

# Elderly care in Nepal: Are existing health and community support systems enough

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## Abstract

In Nepal, a few governmental and community-based programmes for elderly care are in place; however, information about successful implementation and overall effectiveness of these programmes is not well understood. In this article, we introduced these programmes and discussed existing programmes' gaps and implementation problems in light of existing grey and peer-reviewed evidence. A few notable governmental programmes, such as providing monthly allowances, pensions and free health care, have targeted specifically the elderly individuals. Yet, most health care institutions and providers are privately owned and profit-oriented, and there is a general lack of proper governmental health as well as social security systems for the elderly in the country. Generally, Nepalese communities consist of neighbourhood-based and religious-based groups that provide emotional and spiritual support to elderly individuals as well as provide support for health care access when needed. However, the influence that these groups can have on health and social well-being of elderly remains not well understood. Traditional family-based support systems may be feasible only for some families, while for others it could impose financial and psychological burdens. The role of the state is important in the effective implementation of existing programmes as well as in the development and implementation of additional programmes to ensure health and social well-being of elderly individuals. Furthermore, there is a need to establish partnerships with existing community structures and to mobilize them in the implementation of community-based programmes.

## Keywords

Community-based approaches, elderly care programmes, social capital, social justice, social well-being

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## Introduction

Elderly individuals have the right to obtain the highest attainable standard of health.<sup>1</sup> Elderly care is the fulfilment of the health and social needs and requirements that are unique to elderly individuals, which includes assisted living, adult day-care, long-term care, nursing homes, hospice care and home care. It emphasizes the social and personal requirements of elderly individuals who need some assistance with daily activities and health care, but who also desire to age with dignity. However, elderly people often experience problems such as physical or mental health problems as well as discrimination and violations of their rights at the individual, community and institutional levels.<sup>2,3</sup>

Ageing is an emerging global concern, and elderly care programmes are being implemented in many countries. Elderly care policies and programmes as well as their implementation and overall effectiveness, however, seem to vary widely between high- and low-income countries.<sup>4–13</sup> For

instance, the successful implementation and overall effectiveness of community-based approaches for healthy and successful ageing (such as to promote adequate savings and pensions, to provide subsidies for assisted living for needy groups) have been different between more developed and less developed countries.<sup>5,6,9,10</sup> In this view, elderly care policies, programmes and services differ among the countries,

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and the issues about the health and social care of elderly individuals should therefore be analysed and interpreted in relation to the surrounding socio-cultural context.

Particularly, South Asian countries including Nepal are in general lagging in providing adequate elderly care and in these countries, particularly the role of the government in elderly care is very unclear. Besides high burden of communicable and non-communicable diseases and increased health care needs, especially among elderly individuals, Nepal is also generally known to have higher rate of migration abroad. For instance, a survey of 2016 showed that 47% of Nepalese households had at least one member migrated in last 10 years, and 68% of men migrated for work outside the country.<sup>14</sup> Two Nepalese studies have revealed that an increased rate of migration abroad has led the elderly parents to be left behind to bear the physical, social, emotional and financial responsibilities of the family.<sup>15,16</sup>

In Nepal, over 85% of elderly people live in rural areas that are developmentally poor, lack general health care access, and depend primarily on traditional farming and remittance for income generation.<sup>17</sup> Especially in the rural areas, elderly people tend to be illiterate, have limited sources of income, and have poor health and nutrition, leading to an increased burden of both infectious and chronic diseases and further, they lack access to general health and social services.<sup>3</sup> Older adults (60 years and above) who are left behind by the family members face a range of social and health care challenges, including securing foods, clothing, shelter, health care and safe drinking water.<sup>7,18</sup>

Due to general lack of empirical studies and limited discussions on these issues at the political level, the problems related to elderly care are often unrecognized in Nepal. Only a few governmental and community-based programmes, and activities (e.g. old age allowance, old age pension, elderly care homes) are in place; however, information about issues related to programme implementation and overall effectiveness has not been documented. In this article, our aim is to discuss potential gaps and problems in Nepal's existing national and community-based elderly care programmes and their implementation considering available grey and peer-reviewed evidence.

## Main text

### *Existing governmental support programmes*

The Senior Citizen Act 2006 (SCA 2006) mentioned that the social, economic and human rights of elderly citizens should be ensured; yet it emphasized on 'family' as a key 'social unit' to perform the duties of sustaining older people's livelihood, health and care. Under the subheading 'maintenance and care of senior citizen(s)', it states that 'it shall be the duty of each family member to maintain and care for the senior citizen, according to the economic status and prestige of the member'.<sup>17,19</sup> It has been argued that SCA 2006 has indirectly compelled the family to take responsibility for the care

of elderly family members without considering the present issues such as increased rate of migration and existing poor socio-economic status in the general population. Furthermore, the socio-cultural and economic challenges and problems of stigma, stereotypes, livelihood and care required for the older people are also overlooked by the act.

The Government of Nepal has acknowledged the need for stewardship to address important needs of elderly people individually only in paper, but not in practice. The policies on elderly care, for example, have centred on a few welfare programmes which mainly includes providing allowances and pensions; however, such programmes are likely to be ineffective due to poor implementation. For instance, the Government has been providing allowances to senior citizens (aged 75 years and above) or widowed women aged 60 years or above (implemented in 1995 as social security), and more recently, the amount of the allowance has increased from \$5 to \$25.<sup>20</sup>

Although the aim of this programme is to reduce the financial barriers for elderly men and women in gaining access to social and health care, evidence suggests that the allowances have not been enough to meet the health care needs of the elderly.<sup>21</sup> In addition to the old age allowance, the Nepalese government also provides pensions for retired government employees; however, only 7% of total older adults in the country have previously worked as government employees and have received pensions and a clear majority of the older population have to depend on familial support and personal savings or from daily wages.<sup>16</sup> This contrasts with many European countries in which older people are generally covered by societal safety net programmes such as social security, pensions and organized elderly care.<sup>22</sup>

In relation to provision of health care services, a few programmes have been implemented, which include providing free medicine and treatment costs (up to \$20 at a time) targeting mostly to poverty-affected elderly people. However, the implementation of this initiative has been highly criticized for its lack of distribution fairness (ethics of resource distribution). A notable proportion of the elderly do not utilize health services despite having health problems, which could be due to high out-of-pocket health expenditures and a lack of regular health screenings.<sup>23,24</sup> Moreover, available within the country are just a small number of health care workers trained in geriatric health care, and a few hospitals that are elderly friendly, yet they are rather located only in the bigger cities.

Since the majority of health care providers and institutions are privately owned and profit-oriented, there is a general lack of proper governmental health as well as social security systems for the elderly in the country.<sup>25</sup> The priority of the governmental health system lies in other areas of health,<sup>7</sup> and one of the moral dilemmas is how scarce resources are to be distributed fairly among different age-groups and whether the elderly in greatest need should have the priority in resource allocation.<sup>26</sup> Nepal's elderly, who are considered to be the neediest group in terms of health care,

are not often represented in any targeted public health programmes such as health screening, cancer prevention programmes, lifestyle interventions or mental health care.<sup>19</sup> In this view, developing quality and affordable health care services for older adults to ensure equity in accessibility should be a major task for the public health system of Nepal.

### *Existing community structures and support systems*

In Nepal, community structures and norms differ between ethnic groups and caste systems, and rural–urban areas. Generally available to many elderly individuals is neighbourhood social capital, which includes local community groups such as local women’s group, female community health volunteers, local informal groups and so on, that voluntarily provides support to access health and social care for elderly and other vulnerable individuals. Religious social capital based on formal/non-formal religious groups and institutions is also available to some elderly individuals and groups through their social connections with a religious community. Such groups and institutions generally provide regular contacts for different activities, a sense of group identity, social integration, values/norms, bonding/bridging trust as well as social support to elderly individuals. However, the effect of neighbourhood or religious social capital on health and social well-being of elderly remains not well understood.

Communitarian approach is one way to achieve the goal of elderly care, and this approach has the advantage not only for embracing the right values regarding public health among community members but also for developing community structures and implementing community-based programmes that allow local community members to support the health and well-being of the elderly. Examples of such approaches would include micro-financing; volunteer work; and opportunities for self-development, self-fulfilment, well-being and lifelong learning. As shown by the experiences of more developed Asian countries, such as Singapore, Thailand, Japan, and other Western countries, the burden of care and support for older people should also be shared among different stakeholders at the community level as well as by the state.<sup>8,9,10</sup>

Community-based approaches are found to improve overall social capital as well as communication and solidarity among the community members and are considered to last longer than other approaches.<sup>27</sup> Studies from Japan found that community-based approaches such as local self-governance approaches providing autonomy to local people to plan and implement community programmes (e.g. family medicine programme, community care programmes) created roles for elderly individuals which improved community relationships.<sup>28</sup> Especially in the rural and remote areas, improved community relationships provided the basis for improved social capital and communication that contributed to providing needed support for elderly people.<sup>9</sup> However, community-based structures or activities that are specifically

made-up for elderly individuals to increase their health care access and general well-being and promote healthy ageing have not been well-developed in many communities of Nepal.<sup>7</sup> Especially in the rural areas of Nepal, because of the general lack of health care and increasing rate of migration of younger people, the importance of community structures and programmes to promote elderly care and well-being is higher.<sup>29</sup>

### *Roles of families*

The pre-existing community values and, in particular, those ethical teachings handed down by tradition and belief systems require the younger generation to take action to help their elderly parents.<sup>8,16</sup> The general attitude that sons are responsible to take care of their old parents in addition to their spouse and children places a greater responsibility and burden on the younger working generation. This widely shared attitude may also restrict some elderly individuals from being socially and economically productive, and they may simply rely on their sons and daughters to take care of them,<sup>30,31</sup> while such attitude is also changing to some degree due to an increased level of education and migration to Western countries.<sup>32</sup>

In Nepal, health care is largely provided by the private sector, and thus families with elderly individuals spend a considerable portion of their income on providing health care and treatment for elderly family members.<sup>33</sup> Families with one or more elderly individuals who require long-term treatment are therefore more likely to face financial burden in providing the needed medical care. In this context, elderly individuals with longer-term poor health conditions have to depend on other family members for income and health care, and are also likely to face exclusion, isolation and physical abuse.<sup>34,35</sup> Only a few studies have been conducted to identify the health care and social needs of elderly people<sup>23,36</sup> in Nepal, and studies conducted in 2017 and 2018 found a high prevalence of abuse among elderly people, and the most common form of abuse was neglect.<sup>37,38</sup>

European studies documented that people aged 50 years and older, who are most at risk for non-communicable diseases, should have an access to lifestyle changes or long-term medications for the potential benefit of prolongation of life or quality of life.<sup>39–41</sup> In resource-limited settings despite the limited access to medical services, older people’s help/health-seeking behaviours can be affected by their health literacy status, and their perceptions and behaviours about health and diseases.<sup>41</sup> Currently, it is not very clear to what extent health care services are accessible and what sort of perceptions and behaviours in relation to health and diseases Nepalese older people have and how they value adhering to treatments in terms of side effects and out-of-pocket costs.

Even though Nepal is the first remittance-receiving country in the world in terms of the percentage of the gross domestic product (GDP), which increased from 1.5% of GDP in 1993 to 32.2% in 2015 (6.7 billion US\$),<sup>42</sup> there is

no evidence regarding whether remittance is of any benefit for elderly population groups. The increased migration of men for labour jobs abroad have certainly raised concerns about who will take care of the left-behind elderly parents in rural areas. The increasing rate of the migration of the younger generation and the increased burden of work among the left-behind elderly population group may have several psychological consequences.<sup>15,43</sup> A recent study conducted by Thapa et al.<sup>44</sup> found that elderly individuals, females, lower-income households and households with migrated adult children were more likely to report depressive symptoms; for these groups, receiving an allowance, social support and participation in social activities were found to have protective effects.

### Limitations of the review

A key limitation of this review is that we were very specific to include studies with elderly care components, based on our judgement of relevance and those only published in English. We did not attempt to perform an independent search for national-level grey literature in the websites of governmental and non-governmental organizations. As a result, our review may have missed uncovering some other contextual issues. Therefore, we propose that the issues outlined in this review should be seen as the key, rather than the only, issues surrounding the implementation of elderly care interventions in Nepal. In addition, the lack of a systematic process in reviewing as well as a critical appraisal of the included studies might have influenced the applicability of our conclusions, especially for programme purposes.

Despite these limitations, this review is increasingly relevant in view of the contextualization of the elderly care issues of Nepal and providing a comprehensive perspective of how elderly care-related interventions and policies have been implemented.

### Conclusion

Although a few notable programmes have targeted specifically the elderly individuals, they are still lagging to address the health and social care needs of the elderly. More specifically, allowances provided to elderly individuals might not sufficiently cover health care expenses and the current health care practice imposes a huge cost on elderly individuals and families. In every aspect, the role of the state is important to effectively implement existing policies and programmes and further develop and implement additional programmes to promote effective participation of elderly population groups in political, economic, social and health-related aspects of the community.

Elderly individuals, especially those living in the poorest areas and facing financial hardship or discrimination, do not have access to health and social care programmes and thus they can be supported by implementing community-based

programmes. First and foremost, there is a need to increase access to proper medical care specifically among elderly people in the rural and remote areas. For this, local community support groups (e.g. mothers' groups, clubs, religious groups) in collaboration with local health authorities should be able to organize outreach medical care services. Furthermore, there is a need to plan and implement community-based programmes fostering an active involvement of older people, which would also subsequently improve social capital and communication. While situations such as the family's significant role in determining the well-being of older family members and the migration of the younger generation abroad are unavoidable, the role of existing community structures and groups would be more important in the implementation of community-based programmes and activities. Future research is required to examine the true effect of such community support and care systems concerning the health and general well-being of the older population.

### Author contributions

SS and BS performed the literature research and drafted the manuscript. ARA and ST critically revised the manuscript for important intellectual content and approved the final version for publication. All authors approved the final manuscript.

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