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8 Elements of person-centred care of older people in primary healthcare: a systematic literature review with thematic analysis

Abstract

Background: Higher life expectancy in the ageing population and, consequently, an increase in the older population bring additional challenges for healthcare providers, especially in primary healthcare. The person-centred care of older people is defined as an approach that puts older people at the centre of care and recognizes the importance of their needs. The chapter aims to identify the key elements of person-centred care for older people, in primary healthcare.

Methods: A systematic review of relevant literature was carried out. Literature searches were conducted in international databases, with keywords and their synonyms with Boolean operators. The search was limited to articles published until December 2021.

Results: The literature review identified two main themes: (1) personal and communication determinants like the interaction of all participants, the experience of illness and the needs of the older people, the attitude of the primary healthcare team, the wishes of the older people; and (2) managerial characteristics that include qualification, leadership, organization, and operationalization.

Conclusion: The person-centred care of older people should be caring, compassionate, empathetic, confident, supportive, autonomous, and respectful. All these identified elements need to be heard and respected by all primary healthcare teams. It is important to recognize the needs of older people and, at the same time, have a positive experience with professional healthcare. The person-centred care of older people should focus on the patient's needs, family, and the wider local community.

Keywords: older people, primary healthcare team, health personnel, delivery of healthcare

8.1 Introduction

The world population is becoming increasingly older, life expectancy is rising [1], and the ageing population is the dominant demographic phenomenon of the 21st century [2]. The World Health Organization (WHO) states that by 2050, 80% of older people will live in low- and middle-income countries. Similar projections can also

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be seen in Slovenia, as the proportion of working for an active population in 2050 will account for only 50.5% of the total population. Higher life expectancy for the ageing population and the resulting increase in the older population brings additional challenges for all Western countries, due to increasing demand for efficient healthcare systems, especially in providing healthcare for an ageing population [3].

All countries face the significant challenges brought about by ageing and try to ensure that health and social systems are prepared for the greatest possible demographic change [4]. It is known that older people are frequent users of the healthcare system, especially in primary healthcare. Older people with chronic conditions receive person-centred primary healthcare from transdisciplinary healthcare teams, where care is often disorganized and confusing [5]. Primary healthcare teams are, often, the first healthcare professionals the older people consult or visit for their health problems [6].

Primary healthcare teams often face the increasing complexity of health conditions and the multimorbidity of older people [1]. Considering a multimorbidity of older people requires moving from disease-centred to person-centred healthcare. According to various authors, implementing person-centred healthcare means moving from the traditional biomedical model approach to an approach that emphasizes patient autonomy and participation in the treatment process [7]. The number of older people living at home will increase dramatically due to demographic changes [8]. With age, chronic non-communicable disease increases. At the same time, people experience a decline in physical and mental abilities, leading to losing functional abilities that is challenging for the primary care team [9]. Person-centred healthcare outlines a standard of care that puts older people at the centre of events and recognizes the importance of their knowledge and experience [10]. Older people are included as partners in their healthcare planning and disease control, with decisions that take into account their individual needs, values, and preferences [11]. Research shows that person-centred healthcare for older people improves their quality of life, provides better quality healthcare [12], and is linked to greater satisfaction of both users and providers of such care [13].

The person-centred healthcare approach for older people is highly recommended by World Health Organization [4] and McCormack [7] as a means to improve the standards of healthcare [14]. The current use of person-centred primary healthcare in family medicine is effective, because patients better manage their health by changing their lifestyles [15]. However, its implementation in practice is limited, and it also relates to the characteristics of the patient and the primary healthcare team. A primary healthcare team comprises a team of healthcare professionals, who work closely together to provide care and support to older people living in the community [16]. Therefore, to implement such an approach, we want to identify important elements of person-centred healthcare for older people and provide guidelines for such an approach in primary healthcare.

8.2 Methods

A systematic review was conducted using the methods of analysis, synthesis, and compilation of the literature. This methodological approach allows analysis, synthesis of knowledge, and applicability of results to practice. The process of searching and data extraction of the paper was guided by the Preferred Reporting Items for Systematic Reviews (PRISMA) [17] recommendations and is presented in the flow diagram (Fig. 8.1).

8.2.1 Research question

For the systematic review, we developed a PIO question: Which person-centred healthcare elements (I) impact the effectiveness of caring (O) for older people (P) in primary healthcare?

8.2.2 Search strategy

Literature searching took place in December 2021 in the following databases: PubMed, CINAHL, MEDLINE, and ScienceDirect by using search terms in English: person-centred healthcare, elements, impact, caring, older people, primary healthcare, and their synonyms with Boolean operators (AND/OR). The obtained results from databases were imported into the program, EndNote 20, and examined according to the eligibility criteria (Tab. 8.1).

Tab. 8.1: The eligibility criteria for systematic review.

Databases	**PubMed, CINAHL, MEDLINE, and ScienceDirect**	
	Inclusion criteria	**Exclusion criteria**
Participants	– Older people (+65 years)	– A person younger than 65 years
Intervention/ treatment	– Person-centred healthcare	– Exclude person-centred healthcare
Outcome	– Effectiveness of person-centred healthcare for older people at primary healthcare	– Exclude the effectiveness of person-centred healthcare for older people in primary healthcare

Tab. 8.1 (continued)

Databases	PubMed, CINAHL, MEDLINE, and ScienceDirect	
	Inclusion criteria	**Exclusion criteria**
Types of research	– Research article (quantitative, qualitative, and mixed methods research)	– Systematic review articles or other types of reviews – Duplicates, commentaries, editorials, conferences, and research protocols – Reviews that do not relate to our PIO question
Search limits		
Timeframe	Until December 2021	
Language	English or Slovenian	

8.2.3 Methodology assessment

The "Joanna Briggs Institute (JBI) Critical Appraisal Checklist" (2019) was critically evaluated for methodological quality. To assess the quality of the papers, we used the JBI Critical Appraisal Checklist for (i) qualitative research [18]; (ii) analytical cross-sectional research [19]; and (iii) randomized controlled trials [20]. JBI quality assessment tools include methodological appraisal questions that help authors determine the methodological rigour of included studies. For each of the checklists used, the answers were scored: "Yes" got one point; "No", and "Unclear" got zero points. After the assessment, we calculated the sum and percentage of all points for each study. Based on the authors, Camp and Legge's [21] recommendation, we evaluated and divided the studies into four groups: low quality (60–69%); medium quality (70–79%); high quality (80–90%); and excellent quality (more than 90%).

8.2.4 Data extraction and synthesis

The data extraction was conducted based on predefined data extraction criteria (e.g., authors, year, country, andpurpose). The data synthesis was based on a thematic framework by Thomas and Harden [22]. The first author read the text line by line based on each paper's identified free codes. These free codes were then organized in a descriptive primary subtheme and analysed and compared with one another to develop a secondary theme in the MAXQDA Analytics Pro-program. Co-authors reviewed the thematic synthesis, and any disagreements were resolved through discussion and consensus.

8.3 Results

8.3.1 Selection of relevant papers

With the help of the search strategy and limits of the search, we found 4 PubMed records, 4 CINAHL records, 4 MEDLINE records, 60 ScienceDirect records, and 3,557 Wiley Online Library records. After that, we eliminated 779 duplicates. The next step was that two reviewers searched the titles and abstracts of the results independently, depending on the limitations. The next step was to read the full articles and include or exclude the paper, depending on the limitations. According to the appropriateness of the content, we eliminated 39 hits out of 52 fully available papers. We eliminated them because they did not include patients older than 65 years and did not relate to the searched topic. The final number of useful records was 13 papers (Fig. 8.1).

8.3.2 Characteristics of papers

We included 13 studies in a review of the literature related to the approach of the person-centred healthcare of older people in primary healthcare. Nine studies used a qualitative research approach and four, quantitative studies. In qualitative research, four studies used individual interviews, three used focus groups, and two used an observation method. Quantitative studies used questionnaires as a research tool, and two were randomized control trials. A detailed description of each study is shown in Tab. 8.2.

8.3.3 Critical assessment

Details of critical assessment are shown in tables. Five papers were evaluated as medium quality [25, 26, 28, 31, 32], six of them were graded as high quality [6, 11, 23, 27, 29, 30], and two were excellent quality [24, 33] (Tab. 8.3).

8.3.4 Results of data synthesis

To identify the key elements of person-centred primary healthcare for older people, each paper (n =13) was coded line by line, and free codes were established (n = 119). Free codes were then combined in the descriptive primary level subthemes (n = 19), and with their analysis and comparison, secondary level subthemes were developed (n = 7). All themes were synthesized and developed, from which we identified two main themes: (1) the primary healthcare process and (2) person-centred leadership elements (Fig. 8.2).

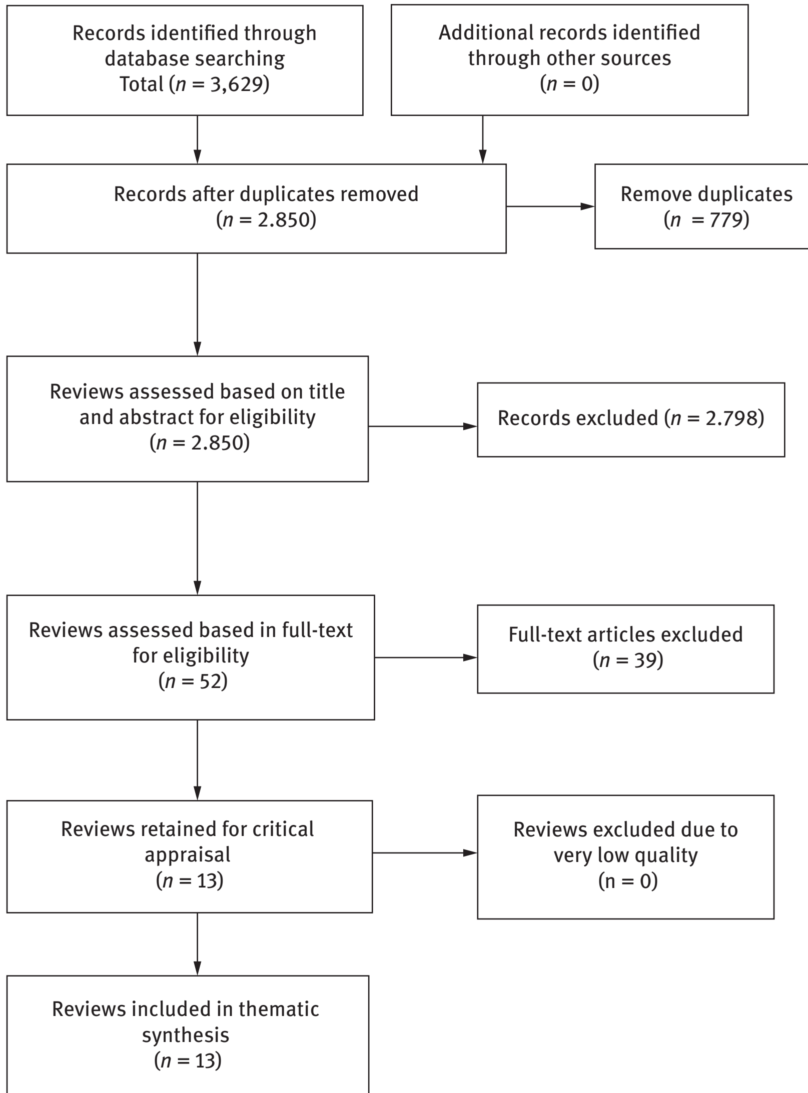

Fig. 8.1: The process of selecting the studies.

The primary healthcare process

Within the primary healthcare process, we have identified four secondary level sub-themes that relate to the person-centred healthcare of older people in primary healthcare: (1) interaction of all participants; (2) the experience of diseases and the needs of the older people; (3) primary healthcare team relationship; and (4) wishes of the older people.

Tab. 8.2: Characteristics of included papers.

Author, country	Research design	Aim of research	Sample size	Main findings related to detected symptoms
Sarkisian et al. [23], USA	Qualitative study; focus group	To compare the expectations of older people and physicians as regards their visits	*n* = 49 older people than 65 years and *n* = 11 physicians of primary healthcare	– The most commonly reported problematic areas about reasons for their visits are physical function, cognitive function, social function, pain, and sexual function – Older people expressed that they felt like numbers and not like people, nor were they involved in decision-making – The physician stared at the computer throughout the conversation and did not make eye contact
Shields et al. [24], USA	Quantitative study; randomized control study	To examine the interaction between the physician and the accompanied older people	*n* = 13 older people with an accompanying person and *n* = 17 without an accompanying person	– Physicians talked for a long time without a break with those who have had a companion because they thought such a visit was more complex and required more explanation – Physicians equally carefully followed the patient's health problems and talked to them about diagnosis and treatment, irrespective of whether they were patients with or without an escort – Escorting a family member or friend does not result in less attention by the physician and does not divert the physician's attention from the patient

Tab. 8.2 (continued)

Author, country	Research design	Aim of research	Sample size	Main findings related to detected symptoms
Bastiaens et al. [6], Belgium Slovenia Portugal UK and Northern Ireland	Qualitative study; interviews	To explore the views of people aged 70 and over on their involvement in primary healthcare in 11 European countries	*n* = 406 older people aged between 70 and 96	– Older people want to be involved in their care and be involved in decision-making. However, their definition of integration focuses on a loving relationship, a person-centred approach, receiving information, communication, and support – The study stresses the importance of good communication, including interest in the problem, clear information, and being reliable and supportive
Smith and Orrell [25], UK and Northern Ireland	Quantitative study; Cross-Sectional Study	Analyse the impact of a person-centred approach in the general practice clinic to identify unfulfilled needs in older people	*n* = 67 older people older than 65 years	– The person-centred approach was very much appreciated but is not associated with reduced unfulfilled needs – Many older peoples tolerate unfulfilled needs, and they are reluctant to acknowledge or mention that to their physician – The most frequent unfulfilled needs were: information (19%), vision/hearing/communication (16%), and physical health (16%)

Tab. 8.2 (continued)

Author, country	Research design	Aim of research	Sample size	Main findings related to detected symptoms
Bayliss et al. [26], USA	Qualitative study; Interviews	Explore the approach of healthcare for older people with multimorbidity	*n* = 26 older people aged between 65 and 84	– Older people try to find such care that includes: the need for convenient access/ making an appointment at the physician (phone, internet, or in-person), clear communication including an individualized plan of health care, support by the healthcare team who could help support the needs of older people and continuity of relationship – it is important for them to be heard and understood – They also want healthcare workers who will listen to them and recognize their needs, identify them as unique and can fluctuate, and have a caring attitude towards them – Older people want more information on managing chronic conditions such as diabetes or the results of various laboratory tests
Berkelmans et al. [27], Netherlands	Qualitative study; interviews	Improve understanding of wishes and expectations of older people regarding non-health characteristics of primary healthcare	*n* = 13 older people aged between 65 and 91	– The older people greatly appreciate the following: continuous healthcare (physicians and nurses), medical expertise, free choice of physicians, trust, and an open attitude – Respondents indicate problems with the 24-h service – The respondents prefer to receive verbal information over information from brochures

Tab. 8.2 (continued)

Author, country	Research design	Aim of research	Sample size	Main findings related to detected symptoms
Wolff and Roter [28], USA	Qualitative study; observation	To explore whether the presence of a family member as a companion in a routine examination with the family physician helps or hinders the person-centred care of older people process	Older people older than 65 years and their family members ($n = 390$ – $n = 80$ older people accompanied and $n = 310$ older people unaccompanied)	– Older people with poor mental health, whom a family member accompanied, the patient gave less psycho-social information, physicians asked less and tried to establish an interpersonal relationship – – Both the patient and the physician had a more task-oriented biomedical discussion – Older people with poor mental health with an attendant were less likely to have received person-centred communication than the unaccompanied patients
Fried et al. [29], USA	Qualitative study; focus groups	Explore the views and experiences of clinical staff (physicians and nurses) with therapeutic decision-making in older people patients with multiple health problems	$n = 40$ healthcare professionals	– Participants were concerned about the ability to cope with a complex regime of treatment for older people – Participants indicated several obstacles to good clinical decisions, and these involve a lack of information on the results of treatment, the role of a specialist, the expectations of patients and families, the lack of time, and reimbursement of expenses

Tab. 8.2 (continued)

Author, country	Research design	Aim of research	Sample size	Main findings related to detected symptoms
van de Pol et al. [30], Netherlands	Qualitative study; focus groups	To explore the main areas for improving older people's healthcare from healthcare professionals and older people in primary healthcare	*n* = 53 older people older than 80 years; *n* = 20 physicians and *n* = 21 nurses	– Participants stressed the importance to clarify different views regarding good health-care among patients and healthcare professionals – Effective interventions for older people require a mutual understanding of the expectations and goals of all involved in primary healthcare – Several requirements were identified, particularly access to information and medical treatment planning, training of health professionals about complex healthcare and multimorbidity, autonomy, setting targets, and common concerns
Bogner et al. [31], USA	Quantitative study; cross-sectional study	Explore the level of older people's satisfaction and perceived quality of health services related to the level of activities of daily living	*n* = 42.584 older people aged more than 65 years	– Respondents were satisfied with the physician's quality of work within the meaning of perceived technical and interpersonal skills and delivering information – More than 80% of older people were very satisfied or satisfied. More than 90% reported that they were very satisfied or satisfied with the quality of care and the technical skills of primary care physicians – It is necessary to use such strategies, including the perception of patients and evaluation of quality assurance

Tab. 8.2 (continued)

Author, country	Research design	Aim of research	Sample size	Main findings related to detected symptoms
Coulourides Kogan et al. [11], USA	Qualitative study; interviews	Obtain the views and experience of implementing such care by the heads of health services at the primary healthcare	The study invited 18 organizations, of which 9 took part in the survey	– There were three identified topics regarding implementing person-centred care of older people (PCC): operationalization (including environmental, attributes of supply and measurement), feasibility, challenges, and language – Older people consider PCC to be quality care and have expressed a strong preference for a PCC that focuses on their needs, puts their preferences first, and addresses the problems that older people identify
Wolff et al. [32], USA	Qualitative study; observation	Explore the communication behaviour of family companions while older people visit their physician	Visits of the older people at the general practice accompanied by a family companion (*n* = 30 visits)	– Family attendants largely facilitated the flow of information between physician and patient – The attendants were more verbally active in visits of the older people who have managed their health with the help of others than in other visits to the older people who were partially dependent or independent in managing their health – Attendants evaluated that they felt more helpful with those older people who want the active involvement of the family in the decision-making process about their health

Tab. 8.2 (continued)

Author, country	Research design	Aim of research	Sample size	Main findings related to detected symptoms
Uittenbroek et al. [33], Netherlands	Quantitative study; randomized control study	Examine the effectiveness of the Embrace program and integrated primary healthcare services for older people	A total of 1,456 older people who have a family physician participated, in 15 clinics	– After 12 months, the Embrace program showed that PCC does not affect the cost increase. – They note that Embrace and the standard treatment increase the cost of treatment in older people; therefore, only one must be used to improve the risk profile – Older people must be provided with such treatment to deal with their complex medical needs

Tab. 8.3: A critical assessment of included papers.

JBI CA checklist CS Including papers (*n* = 2)	1	2	3	4	5	6	7	8	QS
Bogner [31]	Y	Y	Y	Y	U	U	Y	Y	6/8
Smith and Orrell [25]	Y	Y	Y	Y	U	N	Y	Y	6/8

CS, cross-sectional studies; CA, critical appraisal; Y, yes; N, no; U, unclear; NA, not applicable; QS, quality score.
1. Were the criteria for inclusion in the sample clearly defined?
2. Were the study subjects and the setting described in detail?
3. Was the exposure measured validly and reliably?
4. Were objective, standard criteria used for measurement of the condition?
5. Were confounding factors identified?
6. Were strategies to deal with confounding factors stated?
7. Were the outcomes measured validly and reliably?
8. Was appropriate statistical analysis used?

JBI CA checklist QR Including papers (*n* = 9)	1	2	3	4	5	6	7	8	9	10	QS
Sarkisian et al. [23]	Y	Y	Y	Y	Y	N	U	Y	Y	Y	8/10
Bastiaens et al. [6]	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9/10
Bayliss et al. [26]	N	Y	Y	Y	Y	U	N	Y	Y	Y	7/10

Tab. 8.3 (continued)

JBI CA checklist QR Including papers (n = 9)	1	2	3	4	5	6	7	8	9	10	QS
Berkelmans et al. [27]	Y	Y	Y	Y	Y	N	U	Y	Y	Y	8/10
Wolff and Roter [28]	U	Y	Y	Y	Y	U	N	Y	Y	Y	7/10
Fried et al. [29]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8/10
Van de Pol et al. [30]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	9/10
Coulourides Kogan et al. [11]	U	Y	Y	Y	Y	U	Y	Y	Y	Y	8/10
Wolff et al. [32]	Y	Y	Y	Y	Y	N	N	Y	N	Y	7/10

QR, qualitative research; CA, critical appraisal; Y, yes; N, no; U, unclear; NA, not applicable.
1. Is there congruity between the stated philosophical perspective and the research methodology?
2. Is there congruity between the research methodology and the research question or objectives?
3. Is there congruity between the research methodology and the methods used to collect data?
4. Is there congruity between the research methodology and the representation and analysis of data?
5. Is there congruity between the research methodology and the interpretation of results?
6. Is there a statement locating the researcher culturally or theoretically?
7. Is the researcher's influence on the research, and vice versa, addressed?
8. Are participants, and their voices, adequately represented?
9. Is the research ethical according to current criteria o, for recent studies, and is there evidence of ethical approval by an appropriate body?
10. Do the conclusions drawn in the research report flow from the data's analysis or interpretation?

JBI CA checklist RCT Including papers (n = 2)	1	2	3	4	5	6	7	8	9	10	11	12	13	QS
Shields et al. [24]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	13/13
Uittenbroek et al. [33]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	13/13

RCT, randomized control trial; CA, critical appraisal; Y, yes; N, no; U, unclear; NA, not applicable.
1. Was true randomization used to assign participants to treatment groups?
2. Was allocation to treatment groups concealed?
3. Were treatment groups similar at the baseline?
4. Were participants blind to treatment assignment?
5. Were those delivering treatment blind to treatment assignment?
6. Were outcomes assessors blind to treatment assignment?
7. Were treatment groups treated identically other than the intervention of interest?
8. Was follow up complete and if not, were differences between groups in terms of their follow-up adequately described and analysed?
9. Were participants analysed in the groups to which they were randomized?
10. Were outcomes measured in the same way for treatment groups?
11. Were outcomes measured in a reliable way?
12. Was appropriate statistical analysis used?
13. Was the trial design appropriate, and were any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in the conduct and analysis of the trial?

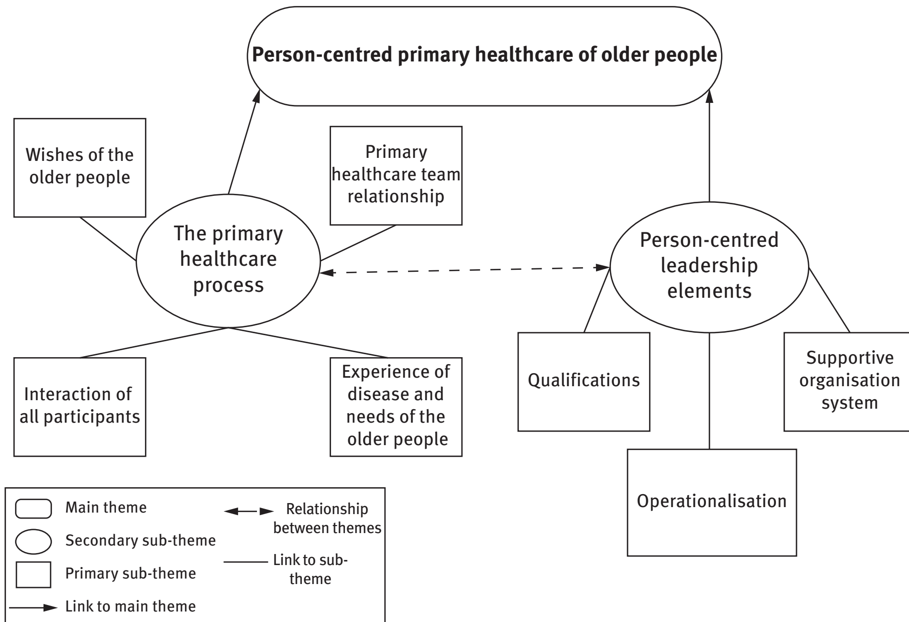

Fig. 8.2: The results from data synthesis with main theme and subthemes.

Interaction of all participants: Interaction of all participants includes three elements: information, communication, and interpersonal relations. Older people appreciate good [6] and clear communication [26], which should be reflected in showing interest in their health problems and giving information to them in an appropriate manner [6]. Furthermore, older people most often wish to receive clear information [6, 26, 30] from healthcare professionals, but the information must be given in person by healthcare professionals [27] and compassionately [31].

Experience of disease and needs of the older people: The experience of disease and the needs of older people are composed of two elements: emotional and physical needs. The primary healthcare team must identify and prioritize the issues and problems of older people [11, 30, 33]. Sarkisian et al. [23] describe the most frequent problem areas such as physical, cognitive, social, and sexual function, and pain. Furthermore, additional areas related to mental health: anxiety, emotional well-being, happiness, sleep, and life/death are mentioned.

Primary healthcare team relationship: The primary healthcare team relationship consists of two elements: the process of the visit and the outcome of the visit. Older people often visit their physician with a companion, who is their family member or friend [28, 32]. Bastiaens et al. [6] found that an accompanied visit in the form of a care partner does not result in decreased attention by the physician, or the attention is not diverted away from the older people. On the other hand, Wolff and Roter [28]

conclude that the physician asks fewer questions to those accompanying older people and tries to establish interpersonal relationships. According to Shields et al. [24], the companions effectively direct the conversation between the primary healthcare team and the older people by opening new issues; for this reason, according to the primary healthcare team, such a visit is more complex and requires more explanation.

Wishes of the older people: Wishes of the older people include three elements: personal, primary healthcare team, and treatment. The views and wishes of the older people regarding their treatment were different. Most often, they want a caring [6, 30] and an open attitude [27], which is believed to be characterized by trust, support, interest, respect, understanding, and listening [6, 24, 26, 30]. The physician must answer their questions, listen to them, have time for them, put their wishes first, involve them in the care, and recognize their needs as unique [6, 26, 30]. Their treatment should be based on mutual understanding and common determination of goals [30], the recognition of their needs [26], and maintaining their autonomy and independence [30]. They also want to spend more time with their chosen physician [30], whom they can choose by themselves [27].

Person-centred leadership elements

Within the person-centred leadership elements, three secondary-level subthemes have been identified: (1) qualifications; (2) supportive organization system; and (3) operationalization.

Qualifications: Qualification is composed of two elements: expertise and skill. Successful performance and quality of care of older people require expertise of the primary healthcare team [24, 25]. The primary healthcare team must have the skills to deal with the complex health problems of older people and treatment regimes [29]; that is why, it is important to train them [30]. The older people expressed most satisfaction with their technical and interpersonal skills, because they feel that their problems are understood and considered by the primary healthcare team [31].

Supportive organization system: The supportive organization system comprises quality, accessibility, and obstacles. Experience of the older people with their healthcare is reflected in satisfaction and dissatisfaction. Older people were satisfied with the quality of provided care but dissatisfied with care coordination, access, and visit coordination [31]. Most obstacles to implementing person-centred primary healthcare for older people have been noted in finance, structure and overburdening of staff, the organization, and the rigidity of staff [25]. Older people have expressed their desire for convenient access or appointment with a physician by telephone, Internet,

or in person [24, 27, 30]. They highly appreciate primary healthcare team visits at home [24] and the support of the healthcare coordinator [11, 26].

Operationalization: The operationalization consists of two elements: form and views. Primary healthcare teams and the older people perceived person-centred healthcare of older people differently. They emphasized the importance of clarifying different views regarding good healthcare between older people and the primary healthcare team [30]. According to Coulorides Kogan et al. [11], the most frequently reported features of patient-centred healthcare are teamwork care, multidisciplinary care, electronic documentation, and care coordination. Furthermore, Coulorides Kogan et al. [11] strongly prefer this approach, because it follows the patient's health problems [24]. In practice, this means implementing continuous care [27], where the interpersonal relationship is independent of the wishes and capabilities of older people being part of the decision-making process [6].

8.4 Discussion

A literature review provided broader insight into elements of person-centred primary healthcare for older people. We identify two key elements of providing person-centred primary healthcare for older people: The primary healthcare process and person-centred leadership elements (see Fig. 8.2). The person-centred care of older people is commonly reported in healthcare literature [34, 35]. It is defined as the preferred approach to the healthcare of older people. However, there is little consensus on its definition, measurement, factors, or association with better health outcomes for individuals [34]. Person-centred care is defined as delivering respectful care and responding to older people's needs and values [36].

Furthermore, it adjusts the care according to the needs of older people [7], understanding the older people as unique human beings and seeing the person as a whole [37]. A literature analysis showed that older people wish for autonomy [30] and involvement in decision-making [6]. At the same time, they want continuity of care and focus on themselves, which allows them to follow up on their health problems and wishes [6, 24, 29].

In the reviewed literature, we have identified specific elements of the person-centred primary healthcare of older people and skills that affect the entire process of healthcare: convenient access to providers of healthcare services (e.g. phone, internet, or in-person), clear communication (e.g., preferably in writing), individualized advance care plan, older people's chosen primary physician who knows them, and respect of primary healthcare team.

Primary healthcare teams face many older people with multimorbidity and complex healthcare needs [38, 39]. One of the many challenges at the primary healthcare level is providing structured and well-coordinated care [38–40]. Bayliss

et al. [26] note that older people want the support of primary healthcare teams, which help them prioritize their health problems and provide continuity of care. Primary healthcare teams should take a holistic approach to the following-up of older people, focusing on the following elements: appropriate communication (e.g., accessibility and empathy), cooperation and partnership, and the provision of clear information [25, 26, 30].

Person-centred primary healthcare of older people should be carried out in such a way that it is caring, compassionate, and empathetic. It puts older people in the spotlight, is unique to the individual's needs, and considers the older people as part of their care. Older people wish for a caring attitude, confidence, support, autonomy, independence, and respect, and they want to be heard and understood. All these elements need to be noted and respected by all primary healthcare teams, so that they can carry out diligent and person-centred primary healthcare for older people.

8.4.1 Strengths and limitations

Our strength lies in that we have followed the recommendation for conducting a literature review by Hannes [41]. Furthermore, we have conducted systematic and detailed search in databases, data extraction, quality assessment, and thematic analysis of the included studies. All steps of our literature review are represented in the tables and figures. However, a limitation of some studies can be the sample size and process of sampling for the research. Although we had access to many papers, some important articles were probably excluded, based on our inclusion criteria. The review included only papers with the specific search terms used. The weakness is that we may not have reviewed all the relevant literature, because we could have used other additional search synonyms. Nevertheless, we believe these identified records are large enough to prove and support our results.

8.4.2 Implications for research and practice

Further research is needed to determine the influence of person-centred primary healthcare and the decision of older people to obtain an emergency department rather than their primary healthcare team. Increasing numbers of older people patients call for well-organized primary healthcare at the local and national level, considering the older people's position, encouraging empowerment, and placing it at the centre of healthcare. Analysis of the literature has helped us easily identify the needs of older people at the primary healthcare level: the interaction of all stakeholders, the experience of disease and needs, attitude of a primary healthcare team, wishes of older people, and person-centred leadership. These identified elements of person-centred primary healthcare for older people have a significant impact on developing a

modern healthcare strategy, meeting the older people's needs, and positively impacting their experience. Person-centred primary healthcare for older people should reflect interprofessional and evidence-based healthcare, which will be focused on older people, their family members, and the wider local community.

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