 80 artikel teks lengkap dinilai, dan 10 studi dimasukkan dalam sintesis akhir. Pada berbagai studi, perawatan lansia yang inklusif paling konsisten diimplementasikan melalui layanan terintegrasi, berpusat pada individu, dan berbasis tim yang menggabungkan asesmen komprehensif, perencanaan perawatan yang terindividualisasi, tindak lanjut terkoordinasi, serta kolaborasi lintas sektor. Manfaat yang lebih besar umumnya terlihat pada lansia yang rentan ketika intensitas layanan disesuaikan dengan kebutuhan yang kompleks melalui stratifikasi risiko dan manajemen kasus. Integrasi kesehatan jiwa muncul sebagai komponen krusial bagi lansia yang tinggal di komunitas, yang mendukung pengintegrasian perawatan psikologis ke dalam jalur pelayanan kesehatan lansia rutin, bukan sebagai program paralel. Bukti dari setting institusi menunjukkan bahwa model berbasis kemitraan yang melibatkan perawat, caregiver, dan lansia dapat meningkatkan luaran fungsional. Secara keseluruhan, temuan ini mendukung perluasan pendekatan terintegrasi berbasis komunitas dan kemitraan di institusi, sementara penelitian mendatang perlu memperkuat pelaporan terkait ketepatan implementasi, dampak kesetaraan, dan cost-effectiveness untuk memandu adopsi berkelanjutan model perawatan yang inklusif dan ramah lansia.

**Kata Kunci :** Layanan Kesehatan Lansia, Perawatan Inklusif, Tinjauan Pustaka Sistematis.

## 1. INTRODUCTION

Population ageing has become one of the most significant global demographic transformations of the twenty-first century. According to the World Health Organization (WHO), the proportion of people aged 60 years and older is increasing faster than any other age group, with the global elderly population expected to double by 2050. This demographic shift presents profound challenges for healthcare systems, particularly in addressing the complex, long-term, and multidimensional health needs of older adults. Ageing is frequently accompanied by multimorbidity, functional decline, cognitive impairment, and increased vulnerability to social exclusion, all of which necessitate healthcare approaches that extend beyond conventional disease-centered models (World Health Organization, 2015).

Traditional healthcare systems are often structured around acute, episodic care, which may be insufficient to address the chronic, progressive, and interrelated health issues commonly experienced by older populations. Fragmentation of services, poor coordination between health and social care sectors, and limited attention to psychosocial and environmental determinants of health have been identified as persistent barriers to optimal elderly care. As a result, there has been growing international recognition of the need for inclusive care models that are capable of delivering comprehensive, coordinated, and person-centered services for older adults (Briggs et al., 2018).

Inclusive care in elderly healthcare refers to approaches that acknowledge and respond to the diversity of older populations while ensuring equitable access to quality services. Inclusivity encompasses not only physical accessibility but also cultural sensitivity, social participation, respect for autonomy, and responsiveness to individual preferences and life contexts. Inclusive care models seek to integrate medical care with social support,



rehabilitation, prevention, and community-based services, thereby addressing the broader determinants of health that shape ageing experiences (World Health Organization, 2017).

One of the most prominent frameworks supporting inclusive elderly care is person-centered care. This approach emphasizes respect for individual values, shared decision-making, and active involvement of older adults in planning and managing their care. Evidence from systematic reviews indicates that person-centered care can improve patient satisfaction, enhance perceived quality of care, and support better functional and psychosocial outcomes among older people living in both community and institutional settings (Santana et al., 2018). By shifting the focus from disease management to holistic well-being, person-centered care aligns closely with principles of inclusivity.

Integration is particularly important for older adults with multiple chronic conditions who frequently interact with various providers and care settings. Community-based and home-based care models further contribute to inclusivity by enabling older adults to receive services in familiar environments, thereby supporting independence and social participation. Evidence suggests that home-based interventions and community support programs can reduce hospital admissions, delay institutionalization, and improve quality of life among older adults (Ebrahimi et al., 2021). These models often rely on collaboration between healthcare professionals, family caregivers, and community organizations, reinforcing social networks that are essential for healthy ageing.

Despite growing evidence supporting inclusive care models, implementation remains inconsistent across countries and health systems. Barriers include limited geriatric expertise among healthcare professionals, insufficient policy support, resource constraints, and structural inequities that disproportionately affect marginalized older populations. Socioeconomic status, gender, disability, and geographic location continue to influence access to inclusive and high-quality care, underscoring the need for evidence-informed strategies to promote equity in elderly healthcare (Lloyd et al., 2022). Given the expanding body of literature on elderly care and the diversity of existing models, there is a need for a comprehensive synthesis that focuses specifically on inclusivity. Therefore, this systematic review aims to examine and synthesize available evidence on inclusive care models in elderly healthcare, identify key characteristics and outcomes, and highlight implications for health system development. By consolidating current knowledge, this review seeks to inform future research, policy formulation, and practice aimed at promoting inclusive and equitable healthcare for ageing populations

## 2. RESEARCH METHOD

This study employed a Systematic Literature Review (SLR) approach to identify, analyze, and synthesize scientific evidence related to inclusive care models in elderly healthcare. The SLR aimed to provide a comprehensive understanding of how inclusive healthcare models are conceptualized, implemented, and evaluated in addressing the complex health needs of older adults. The review was conducted and reported in accordance with the PRISMA 2020 guidelines (Preferred Reporting Items for Systematic Reviews and Meta-



Analyses), which are internationally recognized standards for systematic review reporting designed to enhance transparency, reproducibility, and methodological rigor. Scientific articles were retrieved from major electronic databases, including PubMed, Scopus, Web of Science, DOAJ, and Google Scholar, with additional verification of full-text availability through PubMed Central (PMC) and open-access publishers. These databases were selected due to their broad coverage of peer-reviewed literature in public health, gerontology, nursing, and health services research, particularly studies focusing on healthcare delivery models for older adults.

The literature search was conducted using a combination of relevant keywords related to inclusive healthcare and elderly populations, including “*inclusive care*,” “*inclusive healthcare*,” “*person-centered care*,” “*integrated care*,” “*elderly healthcare*,” “*older adults*,” “*aging population*,” and “*healthcare models*.” Boolean operators (AND, OR) were applied to capture variations in terminology and broaden the scope of the search. The search period was restricted to articles published between 2015 and 2025, ensuring that the review reflected contemporary developments in inclusive elderly healthcare models.

The study selection process was performed in several stages. Initially, titles and abstracts were screened for relevance, followed by full-text reviews to confirm alignment with the objectives of this review. All included articles constituted primary research studies with empirical data, employing quantitative, qualitative, or mixed-methods designs, making them highly appropriate for a systematic review focusing on inclusive elderly healthcare models. Furthermore, the selected studies encompassed a diverse range of inclusive care approaches, including integrated care models, community-based service models, hybrid care models, family caregiving frameworks, and partnership-based nursing models, allowing for meaningful comparison and synthesis across different healthcare contexts.

- 1) Articles were included if they met the following criteria:
  - ✓ original research articles
  - ✓ focus on healthcare service delivery or care models for older adults;
- 2) explicit discussion of inclusivity, integration, person-centeredness, or collaborative care;
- 3) publication between 2015 and 2025;
- 4) availability as full-text open-access articles
- 5) written in Indonesian or English; and
- 6) using a quantitative, qualitative, or mixed methods research design.

Articles were excluded if they addressed only biomedical or clinical outcomes without reference to care models or service delivery, were narrative reviews, editorials, commentaries, or opinion papers, required paid access, or were laboratory-based or animal studies. Data extraction was conducted using a structured form developed in Microsoft Excel. Extracted variables included article title, author(s), year of publication, country and setting, study design, population characteristics, type of inclusive care model, healthcare context, and key findings. The extracted data were synthesized using a narrative and thematic analysis approach, enabling

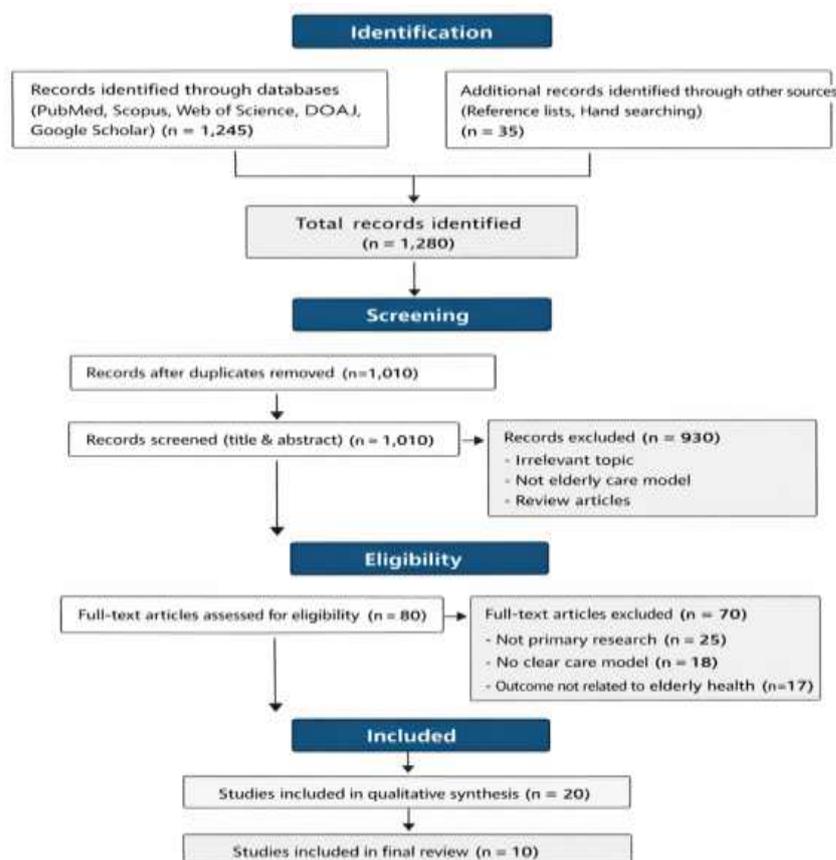


identification of recurring patterns, core components, and comparative strengths across inclusive elderly healthcare models.

### 3. RESULT AND DISCUSSION

The literature identification process yielded a total of 1,280 records, comprising 1,245 articles identified through electronic database searches (PubMed, Scopus, Web of Science, DOAJ, and Google Scholar) and 35 additional records identified through reference list screening and manual searching. After the removal of duplicate records, 1,010 unique articles remained and proceeded to the screening stage. During the screening phase, 1,010 records were screened based on their titles and abstracts. Of these, 930 articles were excluded due to irrelevance to the research topic, lack of focus on elderly healthcare models, or classification as review articles. As a result, 80 full-text articles were assessed for eligibility. At the eligibility stage, 70 full-text articles were excluded for specific reasons, including not being primary research studies ( $n = 25$ ), absence of a clearly defined care model ( $n = 18$ ), and outcomes not related to elderly health or healthcare service quality ( $n = 17$ ). Following this systematic selection process, 20 studies were included in the qualitative synthesis, of which 10 primary empirical studies explicitly addressing inclusive elderly healthcare models were included in the final systematic review.

The article selection process is detailed in the PRISMA 2020 flowchart, as shown in Figure 1.





**Figure 1. Flow Chart of the Systematic Literature Review of The Inclusive Care Models Elderly Healthcare**

**Table 1. Characteristics of Included Studies (n =10)**

| Author (Year)              | Country     | Study Design                                 | Sample & Setting                                  | Elderly Care Model  | Key Outcomes Measured  | Main Results  | Implication for Inclusive & Gerontic-Friendly Model   |
|----------------------------|-------------|--|---|---|--|---|---|
| (Mann et al., 2021)        | Australia   | Cluster RCT (Step wedge)                     | 80 older adults, community                        | Integrated Community-Based Care (OPEN ARCH)   | ED visits, hospital admission  | Reduced unnecessary hospital utilization and improved care coordination                           | Supports community-based, integrated primary care for aging in place  |
| (Yi et al., 2021)          | South Korea | Feasibility study                            | 22 older adults living alone                      | Community-Based Integrated Service (CBIS)   | Feasibility, satisfaction  | High acceptability and service satisfaction   | Demonstrates feasibility of inclusive care for socially isolated elderly  |
| (Uittenbroek et al., 2017) | Netherlands | Stratified Randomized Controlled Trial (RCT) | 1,456 community-dwelling older adults (≥75 years) | Embrace Model community-based, integrated, person-centered primary care combining Chronic Care Model (CCM) and population risk stratification (robust, frail, complex care needs) | Perceived quality of care (PAIEC); Level of implementation of integrated elderly care (AIEC) | Older adults receiving Embrace reported significant higher perceived quality of care than control | Demonstrates that stratified, community-based integrated care, Supports inclusive, gerontic-friendly models emphasizing proactive, preventive, and person-centered services integrated across health and social care systems. |
| (Liao et al., 2022)        | Taiwan      | Quasi-experimental                           | 123 elderly with depression                       | Integrated Care Model (ICM)   | Depression score, QoL  | Significant reduction in depression levels  | Shows effectiveness of interdisciplinary care for mental health   |



| Author (Year)            | Country   | Study Design                 | Sample & Setting             | Elderly Care Model                    | Key Outcomes Measured       | Main Results                               | Implication for Inclusive & Gerontic-Friendly Model        |
|--------------------------|-----------|------------------------------|------------------------------|---------------------------------------|-----------------------------|--|--|
| (B et al., 2024)         | India     | Community-based intervention | 128 older adults             | Hybrid Community Care Model           | Frailty index               | Improved frailty index post-intervention   | Emphasizes preventive and self-efficacy-based elderly care |
| (Shi et al., 2024)       | China     | Mixed-methods                | 98 elderly, primary care     | Community-Embedded Follow-Up Model    | Care continuity, engagement | Improved continuity and patient engagement | Supports continuous follow-up in primary elderly care      |
| (Zhou et al., 2025)      | China     | Cross-sectional survey       | 331 community elderly        | Home-Based Modular Care Model         | Service utilization, needs  | Model aligned with elderly needs           | Reinforces personalization and accessibility               |
| (Hidayat & Wibowo, 2022) | Indonesia | Pre-post quasi-experiment    | 105 elderly families         | Family Caregiving Model               | Family independence, ADL    | Improved family caregiving capacity        | Validates family engagement in inclusive models            |
| (Mudawamah, 2019)        | Indonesia | Qualitative case study       | Community home care          | Community Home Care Model             | Service perception          | Positive community acceptance              | Highlights sociocultural relevance of community care       |
| (Sahar et al., 2019)     | Indonesia | Quasi-experimental           | 90 institutionalized elderly | Partnership Nursing Model (MiRaDaSia) | Functional status, health   | Improved ADL and health outcomes           | Demonstrates interdisciplinary partnership effectiveness   |

**a. Discussion**

Overall, the included open-access evidence indicates that inclusive elderly healthcare models are most consistently delivered through integrated, person-centred, and team-based service delivery, typically combining comprehensive assessment, care planning, coordination, and follow-up across providers. In the Embrace randomized trial, integrated person-centred primary care improved older adults’ perceived quality of care, with the strongest effects in frail



and complex-need groups, suggesting that inclusivity is amplified when service intensity is matched to need (e.g., risk stratification plus case management). This pattern fits broader integrated-care syntheses which emphasize multidisciplinary teamwork and care coordination as core mechanisms for addressing multimorbidity and functional decline among older adults.(Uittenbroek et al., 2017)(Briggs et al., 2018). In addition to the ten studies summarized in Table 1, evidence on non-care model health determinants such as chronic disease management offers important contextual insights for inclusive elderly care. For example, a cross-sectional study examining factors associated with quality of life among patients with Diabetes Mellitus during the adaptation to new public health habits found significant associations between psychosocial variables (anxiety level, physical activity, family support, and healthcare professional support) and quality of life among adults with chronic illness. These determinants — such as support systems and behavioral adaptation — mirror aspects of gerontic-friendly care emphasizing holistic and contextualized service delivery (Yulia et al., 2022)

Mental health integration appears to be a key “inclusivity lever” for community-dwelling older adults, especially where depression and psychological distress co-occur with chronic conditions. The quasi-randomized trial of an Integrated Care Model among older adults with depression reported improvements in depression-related outcomes (including suicide ideation and psychological symptoms), supporting the feasibility of embedding structured, coordinated care pathways for geriatric mental health within community-based services. These results reinforce an SLR-relevant inference: inclusive models should not treat mental health as a parallel program, but as an integrated component of routine geriatric service delivery.(Liao et al., 2022)(Briggs et al., 2018)

Evidence from institutional settings suggests inclusivity can also be strengthened through partnership models that clarify roles and promote collaboration between nurses, caregivers, and older adults. In Sahar et al.’s quasi-experimental MiRaDaSia study, health and functional status were measured using SF-12 and the Barthel Index, and the intervention was associated with improvements in functional condition relative to comparison, indicating that collaborative “partnership” implementation can be operationalized with measurable gerontic outcomes. For SLR synthesis, this highlights that inclusive care is not only a system-level integration issue, but also a micro-level relational design issue—how staff and older adults co-produce daily care in long-term care settings.(Sahar et al., 2019)

From a model-development perspective, the *Frontiers in Public Health* article on a community home-based care service model (modular design) contributes an explicit “service architecture” approach to organizing components of community-based elder care. While its effectiveness should be interpreted in light of the study’s design and context, it is valuable for SLR discussion because it makes the model components more visible and potentially transferable (i.e., what modules exist, how they connect, and how home- and community-based services can be packaged).(Zhou et al., 2025)



Implications for an inclusive & gerontic-friendly model (cross-study): (1) stratify or triage older adults by need to allocate intensity fairly; (2) embed mental health into routine geriatric pathways; (3) use partnership-based practice in institutions to improve function; and (4) design service models as explicit components/modules to support implementation and scaling. (Uittenbroek et al., 2017)(Liao et al., 2022)(Zhou et al., 2025)(Sahar et al., 2019)

#### 4. CONCLUSION

This review indicates that inclusive, geriatric-friendly care models for older adults work best when they are integrated across health and social services, delivered by multidisciplinary teams, and guided by person-centred assessment and care planning. The strongest and most consistent benefits tend to occur among older adults with frailty, multimorbidity, depression, or complex needs when care intensity is matched to need through mechanisms such as risk stratification, case management, and structured follow-up. Overall, the evidence supports scaling community-embedded and institution-based partnership approaches, while future studies should strengthen reporting on implementation fidelity, equity impacts, and cost-effectiveness to inform sustainable adoption.

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