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Navigating the Complexity of Elderly Self-care: A Narrative Review of Barriers and Facilitators in Chronic Disease Management

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Abstract

Context: Global life expectancy is rising, shifting the burden of chronic disease management largely to patient self-care. For the elderly population, independent care is complex and highly susceptible to age-related changes, yet a comprehensive understanding of what hinders or promotes this process remains fragmented.
Objective: This review aims to identify, categorize and analyze the multi-dimensional barriers and facilitators influencing chronic disease self-care among adults aged 60 and older.
Methods: A comprehensive search of databases including PubMed, PsycINFO and Google Scholar was conducted for English language peer-reviewed articles published between 2016 and 2026. A narrative synthesis framework was applied to extract, cross-reference and map critical structural, social, and personal themes.
Results: An initial 974 records were retrieved; 586 duplicates were removed and 466 were excluded during title and abstract screening. The remaining 122 full-text manuscripts underwent evaluation, yielding a final cohort of 42 high-quality, mixed-design studies for thematic synthesis after 74 were excluded for methodological variations.
Discussion: The intersection of physical decline, cognitive limitations and multimorbidity forms a "vulnerability triad", complicating self-care as medical needs outpace patient capacity. While cognitive ageing and low health literacy hinder adherence, robust social networks and self-efficacy facilitate it. Digital interfaces provide essential external cognitive support but require age-inclusive design and human-led onboarding.
Conclusion: Elderly self-care is dictated by a delicate balance between personal limitations and external support systems. Improving elderly self-care and health outcomes requires a shift to holistic, person-centered models. Healthcare providers must actively mitigate physical barriers while leveraging family-centered support frameworks.

Keywords: Barriers and Facilitators, Chronic disease, Elderly, Narrative review, Self-care

Introduction

Global population ageing is driving a demographic shift; by 2050, individuals over 60years are expected to account for 21% of the world population.[1] The steady rise in global life expectancy has resulted in a greater burden of chronic diseases.[2] This is expected to lead to an increased demand for medical and social support services to manage age-related diseases.[3] The National Council on Ageing reports that the vast majority of older adults (80%) suffer

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from at least one chronic disease.[1] Worldwide, chronic diseases account for 74% of all mortality, serving as a primary cause of morbidity. Consequently, these conditions present substantial logistical and financial challenges for global healthcare systems.[2] These challenges could be minimized using strategies such as patient-driven self-care.

Patient-driven self-care is fundamental to chronic disease management. It involves the engaging in actions and behaviours aimed at monitoring and managing chronic illness and maintaining health.[4] According to the World Health Organization, self-care encompasses the abilities of individuals, families and communities to foster health, prevent diseases and maintain wellness through independent actions, thereby empowering people to make health-focused decisions for sustained physical and mental well-being.[3] Self-care encompasses health literacy, self-monitoring, independent symptom management, physical activity and stress management. It serves as a preventive measure against disease progression, achieved through informed lifestyle modifications and the timely utilization of professional healthcare resources.[3] Managing self-care is a complex process. Patients have unique perspectives on their illness, leading to varied priorities, support expectations and self-care practices. Furthermore, these experiences are significantly influenced by health literacy, confidence, social support and access to medical resources.[4] As individuals get older in age, the adoption of positive health behaviours often declines. This decline is driven by personal limitations and systemic barriers such as poverty, isolation and low health literacy which make it difficult for older adults to translate general healthcare information into personalized self-care.[3]

This decline is made worse by a consistent failure of existing well-established self-care frameworks to account for the unique vulnerabilities of the ageing population.[5,6] Current medical guidelines are predominantly disease-centric, offering isolated protocols for single diseases like hypertension, diabetes mellitus or heart failure. However, older adults rarely present with a single pathology; instead, multimorbidity shapes clinical reality, and exponentially increases the complexity of self-care maintenance, monitoring and management.[5,6] Executing these highly granular tasks requires intact physical, sensory and cognitive capacities- faculties that naturally decline with advancing age. When an older adult is faced with polypharmacy and complex dietary restrictions, the cumulative treatment burden can rapidly exceed their functional reserve, leading to non-adherence, medical errors and preventable hospitalizations.[5]

Furthermore, very few studies have holistically addressed the challenges older adults face in adhering to self-care, as existing literature on elderly self-care remains highly fragmented. Quantitative clinical trials frequently isolate specific behavioural interventions but ignore the broader socio-environmental contexts such as social isolation, financial strain or low health literacy, that dictate whether a patient can realistically adopt these tools. Conversely, qualitative studies capture the lived experiences of patients but often lack systemic integration with established theoretical frameworks of self-care science. A narrative synthesis allows for a broad, multi-dimensional integration of diverse evidence. By mapping both quantitative and qualitative data onto a cohesive framework, this review explains not just what makes self-care behaviour fail but how intrinsic biological declines interact with extrinsic system failures to shape health outcomes in older demographics. This study aimed to identify, categorize and synthesize the multi-dimensional barriers and facilitators that influence elderly self-care in chronic disease management.

Methods

Search strategy and information sources

To ensure a comprehensive synthesis of the literature, a detailed search strategy was executed across the following databases: PubMed, PsycINFO, and Google Scholar. The search was restricted to peer-reviewed articles published between 2016 and 2026 and limited to English language publications.

A detailed search was performed using a combination of Medical Subject Headings (MeSH) terms and title/abstract keywords. Search strings included “Aged”, “Older adults”, “geriatric populations”, “self-care”, “self-management”, “chronic disease management”, “chronic illness”, “therapeutic adherence”, “barriers”, “facilitators”,

"enablers", "challenges". Boolean operators, "AND and OR," were applied to anchor the search around three central conceptual blocks: target population; the core phenomenon of interest; and operational determinants.

Study inclusion and exclusion criteria

Studies included in the review were peer-reviewed primary empirical studies (qualitative, quantitative, mixed-methods, systematic reviews, scoping reviews), with a target population of older adults aged 60 years and above; investigations explicitly evaluating self-care behaviours, monitoring or maintenance in the context of one or more chronic diseases; and studies published in English language. Excluded studies were dissertations, grey literature, conference abstracts, editorials and book chapters; as well as studies focusing strictly on acute clinical care settings rather than community-dwelling or outpatient populations.

Data extraction and thematic synthesis

Data extraction and synthesis were executed through an integrated process where findings from the standardized extraction matrix directly informed a thematic narrative synthesis guided by the Popay et al framework.[7] Data was extracted using a standardized form capturing study metadata, participant demographics and specific textual or numerical data regarding self-care barriers and facilitators. The extracted findings were deductively categorized into a multi-level socio-ecological structure spanning patient, interpersonal and systemic domains. Within these domains, line-by-line iterative coding was used to inductively uncover specific sub-themes. The heterogenous qualitative insights and quantitative descriptive statistics were merged textually, culminating in a robust, context-rich narrative.

Results

The initial multi-database search yielded a total of 974 records. Following the automated and manual removal of duplicate citations (n=386), a total of 588 unique titles and abstracts were screened against the operational eligibility criteria. Out of these, 466 records were excluded during the initial screening stage due to a lack of alignment with the target age demographic, a primary focus on acute-care clinical interventions or an absence of explicit self-care behavioural endpoints. The remaining 122 manuscripts underwent a rigorous full-text evaluation. During this secondary appraisal, 74 articles were excluded for specific methodological variations, including: sample populations falling below the age threshold of 60 (n=65) and study designs restricted to grey literature or non-reviewed conference proceedings (n=15). A final cohort of 42 high-quality studies comprising qualitative, quantitative and mixed-methods designs was selected for extraction and narrative thematic synthesis within this review.

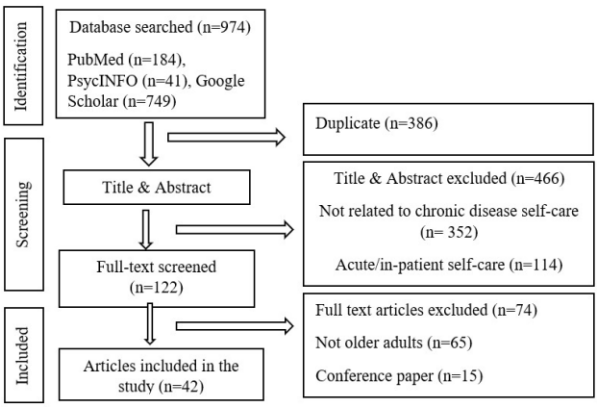

Figure 1: Flow Diagram for Study Selection

Discussion:

The narrative synthesis of the 42 included studies demonstrates that self-care among older demographics managing chronic diseases is governed by a complex, bidirectional ecosystem of determinants. To establish clarity, these empirical findings were classified into four primary thematic domains: Individual-level barriers, psychosocial and socio-economic barriers, healthcare system barriers and facilitators of effective elderly self-care dimensions. Within each respective domain, data had sub-headings of the various individual and systemic variables that influence elderly self-care in chronic disease management.

Individual-level barriers to elderly self-care

Physical limitations and Cognitive Decline

The empirical literature consistently establishes that age-related physiological decline constitutes a fundamental structural impediment to effective self-care maintenance and symptom monitoring.

Sensory impairments including visual or auditory deficits may hinder elderly persons' ability to read their medication labels, comprehend verbal medication directions or engage in self-care practice of eating healthy meals, thereby negatively affecting their independence.[8,9] Also, the physical execution of self-care tasks is frequently restricted by chronic pain and functional mobility limitations.[10]

Furthermore, cognitive impairment severely affects the self-care capabilities and adherence of the elderly, reducing the mental efficiency required to monitor symptoms, manage complex medication schedules, and plan health-maintenance habits.[11-13] Deficits in memory, attention, and executive function impair the perception, interpretation, and processing of early adverse symptoms.[11] Consequently, cognitive deficits and decreased health literacy are significantly associated with non-adherence to self-care behaviours.[12,14] Conversely, higher education is associated with higher cognitive function and better self-care. Patients with cognitive impairment without dementia as well as those with normal mini-mental state examination scores show significantly better self-care outcomes than those with moderate dementia.[11]

Multimorbidity

The physical complexity of multimorbidity care frequently exacerbates individual deficits, as older adults managing multiple chronic diseases often demonstrate lower self-care capabilities than those with a single diagnosis.[15] The interaction of multiple chronic conditions accelerates physical and cognitive decline, increasing physiological strain and deepening overall disease burden. This complexity complicates self-management, diminishes self-efficacy and leaves patients increasingly vulnerable.[16,17] Specifically, patients with multimorbidity must often follow several complex self-management regimens prescribed by multiple specialty health care providers, which may frequently conflict across conditions.[5] Also, the necessity of managing distinct medication regimens for concurrent conditions severely exacerbates the overall therapeutic burden.[18] Consequently, older adults with multimorbidity generally exhibit lower medication adherence, minimal engagement in health information seeking and passive disease monitoring that focuses solely on basic symptom control.[19,20] Since, many older adults with multiple chronic conditions require care from several independent healthcare providers, a lack of institutional coordination forces them to navigate uncoordinated specialists and disjointed medical information. Lacking adequate systemic support and clear clinical direction, many patients eventually manage their illnesses in isolation, facing what is frequently characterized as a "lonely battle".[19]

Psychosocial and socio- economic barriers

Psychological factors

Psychological health plays a critical role in determining an older adult's self-care management efficacy. Psychological distress, including anxiety and depression, can negatively impact older adults' cognitive function and emotional states, thereby reducing their self-efficacy and adherence to self-care behaviours.[17] Negative emotions hinder medication adherence and increase health risks including higher readmission rates and extended hospital stays, which in turn compromise self-care and overall quality of life.[17] Loneliness negatively impacts the motivation and willingness of older adults with chronic diseases to engage in self-care activities, thereby constituting a distinct psychological barrier.[21] Furthermore, literature indicates that depression severity independently predicts treatment adherence, with higher severity correlating to reduced adherence to the treatment plan.[2]

In contrast, a strong sense of self-efficacy consistently emerges as a powerful facilitator of successful self-care in older adults. Individuals with strong self-belief are more likely to adopt and maintain health-promoting habits, resulting in better clinical outcomes.[22,23] Higher self-care self-efficacy fosters greater confidence in disease management, resilience against obstacles and better emotional regulation. Conversely, older adults with low self-efficacy may find self-care overwhelming, leading to disengagement and poorer health outcomes.[16,24] High self-efficacy is associated with increased medication adherence, as older patients with high self-efficacy were able to adhere to complex medication schedules, push through barriers such as side effects and forgetfulness and

reach out for support when necessary.[2,25-27] Ultimately, a significant positive correlation exists between self-efficacy, smoking cessation and stress management.[28]

Social Isolation

Social isolation and solitary living arrangements are identified as major extrinsic threats to sustainable self-care. Social isolation is increasingly recognized as a significant determinant of poor health-promoting behaviours among older adults.[29] Chronically ill older people who cannot care for themselves often choose to live with their adult children. However, with rapid social and economic development, the migration of adult children has negatively impact older adults, resulting in a lack of support and care from family, friends and society. This lack of support can lead to feelings of isolation alongside severe social and psychological pressures.[23] Older adults with chronic diseases especially those with multimorbidity who are socially isolated are more likely to exhibit reduced self-care capabilities, notably poor medication adherence, physical inactivity and diminished spiritual growth. This relationship is mediated by low social support and loneliness.[15,28] Furthermore, relinquishment of occupational roles post-retirement often results in decreased social interaction and heightened isolation, thereby diminishing older adults drive for self-care.[12]

Financial Constraints

Economic constraints serve as a major barrier to healthcare utilization, disproportionately affecting socioeconomically disadvantaged older adults and the underinsured. Despite the availability of services, out-of-pocket expenses frequently render them inaccessible. The affordability challenge is further amplified by the frequent need for medical visits and pharmacological treatments associated with managing multimorbidity in the elderly.[6] Limited income and economic dependency often affect the elderly population, particularly in low- and middle-income countries.[6,20] Financial limitations significantly impede access to treatment and follow-up, thereby undermining older patients' perceived efficacy in symptom management.[16] Ultimately, low income and poverty severely undermine self-care in older adults managing chronic diseases. Constrained by inadequate pensions, many sell off assets or borrow money to survive. Faced with high out-of-pocket medical bills and transportation costs, these individuals often prioritize their families' financial survival ahead of their own routine medical care.[29]

While health insurance remains vital for mitigating out-of-pocket costs, reports from low- and middle-income countries highlight low coverage for older adults, forcing them to rely on expensive alternative care.[29]

Health Literacy

Low health literacy is strongly associated with decreased self-care behaviours.[15,30] In older adults, low health literacy hinders the accurate understanding of health information, thereby negatively impacting chronic disease management.[31] For instance, medication adherence shows a significant positive correlation with health literacy; patients with lower literacy levels often struggle to comprehend prescription instructions, read drug labels, access vital health information and communicate effectively with their physicians.[30,32] Consequently, health literacy emerges as a key predictor of self-efficacy. Older adults with higher health literacy possess a stronger motivation and greater confidence to engage in and maintain successful self-care behaviours.[30,33]

Healthcare system barriers

Limited access to healthcare services

Geographic distance, transportation challenges and shortages of healthcare providers can restrict access to routine care. The intersection of long travel distances, prohibitive transportation costs, and a scarcity of trained healthcare providers frequently exacerbates the impact of age-related frailty, thereby reducing overall service utilization, especially in rural communities.[8,18,29,35] Within healthcare facilities, inadequate clinic space, poor facility designs such as lack of ramps or elevators create major physical accessibility barriers.[6] Also, a notable deficit in specialized geriatric services exists alongside a discrepancy between standard care protocols and the clinical needs of the elderly. Preventive care, which encompasses routine screening and specialized chronic disease management, remains inadequately addressed,

while a scarcity of critical medications, equipment and supplies poses significant obstacle to older patients' care.[6] These physical hurdles transform routine self-care tasks such as attending follow-up appointments or picking up prescriptions into high-stress events that diminish a patient's belief in their ability to maintain a consistent care regimen.[3] As a result, care disruption occurs even in highly motivated individuals due to drug shortages, complex administrative hurdles, distance to healthcare facilities, or fragmented healthcare teams.[8,18] Thus, these systemic failures force older adults to view medical care strictly as a tool reserved for active crisis management rather than a resource for daily personal maintenance.[3]

Poor Patient-Provider Communication

Effective self-care depends on clear communication between healthcare providers and patients, as the quality of provider-patient communication demonstrates the strongest independent positive correlation with both personalized care experiences and favourable clinical outcomes.[18,35]

Older patients with lower education levels and limited health literacy often struggle to fully understand medical information during brief consultations. Furthermore, differing perspectives between doctors and patients exacerbate communication challenges. These structural and interpersonal barriers can prevent patients from clearly expressing their symptoms or comprehending medical advice, thereby reducing the overall quality of clinical interactions and hindering their underlying motivation for self-management.[17] Empirical evidence highlights that these communication gaps are frequently compounded by disrespectful provider attitudes, limited communication, and a lack of institutional accountability, which ultimately causes eroded trust in the health system services.[29]

Facilitators of effective elderly self-care

Social support

Social support significantly predicts self-care behaviours in chronic disease management.[36,37] Strong social networks enhance motivation, facilitate better adaptation to the disease, reduce stress, and improve adherence to treatment recommendations.[1,15,31] Notably, social support is reported to not only directly influences self-care behaviours but to also indirectly influence them by enhancing self-efficacy.[38] Together, social support and health literacy play an important mediating role in self-care capacity, directly influencing health-related quality of life.[31] Effective communication with healthcare professionals coupled with robust family and peer support significantly improves patient self-care, facilitates adaptation to the illness, and enhances self-efficacy.[15]

Specifically, support from family caregivers is vital for maintaining treatment plans and health monitoring, thereby establishing a supportive framework that strengthens older patients' self-efficacy.[16] Social support from family members significantly enhances patient motivation; by assisting with crisis management, sharing vital information, and providing care, families encourage positive health attitudes and behaviours.[39]

While family members serve as the primary source of social support, a combination of both family and peer networks is necessary to feel fully supported. A large, tightly knit network of friends significantly reduces feelings of loneliness; however, unlike family dynamics, building satisfactory friendships relies on mutual exchange of support.[39]

Finally, healthcare professionals' social support is a critical component in minimizing the risk of self-care non-adherence. Conversely, a lack of guidance from healthcare providers heightens risk, whereas ongoing clinical support actively fosters patient engagement and role performance.[12]

Emerging opportunities and technological facilitators

Digital health literacy

Digital health literacy of older adults with chronic disease is positively associated with chronic disease self-care and had an indirect positive effect on self-care through the partial mediating effect of social support.[36,40] Additionally, self-efficacy demonstrates a critical mediating role in this relationship, acting as a bridge through which digital health literacy enhances an individual's capacity to execute chronic disease self-care regimens.[41]

Telehealth and Remote Monitoring

Literature identifies the digital interface as a transformative but complex component of the

modern self-care landscape. Evidence suggests that Remote Patient Monitoring and telehealth serve as vital facilitators, creating a "virtual bridge" that allows for real-time biofeedback and more frequent clinical touchpoints without the physical burden to travel.[42,43] These technologies empower elderly persons by providing immediate data on their physiological status, which demonstrates a clear capacity to increase health confidence and decrease the frequency of emergency interventions.[44]

Mobile Health Applications

Assistive technologies such as monitoring devices, mobile apps, smart medication dispensers and voice activated assistants can support medication reminders, symptom tracking, health education, and communication with healthcare providers.[43] By automating reminders and simplifying complex schedules, these tools compensate for declines in prospective memory and enhance self-care ability in older adults.[44-46] Although digital literacy remains a challenge for some older adults, evidence highlights that these facilitators are effective only when they utilize age-inclusive design.[47-49]

Conversely, current literature identifies various barriers that hinder the adoption of health technologies among older adults.[50] Sociocultural constraints including lower income, poor broad band access, and limited digital literacy, severely impede initial access. Second, age-related cognitive and physical impairments restrict device usability while, dispositional factors such as concerns over privacy, perceived usefulness, and technology anxiety, negatively affect user attitudes. Lastly, technology-related flaws such as inadequate user-centered design and a lack of alignment with older adults' adaptation strategies further hinder successful integration.[50] Older adults living in areas with poor digital infrastructure frequently encounter digital exclusion, which blocks their access to various e-health services aimed at promoting self-care.[1] Many existing e-health services overlook digital exclusion, inadvertently neglecting this vulnerable group of older adults.[1]

Critical analysis: dialectics and unresolved gaps in the literature

While the compiled literature offers a robust foundational map of elderly self-care in chronic disease management, a critical synthesis reveals some conceptual contradictions and systemic gaps that warrant mentioning. First, a social support paradox exists. Family care drives physical adherence but often increases psychological dependency. Conversely, peer networks alleviate loneliness through mutual exchange. Second, a technological contradiction emerges, though telehealth eliminates physical travel burdens. However, it introduces acute cognitive strain and technology anxiety for older adults with cognitive declines. Furthermore, empirical gaps persist regarding age-inclusive design metrics. The literature lacks standardized engineering definitions for software usability. Research also remains patient-centric, ignoring the bidirectional vulnerability of the caregiver-patient dyad. Specifically, rising multimorbidity accelerates caregiver burnout, which ultimately collapses the patient's primary support network. Finally, an existential vacuum remains, as current frameworks fail to examine spiritual coping mechanisms as independent facilitators for chronic disease management.

To effectively address these gaps, future research, should involve collaboration across clinical and engineering disciplines to establish quantifiable, standardized user-experience metric that define "age-inclusive" software design, specifically testing how tailored user interface reduces cognitive load and technology anxiety among older adults with mild cognitive impairment. Additionally, researchers must utilize adaptive intervention designs that dynamically modify interfaces as physical or cognitive capacities decline, while mandating equity-stratified outcomes reporting to measure clinical efficacy across diverse socioeconomic, and geographic baselines. Researchers must shift away from strictly individualistic paradigms to model the bidirectional vulnerability of the caregiver-patient dyad, executing longitudinal studies to determine how rising multimorbidity complexity accelerates informal caregiver burnout and subsequently collapses patient adherence. Finally, future inquiry should operationalize spiritual and existential well-being through validated psychometric scales within geriatric chronic care frameworks, investigating how personal belief systems and community-based

existential support function as active psychological buffers against depression and loneliness.

Limitations of the study

This review acknowledged several methodological limitations. First, restricting the search protocol to English-language publications may introduce linguistic and geographic bias, potentially omitting critical, culturally specific insights into elderly self-care from non-English speaking regions. Also, this synthesis is structurally constrained by the primary literature's frequent grouping of all individuals over 60 years into a single elderly category, which obscures data regarding the unique and severe physical or cognitive barriers faced specifically by the oldest-old sub-population aged 85 and over.

Implications for practice

For healthcare practitioners, optimizing self-care outcomes within an ageing population experiencing multimorbidity requires a fundamental departure from single-disease compliance paradigms. Instead, healthcare delivery must transition towards holistic, person-centered frameworks that explicitly acknowledge the dynamic interaction between an individual's intrinsic functional capacity and their extrinsic socio-environmental ecosystem. It is imperative that clinicians systematically assess older patients' functional, cognitive, and health literacy baselines utilizing validated screening instruments prior to the prescription of complex self-care protocols. Educational interventions must transcend passive didactic methods, utilizing interactive communication techniques such as the "teach back" method, simplified visual schemas and intuitive, gerontological optimized digital health platforms. Furthermore, given that informal support systems function as the primary buffer against self-care failure, clinical workflows should formally integrate family caregivers, ensuring they are systematically trained in symptom recognition and acute management protocols. Also, the utilization of telehealth and digital tools to support ongoing disease management should be encouraged while taking into consideration the development of culturally appropriate interventions tailored to the elderly population.

At the macroeconomic level, public health frameworks must accelerate transitions towards age-friendly health systems that prioritize functional independence and continuous, community-based primary care, thereby improving quality of life.

Conclusion

Self-care is fundamental to successful chronic disease management among older adults. The synthesis of current literature demonstrates that age-related physical and cognitive declines in addition to fragmented institutional infrastructures, constitute formidable barriers to therapeutic maintenance and symptom management. Conversely, these challenges can be effectively buffered by robust informal social networks, clear clinical communication and targeted community-based level resources. To bridge the gap between clinical intent and patient execution, future interventions must prioritize systemic reductions in treatment burden, the structural integration of family caregivers into clinical workflows and the deployment of gerontologically optimized health technologies. Ultimately, fostering sustainable self-care in older demographics requires building age-friendly health systems and policies that structurally compensate for functional vulnerabilities while reinforcing patient autonomy, resilience and overall quality of life.

Addressing the complexity of elderly self-care requires a holistic, person-centered approach that recognizes the interconnected influence of individual, social, healthcare, and environmental factors. Future interventions should focus on strengthening facilitators while reducing barriers to improve health outcomes and quality of life among older adults living with chronic diseases.

Competing interest

The authors declare that there is no conflict of interest.

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