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# Older people's challenges accessing health services in central Nepal: a qualitative study using the domain of access framework

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## Abstract

**Background** Low- and middle-income countries face rapid population aging. However, the health system has remained largely unprepared to deliver health services to an aging population. As the population is rapidly aging in Nepal, their challenges and experience should be the focus for health care providers to address these issues. There is a paucity of evidence on barriers and facilitators to accessing health care services among older people in Nepal. The aim of this study was to investigate the challenges that older people experience while accessing health services in central Nepal.

**Methods** This qualitative study was conducted between April and June 2023. In-depth interviews were conducted among older people of a municipality in central Nepal, which were analysed thematically using a deductive-inductive approach based on the theory of access.

**Results** Hypertension and diabetes were the most common health problems among the participants. The affordability of health services was a major issue, although there is a health insurance scheme and a major focus on universal health coverage from the Government of Nepal. Other issues included poor acceptability, poor communication between older people and health staff, and poor accommodation due to a lack of elderly-friendly services, including long wait times in the clinic. Living with family was a major facilitator of access to health care services and was interrelated with multiple domains of access.

**Conclusions** This study identified barriers to accessing health care services for older adults in Nepal. We found that the affordability of health services, poor acceptability, poor communication between older people and doctors, and a lack of elderly-friendly services are the key challenges experienced by older people. Older people felt that these barriers were easier to overcome when they had family support. Therefore, for those living with their children, family support was reported as the major facilitator.

**Keywords** Aging, Older people, Primary health care, Qualitative method, Nepal, Theory of access

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## Background

It is estimated that the number of people aged 65 and over will reach 1.5 billion in 2050 globally [1]. Approximately 13.7% of the population is estimated to be aged 60 years or older by 2030, with this figure expected to rise to 20.3% by 2050 in Southeast Asian nations [2, 3]. Health issues affecting individuals aged 60 years and older account for 23% of the world's overall disease burden according to a Global Burden of Disease estimates for 2010 [4]. Cardiovascular illnesses account for the largest portion of the disease burden in this age group (30·3%), followed by malignant neoplasms (15·1%), chronic respiratory diseases (9·5%), musculoskeletal diseases (7·5%), and neurological and mental disorders (6·6%) [4]. With the increasing older population, health care demand will increase substantially. Health services in low- and middle-income countries (LMICs) have not been ready to adjust to the growing needs of the aging population.

Multiple studies have documented the barriers to accessing health care services among older people in LMICs [5–7]. A study conducted in South Africa, revealed that individuals in high-income areas had little trouble obtaining access to supportive services or high-quality care; however, those in lower-income areas had significantly less responsive services, low trust in the healthcare system and greater unmet needs [5]. Another study from Ghana reported that older people faced issues with their financial obligations, insufficient information, and a long wait time to access health care services [6]. These obstacles impeded their mobility and affected their social and professional opportunities, furthering their social marginalization [8]. Systemic issues such as political sidelining, discrimination and inequitable access to health services, were also stated as leading to poor health outcomes in older people [7].

In Nepal, people aged 60 years or more are classified as older people [9]. According to the 2021 population census of Nepal, the population aged 60 years or above is 2.97 million (10.21%) [10]. This population increased by 2.07% between 2011 and 2021 [11] and is growing more rapidly than the general population in the country [12]. Only a few studies have reported on the disease burden among older people in Nepal. Previous studies from Nepal reported that functional disability (8.8%) [13], loneliness [14], depression [15] and satisfaction with life were the key health issues facing older people [16, 17]. Being from a privileged ethnic group, having reliable income, and living with multiple morbidities are associated with a greater likelihood of utilizing health services in one of the accessible areas Nepal [18]. Family support for older people is an essential cultural expectation and obligation in Nepal. Younger family members provide economic and day-to-day support for older people, and older people act as patrons of families and communities. However, owing to very few livelihood opportunities within the country, there is a tendency for young people to leave country either to support the families or in search of better opportunities. Previous studies have explored how young adults balance family responsibilities with their own goals [19] and how older people feel neglected when young family members leave the country [20]. However, the impact of this phenomenon on access to health care for older people has not been previously reported. Except for the few studies reported above, there is limited available literature on older people's experiences with accessing health services in different parts of Nepal. With this background, the aim of this study was to investigate key health issues and the challenges that older people experience while accessing health services in central Nepal. The findings from this study will inform the local and federal governments in identifying key activities to address barriers to accessing health care among older people.

## Methods

### Study context

The National Health Policy 2019 [21] highlighted the importance of the lifecycle approach to health, and for the first time, included senior citizens' health services with the aim of strengthening geriatric health. A world report on aging (2015) highlighted that as people age, they utilize healthcare services more frequently because older people generally have multiple health conditions and greater demands for care [22]. In addition, the report also asserted that demand for health services will increase further in LMICs where the population is aging faster.

Older people in Nepal have reported experiencing multiple health issues. A previous cross-sectional study from Pokhara reported that self-reported health issues included hypertension (37.7%), gastritis (28.4%), asthma (25.4%), and arthritis (23.4%) [23]. An earlier review reported that about 38% of people aged 60 and over had chronic illnesses [24]. A full report of recent Nepal Living Standard Survey IV (2022–2023) is expected to provide a more recent data on morbidities among older people, however, the report has not been made public (as of September 2024).

The current study was conducted in Bharatpur Metropolitan City, Chitwan, which is located in the central–southern part of Nepal. The city is inhabited by migrants from neighboring districts because of its location and access to education and health services. According to the National Population Census 2021, Bharatpur Metropolitan City has a total population of 3,69,377, with 29,413 people aged 60 years and above [25]. To the best of our knowledge, no special health services have been provided

to older people, and challenges they face in accessing health services remain largely unexplored.

### Study design, participants and data collection

This qualitative study was conducted in four out of 29 wards of the municipality. Participants were selected purposively from those who were interactive and explicit in communication during the quantitative household study phase that was carried out prior to this qualitative study and were aged 70 years and above. Participants of both sexes and those who consented to participate were included in the study. All approached participants agreed to participate.

Data were collected using in-depth interviews (IDIs) from April to June 2023. An interview guide was developed using available literature [1, 8, 16]. The tool was pretested among four older people in different wards of the Bharatpur metropolitan city. The language and sequence of the questions were modified after pretesting (see supplementary file). Interviews were conducted by the first author in a private space of participant's own house. Each interview lasted approximately 45 min, was audio-recorded with the participants' permission, and notes were taken during the interviews. We stopped recruiting participants after predetermined categories of the participants reached saturation [26]. Ethical approval for the study was obtained from the Shree Medical and Technical College Institutional Review Committee (reference number: SMTC-IRC-20230217-68). The IRB is registered with the Nepal Health Research Council (NHRC) and follows the NHRC guidelines for ethics approval.

**Table 1** Sociodemographic characteristics of the participants

| Variables | Frequency | Percent |
|---|---|---|
| **Age** (in years) | | |
| ≥ 90 | 3 | 15 |
| 80–89 | 7 | 35 |
| 70–79 | 10 | 50 |
| **Gender** | | |
| Male | 8 | 40 |
| Female | 12 | 60 |
| **Marital status** | | |
| Widow/Widower | 12 | 60 |
| Married | 8 | 40 |
| **Living with** | | |
| Son | 15 | 75 |
| Spouse only | 3 | 15 |
| Daughter | 1 | 5 |
| Alone | 1 | 5 |
| **Household income (In NRs)*** | | |
| Less than 20,000 | 7 | 35 |
| 20,000 to 50,000 | 12 | 60 |
| Above 50,000 | 1 | 5 |

*NRs: Nepalese Rupees (~ NRs 130 = USD 1)

Written informed consent was obtained from each participant for data collection. Participant information was kept confidential and personal identifiers were removed before the analysis.

### Data analysis

Audio-recordings were first transcribed by the first author (RA). The Nepali version of the transcript was then translated to English, completed by the first author, and their correctness was checked by RS. Each interview was deidentified and assigned a unique identifier for analysis. A thematic analysis approach, as outlined by Braun and Clarke [27], was used to summarize the findings from the qualitative study. Thematic analysis was deemed necessary, as it helps explain the lived experience of the people and allows researchers to acknowledge the context where the participants are living [27, 28].

We used both deductive and inductive methods to identify themes for our analysis. First, we analysed the data using the six dimensions or domains of access based on the modification of Penchansky and Thomas's theory of access [29, 30]. These dimensions include accessibility, availability, acceptability, affordability, adequacy (accommodation), and awareness. In brief, accessibility refers to proximity-related issues, including time and distance; availability refers to supply and demand; acceptability of services corresponds to consumer perceptions; affordability refers to the cost of accessing health services, including incidental costs; and adequacy refers to the organization of services to accommodate consumer needs which also used interchangeably with accommodation [31]. Awareness is related to communication and information [29–31]. We also identified additional themes using an inductive approach to reflect unique cultural context of Nepal, where family support is crucial. Two authors independently identified themes and compared them, and all the authors finalized them [27]. The authors then continued with the rest of the analysis to identify themes and organize them under different meaningful headings. Microsoft word documents and sticky notes were used for the analysis.

## Results

### Characteristics of participants

Twenty in-depth interviews were conducted, which included 40% males and 60% females. Table 1 shows the characteristics of the study participants. Half of the participants were between 70 and 79 years old, more than half (60%) were female, 60% were widowed/widowered, the majority of them were living with sons, and the majority had household incomes between Nepali rupees 20,000 and 50,000.

### Health issues facing older people

Hypertension, sensory impairment such as vision and hearing impairment, musculoskeletal issues were reported as the key issues facing the older people in this study.

> *"I have a knee problem, for years, and sometimes it becomes difficult to bear pain. I also take medicine for the thyroid. Sometimes, I experience dizziness and headache." [Participant 1; Female; 92yrs].*

> *"I do not smoke and drink alcohol, but I have hypertension. It is already 18 years that I have been taking medicine. Sometimes I have to take medicine for bones and nerve-related problems. The doctor recommends medicine according to my disease condition, and I take them. It obviously feels different and difficult than before; now I cannot work like I used to do. Now I cannot function like before." [Participant 9; Female; 80yrs].*

> *"What to say at this age. I rate my sensory abilities as not good. … Sensory impairment has affected my life and conversation, and it also makes me feel lonely sometimes. It gets little uncomfortable during the conversation due to loss of sensory abilities [hearing loss]. I do not go to temple because I have problems hearing adoration in religious meetings." [Participant 3; Female; 72yrs].*

> *"I have already passed 77 years. My vision has slightly impaired over the years, so I bought glasses from insurance. Rest of my body is fine. I am taking medicine and wearing glasses sometimes." [Participant 4; Male; 77yrs].*

> *"My hearing ability has been reduced than before. Now I do not understand much. Sometimes I have to ask twice or thrice in order to assure what second person is saying and takes time to understand." [Participant 9; Female; 80yrs].*

### Health services access and utilization

#### *Accessibility (transportation, travel time, distance)*

Proximity to health services was one of the important challenges for the participants. Although this study was conducted in one of the highly accessible regions of Nepal, one participant still stated that:

> *"I go to nearest government hospital. It would be much easier if our children had helped us. If they were living with us, they would take care of tickets and take us to the hospital. However, we do not get such support; sometimes we walk to the hospital, while sometimes we go by a public vehicle. We even have problems reaching the hospital sometimes." [Participant 7; Female; 74yrs].*

#### *Affordability (direct and incidental costs)*

The majority of older people preferred to visit government hospitals for regular checkups because of the free health care provided by health insurance. The Government of Nepal launched the first round of Social Health Insurance Program during the 2015/2016 fiscal year and by June 2021 it was rolled out to all 77 districts of the country, including the current study setting [32].

A household of up to five members must pay NRs 3,500 under the health insurance system to receive medical care, including prescription drugs up to NRs 100,000. The government-designated health facilities offer the service [33]. This initiative is funded and led by the Federal Government of Nepal. The local government has not made any systematic policy or programs at the local level. In the current federal structure, key primary health care services, including preventive and promotive health services, are the responsibility of the local government [34]. For older people, health insurance provided crucial to obtain health services free of cost and to increase the affordability of health care.

> *"We have membership of both my wife and me, and we visit government hospital when we are not well. Yes, service is not so good, but still it has been so easy for us to get health services free of cost through health insurance. About the long waiting line, I think we have to be understandable." [Participant 19; Male; 82yrs].*

> *"We have so many financial problems in utilizing health services. Recently, I came back from the hospital due to insufficient money for injection. After two days, I managed money and then only received an injection shot. Nobody says take some*

*money because you are old and poor." [Participant 7; Female; 74yrs].*

#### *Availability (supply and demand)*

The findings revealed the unavailability of high-quality medicines, timely services, specific doctors, sufficient time for checkups, counselling, and facilities which required for older people at health facilities. Moreover, after waiting for a fairly long time to see a doctor, the doctor did not have sufficient time to check them. The participants mentioned that they would like to ask several questions and expect proper counseling from doctors, but they were only provided with a few-minute session.

*"It depends upon who a person is. If a patient is known, relative or friend of a health worker, then s/he receives service quickly. At the hospital, if someone of your known work there is, then you receive a checkup early. People judge you and nobody treats us well because we are older people. Treating older people nicely is only in words but not in reality." [Participant 7; Female; 74yrs].*

*"There is no friendly environment for older people in hospitals. As I said previously, "We old people are not well consoled by doctors, make us wait in long queues. There is no different system for older people. There is no different service for older people. What is in words is not in behavior." [Participant 17; Male; 73yrs].*

#### *Acceptability*

As mentioned earlier, health insurance has been deemed helpful to many older people. However, the health services delivered through public hospitals have limited acceptability, particularly with respect to the quality of medicines.

A participant with health insurance expressed mistrust and questioned the integrity of the hospital:

*"They give us cheap medicine and ask us to buy other medicines on our own. If a hospital receives 100 rupees [NRs] for medicine, then 40 rupees [NRs] will be used only in medicine. They only provide paracetamol. Now that most of the people have health insurance, it is certain that older people will have long queues." [Participant 4; Male; 77yrs].*

Another female participant highlighted multiple issues affecting her decision not to take part in the health insurance scheme:

*" We do not have health insurance because there will be so many strong and smart people in the queue; we old people have to wait all day long to obtain health services. Sometimes we do not get place to sit. They provide us useless and discarded medicine that does not work for us, and we do not get cured. They do not provide antibiotics or other medicines. They ask us to buy other medicine outside and only provide medicines for headache, stomachache that does not work. Therefore, we did not take health insurance membership." [Participant 7; Female; 74yrs].*

There was a general preference for private providers. The participants stated that they were satisfied with services from private hospitals, which are expensive. However, they were still using services from public hospitals, as these were economically the most feasible option for them. They expressed dissatisfaction over:

*"I am satisfied with the health services I get [from private service providers]. It is true that whenever I visit a hospital, it takes so much time to be checked. Last year, I went to government hospitals due to asthma. They asked me to go to different departments. If I go to one department, they will say something and send me to another department. What could we do? We are provided with fewer options and are bound by financial problems such that we must visit government hospitals despite the poor service they provide. There is no such environment that would be helpful for older people." [Participant 2; Female; 90yrs].*

#### *Awareness (communication and information)*

A number of issues mentioned earlier highlighted the communication gaps between health providers and consumers. Furthermore, provider–consumer communication, i.e., doctor–patient communication, was also described as poor.

*"Even doctors do not console us properly at the hospital. They take only a few minutes to check and send us, but we expect them to check for a longer period of time." [Participant 7; Female; 74yrs].*

#### *Accommodation (suitability, wait time)*

Some older people living with spouses reported that they face problems (or difficulties) visiting the hospital and

waiting in long queues. They reported sadly over the long wait times and scarcity of medicines and other resources at health facilities. They also highlighted that they would receive preferential treatment. If they knew someone in the hospital, they would see the doctor earlier; otherwise, they had to wait all day long.

*"We do not have health insurance because there will be so many strong and smart people in the queue; we old people have to wait all day long to obtain health services. Sometimes we do not get place to sit." [Participant 7; Female; 74yrs].*

*"At the hospital, if someone of your known work there is, then you receive a checkup early. People judge you and nobody treats us well because we are older people." [Participant 7; Female; 74yrs].*

#### Role of family as facilitators and barriers to access

*"They (children) take me to the hospital regularly. I have diabetes and hypertension, so I need to visit the hospital regularly. They (children) go to the hospital to get tickets so that I do not have to wait in long queues in ticket counters. They (children) are with us, so it has been easy to visit the hospital." [Participant 19; Male; 82yrs].*

Older parents living with their children is common and widely desired phenomenon. Many participants, living with their children, felt privileged to receive support from their children. They received support with everyday work, emotional support and financial support. For older people living with children, visiting hospitals was easier compared to those who did not have their children's support. The participants believed that their children, especially their sons, have the responsibility to take care of them in old age.

*"My family helps me. If they had not, I would not have been able to live. They take care of everything. There is no chance of not taking care. Everything is fine until now." [Participant 3; Female; 72yrs].*

*"Of course, they (children) help me and love me. If they do not who else will do. My husband is no longer. My daughter and sons help me. The son takes care of everything, including treatment, and daughters help with day-to-day work." [Participant 13; Female; 74yrs].*

Conversely, a few participants, living with spouses only, reported that they barely received financial support from their children. Therefore, they had to manage money for health care on their own. However, sometimes, their sons helped them financially when they were unwell. Some older people mentioned that even though their children helped them financially, that was not sufficient for them. An older woman living with her spouse whose sons were both living in foreign countries with their own families reported a lack of support from her sons:

*"They [children] do not support us. Sometimes they show up with very little money, which is not enough for us. They do not listen to us, so there are no points asking them for any support. When my husband told our sons about my illness and that we need some money, then they (sons) started ignoring our calls. The X-ray, blood test and injection methods require approximately five thousand samples. We did not have enough medicine and told them (sons) that injection is very expensive, but they did not listen to us. I doubt whether they will come in our funeral or not. Sometimes we talk with our grandchildren, but they do not show any sympathy. If they have seen their parents loving us or if our children have taught our grandchildren to love us, then they would have definitely learned, but when our own children do not love us, then why their children would." [Participant 7; Female; 74yrs].*

*"My family supports me. They [children] provide me with food every day; sometimes they console me when I need any emotional support. Now that I'm totally fine and do not need to depend upon other family members, everything is okay. However, I do not know how they would react if I have to be dependent upon them. If I become severely ill, I do not know what they will do. I do not know about the future. Now, everything is okay." [Participant 4; Male; 77yrs].*

*"Nobody shows love. Anyway, why to be sad that others did not give money when my own sons are not giving money even for health service." [Participant 7; Female; 74yrs].*

Being close to family was also stated as their wish. A female living alone stated that:

> *"I wish that my children were with me and around the house. Now, I live alone, so I feel very lonely. My children bring food and medicine for me when they visit me once every three months; that is it. I wish they were with me." [Participant 9; Female; 80yrs].*

> *"We do not have anyone who would take us to the hospital and wait." [Participant 7; Female; 74yrs].*

The majority of the participants living with their sons and daughters reported feeling happy and satisfied. They received food on time and had clothes to wear. However, participants who were living with only their spouse or living alone reported feeling sad about being far from their children in old age and not receiving support.

An 80-year old women, living alone, whose sons were living in other districts of Nepal with their families for employment, and another 74-year old woman, living with her spouse, whose sons were living in Australia and Finland, both felt neglected by their children.

> *"I do not think that I have many days to work because I'm having difficulty cooking for myself. I do not know whether I am happy with my current life. I wish children were here with me; there used to be the house full of children. However, now, I feel like I am all alone. Every older people feel that, I guess. It is ritual that we have to get our daughter married and send her to the son-in-law's house. We have to send our sons to earn for their living. They also have family to feed." [Participant 9; Female; 80yrs].*

> *"I had been consoling my heart and was satisfied with whatever I have got. I had done everything I had to and struggled so much. If other things are not feasible, at least one should not make their parents cry. They should sometimes send us money and show some empathy to us. Son is parents' stick at old age. Everyone needs their children. Everyone needs a wife. However, you should not take care of only one and overshadow others. I understand that they have to look after their kids and wife, but they also need to look after their parents. A child and elder person are the same. Now we have become like a child. Do not you think they need to take care of us?" [Participant 7; Female; 74yrs].*

## Discussion

The aim of this study was to investigate the challenges that older people experience while accessing health services in central Nepal. Multiple themes and subthemes emerged from the study, all interconnected by the influence of living with family members on health care access. This qualitative study provides valuable insight into the access issues faced by older people when using health care services.

In this study, hypertension and diabetes were the most common health problems among the majority of the older people. A recent study from eastern Nepal reported that 48% of older people were living with at least one health issue, with 17.3% reporting multiple health issues [35]. Similarly, in a South Indian study, hypertension and diabetes were reported as common health conditions among older adults [36].

Family support was found to significantly influence the overall experience of health services and access issues. Most older people living with their children reported receiving support with money, transportation to hospital and day-to-day activities. In contrast, older people living with spouses only or alone experienced a lack of love, care and support. These findings align with existing literature. Similar findings were reported in a study from Nepal, where 78.8% of older adults had emotional problems and 18.2% faced social issues such as having to leave their close friends, and migration of their children [37]. Previous studies support that living with family is associated with a better quality of life [38], while, living alone tended to decrease quality of life [39]. Support, affection and other assistance from family can enhance satisfaction with life improving overall health and well-being [40]. However, due to current socioeconomic trend in Nepal, there is widespread migration of young people to overseas searching for better education, economic and livelihood opportunity. It is increasingly common for rural communities to be inhabited by older people, women, and children. Unfortunately, the government has not effectively addressed the challenges to retain productive human capital within the country.

In this study, access to health care was evaluated using widely accepted theory of the access [41–43]. Most of the older people faced difficulties in accessing and affording health services. A previous study reported that increased age exacerbates the burden of high healthcare costs [44]. Affordability for daily necessities, access to healthcare and purchasing power are influenced by income, which can be very low or non-existent for older people [45, 46]. Another study from Nepal reported that over one-third of the participants had not visited a health facility in the previous 12 months, and the overwhelming majority (9 of 10) did not know that the government offered free health care for senior citizens [47]. This implies that the

universal free health service has not reached older people as intended.

The current study revealed that older people value the contribution of health insurance to improving their access to health services. However, the acceptability of public facilities offering health services through health insurance were compromised by dissatisfaction and a lack of trust in the quality of available medicines, long waiting lines, and constant shortages of medicines and other testing facilities. Similar issues were reported in a study of rural Tanzania, where health insurance made it easier for older people to receive healthcare [48]. Owing to the limited stock of medicine and restricted use of services under these schemes, health insurance programs fail to ensure equitable access [48].

Patient communication and inadequate information were additional issues affecting access to health care services. Participants were concerned that they were not counselled properly and that consultation with doctors were very short after a long wait. A former study from Kathmandu, Nepal reported that none of the health workers had received geriatric health care training, and that no hospital had developed elder-friendly hospital guidelines or policies indicating major systemic issue [49]. Negative experiences or fears of health workers' rough attitude such as scolding or shouting were also a barrier to accessing health services among other age groups in the country [50].

Difficulties with transporting patients to health services were also reported as an issue, although this was not the major issue in our study. Notably, this study was conducted in one of the highly accessible areas of Nepal where have access to multiple means of transportation, yet the participants faced challenges to get to the health services. In remote and rural areas and in mountains, transportation is the major physical barrier, often preventing older people from reaching health facilities unless their condition is very serious [51, 52].

In the current study, long wait times and a lack of user-friendly health services, i.e., issues with accommodations, were expressed as major issues by multiple respondents. A study from rural Nepal reported that people had to wait longer than the national average to visit a hospital and were more likely to choose private care over public [51]. Another study from rural Nepal highlighted that distance was another reason preventing people from accessing health care and service did not meet needs of older people [52].

### Strengths and limitations

This study has several important strengths. Qualitative exploration of the challenges facing older people while accessing health care services in Nepal is limited. To our knowledge, this is the first study to explore challenges using a widely accepted theory of access. The first author's connection to the local communities and understanding of the local context and culture facilitated the engagement with older people and helped gather meaningful insight. In-depth interviews were conducted after the initial interaction and once rapport was established in the initial quantitative phase of the study, which allowed opportunities to achieve better engagement with the participants.

A few limitations must be acknowledged. This study represents the experience of older people who are the consumers of health services. The experiences and barriers encountered by health service staff can be different from those of consumers, and warrant further exploration. Another major limitation is that this study was conducted in one of the most accessible locations in Nepal. Therefore, the issues stated by residents may not fully represent those faced by individuals in rural, remote and mountainous regions of Nepal. Nevertheless, the study highlights important issues that older people face when accessing health services in Nepal.

## Conclusion

This study investigated the experience of older people accessing health services in central Nepal and the key challenges facing them. The affordability of health services i.e. cost of health care, was reported as a major issue. Older people suggested that there was poor communication from the health professionals, and that health services were not accommodating to their needs. In general, there was poor acceptability of government-managed services including the health insurance scheme. On the other hand, living with family was a major facilitator of accessing health services.

Further studies should explore service providers' perspective and feasibility of health services, focusing on a holistic model of care that relies less on individual doctors and more on multidisciplinary teams, such as nurses, allied health professionals and paramedics. Similar models have been successful in many developed countries [53], although such models may need some adaptation to fit the local context. It is also important for the government to support family members who care for their seniors. The Geriatric Health Service Strategy [54] should be implemented in a way that meets community needs, and be adapted to the local context to respond the holistic needs of older people. Different levels of government need to be proactive in identifying funding mechanisms and formulating key policies and programs to improve access to health care services for older people.

#### Abbreviations

| | |
|---|---|
| IDI | In depth Interviews |
| i.e. | That is |
| QOL | Quality of Life |

| | |
|---|---|
| GBD | Global Burden of Disease |
| LMICs | Low-and-middle-income-countries |
| NRs | Nepalese Rupees |
| GoN | Government of Nepal |

## Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-024-11717-2.

Supplementary Material 1.

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**Authors' contributions**

RA designed the study, designed the protocol, and conducted the field work. RA analysed the data with significant contributions from RS and VK. RS and VK supervised the project. RA wrote the first draft of the manuscript with significant input from VK. RS and VK contributed to finalizing the themes and facilitated the analyses. All the authors revised the initial draft and finalized the manuscript. All the authors approved the final version of the manuscript.

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**Data availability**

No datasets were generated or analysed during the current study.

## Declarations

**Ethics approval and consent to participate**

This qualitative study received ethical approval from the Institutional Review Committee of Shree Medical and Technical College (SMTC-IRC-20230217-68). All the participants provided verbal and written informed consent. The Institutional Review Committee of the college adheres to the same ethical standards of the NHRC and ensures that all student projects are conducted in accordance with relevant guidelines and regulations. The review board adheres to strict guidelines aligned with both national and international ethical standards, ensuring that all research involving human participants is conducted with the utmost care and adherence to ethical principles. The research protocol and tools were reviewed by independent reviewers and necessary changes were made prior to approval.

**Consent for publication**

Not applicable, as we used deidentified data.

**Competing interests**

The authors declare no competing interests.

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