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Perceived Health Status of Older People: Evidence from Sunkoshi Rural Municipality, Sindhuli, Nepal

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Abstract

The increasing older people in a population poses significant challenges to society concerning health status, and health care. This study aims to assess the self-reported health status of older people living in rural setting. This study used primary data collected through community-based survey conducted in Sunkoshi Rural Municipality, Sindhuli. The study sample consisted of 413 older people aged 60 and above. Self-reported health status was selected as the outcome variable, while demographic and socio-economic factors were considered as independent variables. Descriptive and inferential statistics were used in data analysis. Chi-square test was performed to determine statistically significant association between outcome and independent variables. The results showed that about 63 percent of older people reported good self-reported health status, and about one in ten older people reported poor health status. The prevalence of poor health status was four times higher among the older people aged 80 and above and two times higher among the older people aged 70-79 than older people aged 60-69. Males have higher prevalence of poor health status (10%). The prevalence of good health is higher among older people who were currently married, who had primary education, and were currently working, with statistically significant differences in the self-reported health status. This study provides insights into self-reported health status among older people in the context of rural setting of Nepal. The result of this study can inform to develop programs aimed at promoting good health status and reducing disparities in health status among older people.

Keywords: Disparity, health status, older people, population aging, self-reported

Introduction

Population aging has become a major demographic trend, with the number of older people increasing. This growth is mainly due to lower birth rates and better healthcare, which have led to longer life expectancy. Both developed and developing countries are experiencing this rise in the older population, leading to increasing concerns about global aging (United Nations Population Fund, 2012).

The fast-growing elderly population in Nepal is becoming a significant demographic trend, highlighting the need for policies and plans to ensure healthy and successful ageing. Both the number and proportion of elderly people have been rising over time. In 1981, Nepal had 857,061 people aged 60 and above, but this number increased 3.47 times to 2,977,318 in 2021, making up 10.2 percent of the total population (National Statistics Office, 2023). In Nepali society, the traditional joint family system is gradually being replaced by nuclear families. As a result, older family members often experience isolation, lack of proper care, lack of happiness, and lack of meaningful conversations with their family members. Changes in cultural values and traditional family support systems have put significant pressure on the older people (Dhakal, 2012).

Oldre people face distinct health challenges that differ from those of younger adults. In Nepal, a growing number of older people are experiencing various health issues (Shrestha, 2013), including malnutrition, chronic illnesses, and limited access to healthcare services. Many health problems in old age are long-term, such as heart disease, arthritis, high blood pressure, stroke, diabetes, cataracts, cancer, and chronic infections. Additionally, older adults often suffer from multiple chronic conditions, including vision and hearing impairments as well as speech difficulties. Most previous studies have focused on the use of healthcare services by older people, while research on disease patterns among older people in Nepal remains limited. As the prevalence of multiple chronic conditions rises, it is essential to understand these health issues and the factors influencing them.

The United Nations has been observing the UN Decade of Healthy Ageing (2021-2030), emphasizing the importance of daily activities for healthy and successful aging. Longer life expectancy creates opportunities for older people, their families, and communities. Goal 3 of Sustainable Development Goals focusing on ensuring healthy lives and promoting well-being for all ages (United Nations, 2015). This goal can be achieved by employing the experiences, knowledge, and skills of older people.

Engaging in various daily activities is essential for maintaining good health as well as healthy and successful aging. However, older individuals face challenges as they suffer from both communicable and non-communicable diseases, leading to higher healthcare costs and a decline in the number of active older adults (Rai & Thapa, 2023). This study aims to assess health status of older people living in rural community.

Methods

Study Design and Sample Size

A descriptive cross-sectional study design was used to assess health status of older people. This study has been carried out among older people living in Sunkoshi Rural

Municipality, Sindhuli district. A total of 413 older people aged 60 years and above were included in this study. The sample size was calculated using Epi-Info software, considering following parameters: 62 percent of older people utilized health service utilization (Ghimire et al., 2021), 95 percent confidence interval, 5 percent margin of error, a design effect of 1.2, and 10 percent non-response rate. The data were collected from October to November 2021.

Study Variables

The independent variables used in this study were demographic and socio-economic factors such as age of respondents, sex, marital status, caste/ethnicity, religion, education, working status, living arrangement, economic source of living, family types, health insurance, and wealth index.

Self-reported health status was taken as a dependent variable. This variable was assessed by asking a question " How is your health condition now?". The responses were very good, good, moderate, poor and very poor. These responses were categorized into three groups: good (very good and good), moderate, poor (poor and very poor).

Data Analysis

STATA 15 was used for data analysis and statistical testing. Descriptive analysis was conducted to assess the socio-demographic, economic and health behavior characteristics and chi square test was employed to examine the association between dependent and independent variables.

Result and Discussions

The background characteristics such as demographic and socioeconomic characteristics of older people are given in Table 1. The table shows that above two-fifths of older people were from 60-69 age-group, two-fifths were in the age group 70-79 and less than one-fifths (16.5%) were above 80 years. A study conducted by Chalise and Rosenberg (2019) found that majority of older people belong to the age group 60-69 years. About 52 percent of older people were male and 48 percent were female. In terms of caste and ethnicity, the Hill Caste makes up the largest share (50.6%), followed by Janajati (39.5%) and Dalit (9.9%). About 62 percent of older people were married, while 37 percent were widowed or separated. Regarding education, a significant portion (69.2%) of older people had no education, 18.6 percent were literate but no formal education. Most older individuals follow Hinduism (88.9%), with smaller proportions identifying as Buddhists (10.6%) and Christians (0.5%). In terms of living arrangements, the majority older people were living with their sons and daughters-in-law (63.9%), whereas 9.7% were living alone. About 49 percent of older people were currently working, while 51 percent were not currently working. Thirty percent of older people reported son and daughter-in-low income as a main economic source, followed by self-income (29.8%). The majority of older people did not have health insurance (84.5%). Two-thirds of the older people were from joint families. The older people were fairly evenly distributed across the wealth quintiles.

Table 1

Percentage Distribution of Older People by Demographic and Socioeconomic Characteristics

Background characteristics	Percent	Number
Age group		
60-69	44.6	184
70-79	39.0	161
80+	16.5	68
Sex		
Male	51.6	213
Female	48.4	200
Caste/Ethnicity		
Hill caste	50.6	209
Hill Janajati	39.5	163
Hill Dalits	9.9	41
Religion		
Hindu	88.9	367
Buddha/Christian	11.1	46
Current marital status		
Unmarried	1.5	6
Married	61.5	254
Widowhood/separated	37.0	153
Education		
No education	69.2	286
Primary	24.7	102
Secondary	6.1	25
Working status		
Currently working	48.7	201
Not working	51.3	212
Living arrangement		
Living alone	9.7	40
Living with spouse and children	21.8	90
Living with son/daughter-in-law	63.9	264
Living with daughter/grandchildren/relatives	4.6	19
Main economic source of living		
Pension	5.6	23
Self-income	33.4	138
Social security allowance	12.1	50
Son/daughter support	16.0	66
Son/daughter-in-law	30.3	125
Daughter/Son-in-law/grand children	2.7	11
Health insurance		
No	84.5	349
Yes	15.5	64
Type of family		
Nuclear family	34.4	142
Joint family	65.6	271

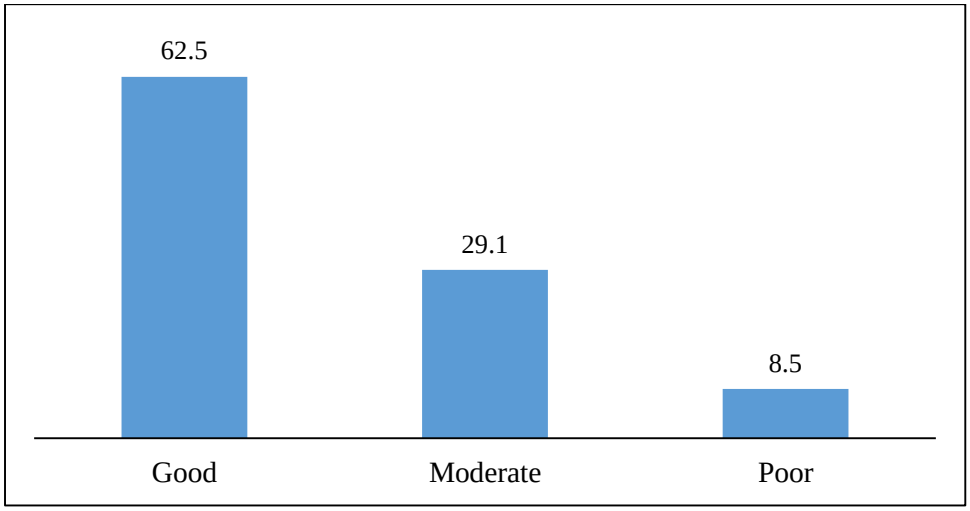
Background characteristics	Percent	Number
Wealth index		
Poorest	20.3	84
Poorer	19.9	82
Middle	19.9	82
Richer	20.1	83
Richest	19.9	82
Total	100.0	413

Health Status of Older People

Overall, about 63 percent of older people reported good self-reported health status, and about one in ten older people reported poor health status, the remaining proportion of older people (29%) reported moderate health status (Figure 1). This study found a higher prevalence of good health status than previous studies (Paudel, 2022). Percent distribution of older people by self-reported health status according to selected background variables are presented in Table 2. The prevalence of poor health status is two times higher among the older people aged 70-79 (10%) and four times higher among the older people aged 80 and above (18%) than older people aged 60-69 (4%). The findings of age patterns of self-reported health status are consistent with previous studies in Bangladesh (Rahman et al., 2018) and India (Basumatary et al., 2024). This result may be attributed to the health problems that tend to increase with age among older people. The prevalence of poor health status is higher among males (10%) than females (7%). which is inconsistent with previous studies (Basumatary et al., 2024; Rahman et al., 2018). Males may perceive poor health status due to greater use of healthcare services and higher health awareness. Among different caste and ethnic groups, the prevalence of good health is higher among Hill Janajati older people (66%), followed by Hill Dalits (61%) and Hill Caste (60%), while the prevalence of poor health status is higher among Hill Dalits (15%), followed by Hill Caste (8%) and Hill Janajati (7%). Disparities in self-reported health status between social groups indicate underlying deeper social inequalities and structural barriers in Nepali societies.

Figure 1

Prevalence of health status among older people



The prevalence of good health status is higher among older Buddhist/Christian than Hindu, whereas prevalence of poor health status is lower among older Hindu than among Buddhist/Christian. However, there is no statistically significant association between self-rated health status and religion. A higher proportion of married older people (69%), older people with primary education (74%), those currently working (79%), and those living with spouse and children (68%) had reported good self-reported health status. There are statistically significant differences in the self-reported health status distribution by marital status, level of education and working status. Currently married older people receive better healthcare and support compared to those who are unmarried or widowed.

Additionally, older people with education are generally more aware about health and diseases, enabling them to take timely preventive and curative measures. As a result, currently married and educated older people more likely to report their perceived health status as good. Economically dependent older people have a higher likelihood to perceive their health status as poor in comparison to those who are economically independent (Srivastava et al., 2021). It may be argued that older people who are working tend to be financially independent, have better access to healthcare and are able to prevent health problems and cure diseases in timely, making them more likely to perceive their health status as good compared to those who are not working.

Table 2

Percentage distribution of older people by self-reported health status according to background characteristics

Background characteristics	Self-reported health status				Statistical test
	Good	Moderate	Poor	Total	
Age group					
60-69	78.8	17.4	3.8	100.0	$\chi^2 = 50.53$
70-79	56.5	33.5	9.9	100.0	$p = 0.000$
80+	32.4	50.0	17.6	100.0	
Sex					
Male	69.0	21.1	9.9	100.0	$\chi^2 = 13.53$
Female	55.5	37.5	7.0	100.0	$p = 0.001$
Caste and ethnicity					
Hill Caste	59.8	32.1	8.1	100.0	$\chi^2=4.09$
Hill Janajati	66.3	26.4	7.4	100.0	$p=0.396$
Hill Dalits	61.0	24.4	14.6	100.0	
Religion					
Hindu	61.3	30.5	8.2	100.0	$\chi^2=3.49$
Buddhist/Christian	71.7	17.4	10.9	100.0	$p=0.176$
Current marital status					
Unmarried	50.0	33.3	16.7	100.0	$\chi^2=13.43$
Married	69.3	23.6	7.1	100.0	$p=0.010$
Widowhood/separated	51.6	37.9	10.5	100.0	
Level of education					
No education	58.0	31.5	10.5	100.0	$\chi^2=9.54$
Primary	73.5	22.5	3.9	100.0	$p=0.050$

Background characteristics	Self-reported health status				Statistical test
	Good	Moderate	Poor	Total	
Secondary	68.0	28.0	4.0	100.0	
Working status					
Currently working	79.1	16.4	4.5	100.0	χ^2=46.25
Not working	46.7	41.0	12.3	100.0	*p*=0.000
Living arrangement					
Living alone	60.0	32.5	7.5	100.0	χ^2=11.88
Living with spouse and children	67.8	22.2	10.0	100.0	*p*=0.066
Living with son/daughter-in-law	62.5	30.7	6.8	100.0	
Living with daughter/son-in-law/grand children	42.1	31.6	26.3	100.0	
Main economic source of living					
Pension	69.6	26.1	4.3	100.0	χ^2=10.78
Self-income	68.1	24.6	7.2	100.0	*p*=0.377
Social security allowance	52.0	42.0	6.0	100.0	
Son/daughter support	60.6	28.8	10.6	100.0	
Son/daughter-in-law	62.4	28.0	9.6	100.0	
Daughter/Son-in-law/grand children	36.4	45.5	18.2	100.0	
Health insurance					
No	62.2	30.1	7.7	100.0	χ^2=2.30
Yes	64.1	23.4	12.5	100.0	*p*=0.318
Type of family					
Nuclear family	68.3	26.8	4.9	100.0	χ^2=4.78
Joint family	59.4	30.3	10.3	100.0	*p*=0.093
Wealth index					
Poorest	67.9	20.2	11.9	100.0	χ^2=11.96
Poorer	68.3	23.2	8.5	100.0	*p*=0.155
Middle	54.9	39.0	6.1	100.0	
Richer	60.2	28.9	10.8	100.0	
Richest	61.0	34.1	4.9	100.0	

The prevalence of good self-reported health is higher among those older people who rely on a pension (70%) or self-income (68%) for their main economic source of living. The prevalence of good self-reported health is higher (64%) and among older people with health insurance, while the prevalence of poor self-reported health is also higher in this group compared to those without health insurance. Older people living in nuclear families have a higher prevalence of good self-reported health than those living in joint families. The prevalence of good self-reported health is nearly consistent pattern with wealth index except middle wealth index, whereas the prevalence of poor self-reported health does not seem to be consistent pattern with wealth index. Older people form poorest (12%) and richer (11%) households have higher prevalence of poor health status. The results further indicate that there are no statistically significant differences in self-reported health status across living arrangements, economic source of living, health insurance, family type, and wealth index.

Conclusion

This study provides valuable insights into the self-reported health status of older people in Sunkoshi Rural Municipality, Sindhuli District as health issues among older people are a growing concern due to a decline in physical, mental, body functions and high vulnerability to chronic diseases. A majority of older people perceived their health status as good. The results of the study shows that age, sex, marital status, level of education, and working status have significant ($p<0.05$) relationship with self-reported health status of older people. As older population continues to grow in Nepal, it is crucial to address health related challenges. Inclusive and sustainable initiatives are especially essential for older people living in rural communities such as Sunkoshi Rural Municipality.

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