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For many Nepalis abroad, the most frightening phone call is not about money.

It is the call saying a parent has fallen in the bathroom. The blood-pressure reading is wrong. Someone needs to go to the hospital. A document must be signed. The neighbour has noticed that father has not opened the gate. Mother says she is fine, but nobody is completely sure.

Migration can improve a family's finances while making care physically harder. This is one dimension of how migration is reshaping the Nepali family. A son in Dubai can transfer money in minutes. A daughter in Sydney can arrange a doctor's appointment online. Neither can immediately accompany a parent

down three flights of stairs in Kathmandu.

This is becoming a structural question for Nepal, not merely a private family problem. The 2021 census counted people aged 60 and above at about **10.2 percent of the population**, while migration continues to remove large numbers of working-age adults from the households in which older people traditionally expected to age.

What happens when the children leave, the parents grow older—and the family discovers that remittances cannot perform every kind of care?

Nepal's family-care model was built around proximity

Older-age care in Nepal has historically depended heavily on family.

In the traditional multigenerational household, care did not necessarily appear as a formal service. Someone was simply there. A daughter-in-law prepared food. A son arranged transport. Grandchildren fetched medicine. A relative accompanied an older person to a clinic.

That model works only when enough family members remain geographically close.

Research on Nepal's ageing population notes that household structures are changing as migration, urbanisation and preferences for smaller nuclear families increase. Nepal's average household size fell from roughly six people in 1991 to about four in 2021, while a significant share of households now has a member abroad.

The implication is straightforward: Nepal is ageing at the same time that its informal care system is being geographically stretched.

Money can travel. Hands-on care cannot.

Migration often improves the material circumstances of parents who remain in Nepal.

Remittances can pay for medicines, better food, private consultations, home repairs and emergency treatment. They can reduce the financial anxiety that accompanies ageing.

But care has a physical component.

A recent mixed-method study of older parents in Kathmandu whose children had migrated abroad described precisely this gap: digital communication and remittances provided connection and financial support, but they could not replace practical care such as accompanying a parent to hospital.

This distinction is fundamental.

A family may have enough money to purchase healthcare and still lack someone who can recognise that healthcare is needed.

Loneliness is not the same as living alone

The evidence on migration and older parents in Nepal is more nuanced than the assumption that every parent left behind becomes isolated.

A 2018 study of 260 older adults in Krishnapur municipality found that 51.2 percent of households had at least one migrant adult child. Most older participants still lived with family and had a caregiver available. Migration was not significantly associated with most of the measured adverse health outcomes, although parents with migrant children had higher odds of self-perceived loneliness.

That context matters. A parent whose eldest son is abroad may still live with another child, grandchildren and extended family.

But the protection offered by the joint family may weaken as multiple children migrate, couples move to cities and household sizes shrink.

More recent research points in that direction. A study based on 697 left-behind older adults found that parents whose children had all migrated internationally faced higher risks of anxiety and stress than parents whose children had migrated internally.

Mothers of internationally migrated children were particularly vulnerable.

The problem, then, is not simply migration. It is migration combined with the disappearance of the remaining care network.

The emergency exposes the real system

Families often believe they have an ageing-parent plan until something happens at 2 a.m.

Consider a common arrangement: two children live abroad, the parents live in the family house in Nepal, money is sent regularly and everyone speaks on WhatsApp every day.

Then one parent falls.

The actual care system suddenly becomes visible. Who has a key? Who can reach the house within twenty minutes? Who knows the medications? Which hospital should the ambulance use? Who can authorize payment? Who will stay overnight? Who updates the children abroad?

If the answers are “the neighbour” or “we will call a cousin,” then the family has an informal dependency, not a plan.

The cost of distance can be calculated

Distance creates financial costs as well as emotional ones.

Suppose a migrant child makes two emergency trips to Nepal in a year. If each trip costs the equivalent of NPR 120,000 in airfare, local travel and immediate expenses, that is NPR 240,000. Add ten unpaid or disrupted workdays valued at NPR 15,000 per day and another NPR 150,000 disappears.

The annual distance cost becomes approximately:

NPR 240,000 travel + NPR 150,000 lost work = NPR 390,000.

This is an illustrative example, not an average. The actual figure varies enormously by country, job and season.

But it demonstrates why eldercare should be included in diaspora financial planning. A migrant who carefully budgets remittances but keeps no emergency travel reserve has ignored one of the most predictable risks of having ageing parents thousands of kilometres away.

The sibling problem

Migration can also redistribute family responsibility unevenly.

One sibling lives in Australia and sends money. Another remains in Nepal and takes parents to appointments, handles government offices, buys medicine and responds to emergencies.

Both may believe they are carrying the heavier burden.

The migrant may say: “I pay for everything.”

The sibling in Nepal may say: “I do everything.”

Both can be correct.

Money and time are different forms of care. Families get into conflict when one is treated as automatically more valuable than the other.

A more explicit system can help: agree which expenses are shared, compensate a sibling when caregiving materially affects work, divide administrative responsibilities and avoid treating the person who stayed in Nepal as permanently available simply because they live closer.

Parents often hide the problem

There is another complication: older parents may actively protect their migrant children from bad news.

A parent may minimise pain because a daughter has an important job abroad. A hospital visit is mentioned only after discharge. Financial difficulties are concealed because “the children already have enough pressure.”

Daily video calls can therefore create an illusion of visibility.

“I am fine” is not a medical assessment.

Families need additional signals: regular health checks, a trusted local contact and permission for someone nearby to communicate concerns directly.

Technology helps most when it is organised before the emergency

Digital tools have made transnational caregiving much easier.

Video calls allow children to see parents rather than merely hear them. Banking apps move money instantly. Reports can be photographed and sent to doctors. Appointments can be booked remotely. Medicine can sometimes be ordered for delivery.

But technology works best when the family has organised information in advance.

A useful eldercare file should contain current medications, diagnoses, allergies, doctors, hospital preference, insurance or health-program information, citizenship details, emergency contacts and copies of relevant documents.

It should be accessible to at least one trusted person in Nepal and the children abroad.

The objective is not surveillance. It is reducing decision-making time when somebody is frightened.

Healthcare becomes harder when several conditions accumulate

Ageing rarely arrives as one isolated medical problem.

Diabetes may coexist with hypertension. Arthritis makes travel difficult. Hearing loss complicates telephone conversations.

Memory problems make medication management less reliable.

Nepal's health system also faces structural challenges in delivering geriatric care. Research on older-adult healthcare points to shortages of specialised services, uneven access and the growing burden created by demographic ageing.

For diaspora families, this means the question is not only whether a good hospital exists. It is whether the parent can reach it, navigate it and follow the treatment plan afterward.

The house that once represented security can become a risk

Many older parents remain in houses designed for a younger family.

Bedrooms are upstairs. Bathrooms have slippery floors. Stairs lack rails. The kitchen requires bending and lifting. The house may be large enough for eight people but occupied by two.

Families often spend heavily on medical treatment while ignoring the cheaper intervention of making the home safer.

Grab rails, better lighting, non-slip flooring, accessible bathrooms, a downstairs sleeping area and reliable door access can reduce everyday risk.

The diaspora's instinct is often to build a bigger house in Nepal. Ageing may require making the existing one smaller and easier to use.

Property and paperwork become care issues too

Ageing parents frequently remain the legal centre of family property.

Land, bank accounts, pensions, citizenship records, tax documents and inheritance questions can become difficult when children live abroad and parents become less mobile.

This is where families need planning before capacity declines.

The appropriate legal arrangements depend on the family and current Nepali law, so professional advice may be necessary. The general principle is simpler: do not wait for illness to discover where documents are or who is authorised to act.

The remittance paradox

Our analysis of where remittance money goes showed how migration income can strengthen household welfare, healthcare and financial resilience.

Eldercare reveals the other side.

The same migration that generates the money may remove the person who would traditionally have provided daily care.

This is not an argument against migration. For many families, migration is precisely what makes good medical care affordable.

It is a reminder that money solves one dimension of vulnerability while potentially increasing another.

The return question changes when parents age

For younger migrants, returning to Nepal is often discussed through career and income.

Later, parents enter the equation.

Our return-to-Nepal financial framework treated family proximity as one of the assets that a salary comparison cannot capture.

Ageing makes that asset concrete.

A professional may sacrifice substantial overseas income by returning. But if the alternative is repeated emergency travel, outsourced care and years of anxiety, the financial difference is not as simple as foreign salary minus Nepal salary.

That still does not mean returning is automatically the right decision. A child may have their own children, mortgage, citizenship path and career abroad. Parents may explicitly prefer to remain in Nepal.

The correct decision depends on the whole family, not a cultural assumption that migration creates a debt that can only be repaid by coming home.

Bringing parents abroad is not a universal solution

Families sometimes imagine reunification as the obvious answer.

But moving an older parent abroad can exchange one form of isolation for another.

A parent who had neighbours, relatives, familiar food, temples and independence in Nepal may become dependent on children for transport and conversation in another country. Visa eligibility, health insurance and healthcare costs can also be substantial constraints.

Some parents thrive after joining children abroad. Others count the days until the next Nepal visit.

Care should not be confused with relocation.

A practical diaspora eldercare plan

A family does not need a sophisticated care company to become better prepared.

At minimum, five systems should exist before a crisis:

Local person: one reliable relative, neighbour or paid caregiver who can physically reach the parent.

Medical record: an updated list of conditions, medicines, doctors and preferred hospitals.

Emergency money: funds immediately accessible in Nepal without waiting for an international transfer.

Travel reserve: enough liquidity for a child abroad to fly home at short notice.

Decision agreement: siblings understand who handles medical, financial and administrative responsibilities.

The goal is not to professionalise family love. It is to stop love from being forced to improvise under pressure.

Nepal will eventually need more care outside the family

The deeper policy question is what happens when family care is no longer enough.

Nepal will need stronger community-based elder services, geriatric healthcare, home-care options, social protection and credible assisted-living models. These services should complement families rather than assume abandonment.

The demographic direction makes this difficult to avoid.

As migration becomes generational—as explored in what happens to Nepali families after a generation abroad—fewer households can assume that an adult child will eventually return to provide full-time care.

The hardest transfer cannot be made through a bank

Nepal's migration story is often told through departures and remittances.

Ageing parents reveal what those statistics leave out.

A migrant can finance medicine from another continent. They can call every evening. They can install cameras, hire help and book flights.

What they cannot transfer electronically is presence.

Families do not need to respond to that fact with guilt. They need to respond with planning.

The question is no longer simply whether children abroad are supporting their parents.

It is whether the family has built a system that still works on the day money is not the thing their parents need most.

Research note: Nepal's older population figure refers to the 2021 census definition of age 60 and above. Research on migration and parental well-being is context-dependent: studies cited here differ by location, sample and migration pattern, and association should not be read automatically as causation. Financial examples are illustrative rather than estimates of typical diaspora-family costs.

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