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Dynamics of Health Care Seeking Behaviour of Elderly People in Rural Bangladesh

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Abstract

Bangladesh is projected to experience a doubling of its elderly population from the current level of 7 million to 14 million by the end of the next decade. Drawing upon qualitative evidence from rural Bangladesh, this article focuses on coping strategies in cases of illness of elderly people and the contributing factors in determining the health-seeking behaviour of elderly persons. The sample for this study consisted of elderly men and women aged 60 years or older and their caregivers. Nine focus group discussions and 30 in-depth interviews were conducted. Findings indicate that old age and ill-health are perceived to be inseparable entities. Seeking health care from a formally qualified doctor is avoided due to high costs. Familiarity and accessibility of health care providers play important roles in health-seeking behaviour of elderly persons. Flexibility of health care providers in receiving payment is a crucial deciding factor of whether or not to seek treatment, and even the type of treatment sought.

Keywords: Health-seeking behaviour, elderly people, Bangladesh.

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Introduction

A changing demographic structure is occurring worldwide with a gradual shift towards a higher proportion of older people. With a few exceptions, more people—in both high- and low-income regions—are living longer than ever before. A declining trend in both fertility and mortality rates has increased average life expectancy and created a new set of challenges in today's society. The number of older people in the low-income countries is expanding rapidly. The net increase of older population worldwide is about one million every month—two-thirds of them in the low-income countries (Gorman 2002). In recent years, as population ageing has grown into a "defining global issue" (HelpAge International 2002), concerns have emerged regarding policy interventions appropriate for older people (Gorman & Heslop 2002; Barrientos & Lloyd-Sherlock 2002), especially in the area of elderly health care.

Bangladesh, with one of the highest population densities (985/km^2) (United Nations 2005) in the world, is projected to experience a dramatic growth in the absolute number of its population aged 60 years or older from the current level of approximately 7 million to 14 million by 2020 (WHO 2005; Solomons 2001). While a longer life may offer greater fulfilment in some ways, it also presents multifaceted health problems not commonly associated with low-income countries and thus creates unique challenges for the national health care service. Bangladesh faces a particularly complex situation. On the one hand, the health care needs of older people put increasing pressure on an existing system that is insufficient to meet the needs of all its citizens (Davies 2003). On the other hand, the government primary health care services remain underutilized (Vaughan et al. 2000), or poorly utilized (Pearson 1999), and older people often seek health care services too late, when "extremely ill", to obtain adequate treatment (HelpAge International 2000). The importance of understanding constraints to health care seeking behaviour of older people is of fundamental importance, if a responsive and efficient health care system is to emerge.

This article explores the underlying aspects of health care seeking behaviour of older people in rural Bangladesh. Drawing upon qualitative evidence from rural Bangladesh, the paper focuses on coping strategies of elderly people in case of illness and the contributing factors in determining their health-seeking behaviour.

Research Context and Methodology

In Bangladesh, an estimated 7.3 million people are currently 60 years or older, and it is projected that these numbers will increase by 173% by 2025 (HelpAge International 2000). Around 34% of the Bangladeshi population lives below the national poverty line[1] (UNDP 2003), and 36% of the population earns less then $1 a day. More than 85% of the poor live in rural areas (BBS 2002, World Bank 2002). Although it is one of the poorest nations in the world, Bangladesh has enjoyed an impressive rate of sustained economic growth. During the period 1992–2000, real Gross Domestic Product (GDP) per capita increased by 52 percent, although in a highly inequitable manner. The incidence of poverty and the levels of inequity have increased (DFID 2003), and the share of income controlled by the top 10% of the population is almost seven times more than the share of the bottom 10 percent (UNDP 2003).

Universal primary health care has been the central principle of the public health policy of Bangladesh since the Alma Ata declaration of 1978. Current health policy is articulated in the national Health and Population Sector Program (1999–2003), which emphasises a grassroots, decentralized approach to primary health care delivery. A significant amount of donor assistance has complemented government investment to support the implementation of this program. Primary health care in Bangladesh is provided through three main types of institutions. The *Thana* (sub-district) Health Complex (THC) is designed to bring the primary health care service to the doorstep of the rural people; secondly,

1 The national poverty line—based on 1999-2001 data—was established by national authorities using population-weighted subgroup estimates from household surveys (UNDP 2003).

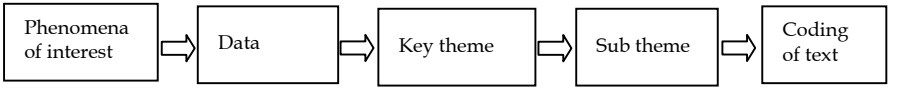
the Union Health and Family Welfare Centre (UNFWC) provides family planning outpatient service at the union level; and thirdly, hospitals and clinics serve as referral points for primary health care. As of 2000, Bangladesh had 460 rural *thanas* and 402 *thana* level health complexes (BBS 2002). In addition to the public health care services, a wide range of private health care services are also available, which include services provided by the non-government organisations (NGOs) and other non-profit entities, traditional and homeopathic providers, qualified pharmacists, and unlicensed drug sellers (World Bank 2002, Ahmed et al. 2005).

The evidence in the present paper is drawn from a qualitative baseline study which was a part of a multi-country health care intervention study, Primary Health Care in Later Life: Improving Services in Bangladesh and Vietnam (PHILL), aimed at improving health and quality of life of elderly people. The project was conducted in the south-eastern part of Bangladesh, in four villages in Chandpur district. Primary health care in the project was defined not only in terms of the government health care system, but also the wide range of health care sources available for the older people in the study area, including community-level health care, private and public services, and self-care at household and individual levels.

Qualitative analysis is widely accepted in health and old age research (Fry & Keith 1986; Sokolovsky & Vesperi 1991, Hutchinson 2001, Pope & Mays 1995). Methods such as focus group discussions (FGDs) are usefully employed to identify the aspects of health care that users value the most from their own perspectives (Schneider & Palmer 2002). Moreover, interviews with older individuals in anthropological studies often provide greater insights since older people retain "in-depth information about the subject" (Shield & Aronson 2003:27) and often reveal the "reasons" behind the facts (Jones 1995). Thus, in this study, semi-structured interviews and focus group discussions with participant respondents were the principal research tools.

The sample for this study included elderly women and men over 60 years of age and their caregivers. Age estimation of older persons can be a difficult exercise due to the non existence of written or numerical

Figure 1. Thematic analysis



Health-seeking behaviour of older people	5 FGD (elderly 4 FGD (care givers) 30 interviews (elderly)	Old body – Ill health Severity of illness Health-seeking experience of two elderly individuals Decision making in health care	Illness severity Accessibility to health care provider Familiarity with health care provider Financing treatment

records, as well as the higher time demand for estimation on the researchers (Howell 1986). In the present study, older individuals' chronological age was estimated using an events calendar which lists key memorable events such as the partition of India, liberation war of Bangladesh, a devastating tornado, flood, and famine in the area. The older persons' biological events were also taken into account to estimate their chronological age.

The qualitative data collection took place during February-November 2003. Two non-random sampling strategies were followed: stratified purposive sampling and opportunistic sampling (Rice & Ezzy 1999). The research team sought out sources of maximum variation, such as gender and economic status, ensuring that older women as well as older men and the different wealth categories were included. The team also took advantage of interviewing opportunities, which arose in the course of the fieldwork. For example, in cases where the selected individuals were absent or did not participate for any reason, the person was replaced by other individuals who fulfilled the research selection criteria and were keen to take part in the interview. Also, both the physical and mental abilities of the elderly participants were taken into consideration while selecting respondents. During the fieldwork, nine FGDs (five with elderly groups and four with caregivers with an average of five individuals per session) and 30 interviews with elderly people (15

men and 15 women) were conducted. The interviews were semi-structured and informal, and respondents were provided ample opportunity to talk about the issues in a flexible and friendly environment. As Gubrium and Sankar (1994) point out, "flexibility" and "sensitivity" to the qualitative research process allow the important issues and discussion to emerge in the course of the research.

The fieldwork focused on elderly persons' perceptions of health and illness and their health-seeking behaviour in the event of illness. The interviews focused on two main aspects. First, the team depicted the pathways of health-seeking strategies, which effectively described the decision-making patterns of the elderly respondents. Then the team focused on the motives for these health-seeking decisions. Taken together, these aspects provided comprehensive insights into how health-seeking behaviour by elderly persons is determined. The heterogeneous nature of the existing primary health care services in rural Bangladesh as well as the unique socio-cultural characteristics of the rural population is explored in this qualitative methodology.

Each individual was interviewed at his/her own premises at his/her preferred times. Some respondents were interviewed several times on different topics related to their health care using personal experiences, preferences, and satisfaction. The interviews were taped and transcribed soon after the interviews. An interactive process between data collection and analysis was maintained (Donovan & Sanders 2005), and the analysis was carried out in three sequential stages. First, a preliminary analysis was conducted based on the initial themes identified in the original research protocol (Grbich 1999; Boyatzis 1998). As these themes were coded in the text, they were situated in a larger thematic context, highlighting the sections and responses as appropriate to an individual respondent's coded identification (Miles & Huberman 1994). Each theme was then divided into sub-themes to identify cluster responses with more specific focus. Finally, an electronic 'scissors and paste' technique was applied to create a table of responses (Green & Thorogood 2004), and each table of response was analysed for generalisable patterns and propositions. The process revealed similarities and differences across the respondents and enabled the documentation of health-seeking patterns

for various types of illness episodes as well as for the recording of the individual illness stories.

Research Findings

Old Body — Ill Health

The qualitative data suggest that, in general, respondents use "old age" and "ill-health" as inseparable entities. When older people's illnesses do not respond to treatments, they tend to explain it by their "old age". As one female respondent stated:

> His (village doctor) treatment is very good; he takes good care of the patients and his medicine is good too. I like him a lot but as I have said, medicine is not effective in old age… (64 year old female respondent, a traditional health care provider—kabiraj).

> He (village doctor) does not pay as much attention to me as he used to... does not touch the pain areas with care either… …well, it is a ripened body and cannot get totally cured…(72 year old female respondent).

Health-seeking behaviour depends on the "perception" of health and ill-health, and there is a fine line between the normal health status of an older person and that of an older person suffering from an ill condition. A number of respondents classified specific health crises as old age illnesses, such as cataracts, toothache and gastric pain, body pain and arthritis, fever, uterine problems, loss of appetite, and general weakness.

Severity of Illness

The perceived severity of old people's health problems is another key factor affecting health care seeking behaviour, and we sought to define the threshold at which an illness is considered severe enough to be treated. The data shows that sudden dramatic deterioration of a "regular" health problem is considered severe. For instance, if someone who has chronically experienced a feeling of "unwellness" suddenly falls

and loses consciousness, it is treated as a severe condition. A 62 year old male respondent uses "donkey" for a metaphoric comparison. In his words:

> …donkeys do drink water but before that they will stir it to make the water dirty...that is our situation, we don't have much money, visiting doctors means expense, so we wait and wait, until it is unbearable...I had stomach pain, with diarrhoea, I suffered the first three days without treatment, then it got worse... I went to the toilet about 30 times and then I decided to go to the doctor and seek treatment... my stomach pain became totally unbearable, so I had to go actually...

Such behaviour seems to be common across respondents, as the excerpt below reveal:

> ... I have been suffering from chest pain... it started about 6 months ago, a constant pain, I felt very bad; however, I did not do anything and just suffered... it got worse and I had to go to the doctor...(62 year old male respondent).

Other cases are considered severe when the condition affects the ability to work and look after oneself physically or, even more importantly, requires the care of other family members.

> …I buy and sell small baskets (tukri/ora), I buy from one market and sell in another on market day. I walk to the market...but I am very weak now, too weak to walk...(80 year old male respondent).

When discussing professionally trained medical physicians, commonly known as MBBS doctors, terms like, "*too expensive*", "*have to have money upfront*", were used. The overall tendency is to avoid going to qualified doctors with formal medical training because they are expensive and hence not consulted unless the situation deteriorates too much. Even if MBBS doctors are consulted, follow-up visits are rare due to financial constraints. Box 1 describes how a 60 year old man suffering from rheumatism handles his illness and how this is related to his family and financial situation.

Box 1: Illness experience of Aziz, a 60 year old man

Aziz suffered from rheumatism for about a decade but learned to live with it. It had not bothered him so much during the previous year (the year before the interview), but he suffered from fatigue and lack of strength. He tended to spend the day reclined, and when he got up, his head spun and he had a burning sensation in his body. He felt as if someone was pushing him from behind. He attributed this to his arthritis. After suffering for about four months, he went to a *kabiraj* (herbalist) recommended by his neighbours. His brother took him to several *kabiraj*, who treated him with holy oil and water and one of them told him that he was suffering from the force of evil spirits (*porir asor)*. The *kabiraj* asked for a payment of Tk. 5000[2] for a cure, but he did not have money, so he paid Tk. 50 for the first day's consultation fees. For all the *kabiraj* visits, he spent around Tk. 500 in total but still remained ill. Finally, when he became too weak to even walk, his brother took him to the Chandpur (local) general hospital. His brother and his sister-in-law stayed with him, and he had to stay there two days and two nights. The doctor examined him by doing an ultra-sonogram and giving him a blood transfusion. One of his brothers donated a bag of blood and bought another bag for him. In two days, they spent Tk. 4000 for the hospital bill, rickshaw fare, and blood. He did not work for a year due to the illness, and he spent all his savings on subsistence and *kabiraj* treatments. He had to sell part of his land worth Tk. 2000. He said he felt better during his time in the hospital, and the doctors and nurses were good, but he started to feel ill again after returning home. He could not walk easily, felt depressed and anxious, and he only wondered why he did not get well.

Health Care Seeking Experience of Two Elderly Individuals

The dynamic and complex reality of health care seeking behaviour is exemplified by two neighbours and friends, one of them a *kabiraj* (herbalist). Saleha is 65 years old and lives with five other family members. Early June the previous year, she became ill. She had a large

2 The exchange rate at the time of the study was approximately US$1= Tk. 60.

painful spot on the spine near her waist, and it bothered her for months. People in the neighbourhood said she had a *pistok* (locally known/used term for this health problem). She agreed but was unsure about the reason, thinking perhaps it was due to fate or bad luck. After a while, the spot became too painful and needed to be dealt with.

First, she went to her sister-in-law Rohima, who was a *kabiraj* in her neighbourhood. Using a blade, the *kabiraj* cut the spot open and squeezed out the bad blood, then put some plant paste on the spot. Five days later, it worsened, and the *kabiraj* took her to visit a doctor. The doctor, who was well-known in the village, cleaned the infected spot with warm water and treated it with an injection and medicine. He also suggested that she returned every other day to get the wound dressed and cleaned. She continued to visit him for about two weeks and then when the pain got better, she stopped. The infection had not totally cleared up, but the pain got better and she started to put plant paste on the spot again. After two more weeks, she was better. In her words:

> The kabiraj is good, but it was my fate that I did not get well. The doctor was good too, I was half-cured with his medicine, perhaps if I continued it might have been cured quicker, but I did not have much money to continue that treatment. It might have taken longer to cure, but with God's blessing, I got well at last….

Rohima (Saleha's sister-in-law), on the other hand, is a 64 year old woman in Saleha's neighbourhood. Two of her sons work in Saudi Arabia, but she does not receive remittances from them. Another son lives in the village but is poor and unable to help his parents financially. Rohima's husband is frail and ill, so he can't work. Rohima is known as a *kabiraj* in the village. She treats an array of health problems for different age groups—problems ranging from cataracts in old people to uterus problems in younger women. She also treats such things as fever, arthritis, body pain, and toothache. She uses diverse plants and other materials and also uses *jhar-phuk* (spiritual healing) and *mantra* (incantation). During the interview, she insisted on maintaining secrecy regarding the specific characteristics of the plants that she uses for treatment. Recently, Rohima began suffering from a kind of arthritis (*aguinya bat).* Her fingertips were swollen and very painful, and some type of infection was visible. She also complained of body pain. Since

Rohima had been suffering from high blood pressure for 30 years, she thought that the cause of the arthritis was linked to her high blood pressure.

Although Rohima was a *kabiraj* herself and provided treatment for a wide range of health problems to patients of all ages, she did not treat her own health problem. She first went to a homeopathic practitioner whom she had known for a long time and had visited for a similar problem before. She reported that despite her not getting well the last time from his treatment, she prefers to go there because she can acquire medicine on credit. She believed that he was a good doctor for younger patients, and his treatment did not resolve her illness because of her old age. She has also been treating her high blood pressure with another allopathic doctor for years. For the most recent illness, Rohima had to borrow money from relatives and neighbour. She noted with sadness:

> whatever I earn from my kabiraji (herbal practice), goes to doctors for my own treatment.

These two cases demonstrate a very interesting scenario. Clearly Rohima enjoys a significant level of trust and influence from her patients; however, for her own health problems, she does not use her own treatment, instead spends most of her earnings to pay for other types of treatments. In this case, health care seeking is determined more by personal relationship rather than medical outcome. Even though Saleha is aware of her *kabiraj's* personal health care seeking practice (i.e., not using her own treatment), she maintains trust in Rohima's treatment. Despite the severe pain and cost of curing her infection, she attributes it all to her own "ill-fate" (*kopaler dosh*), not the inadequacies of her neighbour. While the two women suffered from problems locally known to be similar, they pursued different health care seeking trails.

Decision Making in Seeking Health Care

Illness Severity: Severity is perceived as either low or high. If it is regarded as low, then self-care is most commonly practiced, using home remedies and drugs bought from a drugstore, often by a family member.

> …I was feeling unwell for some time, I had fever, I was shivering, my body had some burning feelings, I was coughing as well…I

> thought it was just normal fever, and my family had poured water on my head to reduce the temperature. After eight days, my son brought me some medicine from a village doctor, I took that but it did not work either…in fact, for 20 days I did not go to any doctor... then I went to the doctor, and he said I had typhoid and gave me medicine…I am better now but feel very weak …(80 year old male respondent).

When the severity of illness is perceived as high, several factors enter into the decision making process. At this stage, the three key decisions of health-seeking behaviour for older people are "where" to take the person, "who" can accompany the older individual and "how" the finances can be managed. The decision about where to go is based on several factors including the treatment outcome, although it is not given first priority. In general, cost flexibility by the health care provider is the most important factor. A service provider who is flexible about the treatment cost and payment options is more attractive to the respondent than others.

> …I like him (village doctor) because he is flexible… if we pay Taka 20 he will accept it, if we pay Taka 10, he will accept that too. He understands poor people's problems and also gives good medicine ...(70 year old female respondent)

Accessibility to health care providers: The mobility and accessibility of older people are also critical. Especially for older women, a cultural stigma is attached to visiting a male doctor who is not directly a family member. In such cases, even if it is possible to take the doctor to the patient, that is not always an option for the older women patients. If the doctor insists on seeing the patient, he may have a counter-productive effect, such as deeper anxiety of the older patient. As a 90 year old woman puts it:

> I have pledged ('manot') to God not to be seen by any doctors… all big doctors (qualified) want to see patients, my family members explained my problems but they demanded to see me…(90 year old female respondent)

For some, it is important that the doctor is available during day and night for home visits. It brings a sense of confidence to the older patients. One respondent stated,

> … we always go to him… he is our regular doctor (village doctor), he is available whenever we need him, day or night… he also comes to our home when needed… we are happy with him...(68 year old male respondent)

Familiarity with health-care provider: Another pattern emerging from the data is that older people tend to go to the doctors who are well-known and are friends of the older person's male family members. Often the family members take the elderly patient to be treated.

> ... it is very convenient…the doctor knows me, he does not need to see me in person…he gives good medicine…(90 year old female respondent)

> …I like his (village doctor) treatment, we always go to him, he treats everyone in my family, whenever we have any problem he comes running ... I am very satisfied with him...(70 year old male respondent).

Sometimes this "known" status runs through generations. Intergenerational health care provider and receiver relationships appear quite strong, and the reputation of a service provider can be inherited by the next generation. As one 81 year old woman respondent asserted,

> ...we always go to him (village doctor), we used to go to his father (another village doctor)…he was a very experienced doctor... they are oldest in this area...(81 year old female respondent)

Financing treatment: How to finance the older person's treatment is another part of the decision-making process in seeking health care. Strategies of paying for health care include the use of savings, help from adult children, sale of livestock and poultry, and a formal or an informal loan from a friend, relative or NGO. Because older individuals generally do not have direct access to loan, a female family member or relative who belongs to a NGO acquires the funds.

> ...I have been suffering for a month with this diarrhoea, and it cost me Taka 700. I have no savings, no assets, and my shop is my single source of income. I borrowed Taka 2000 from my cousin… she is a member of Grameen Bank (Non-government organisation)… and visited the doctor. Now I am better and paying her

instalments... thank God I got better and now can pay her off...(62 year old male respondent)

Box 2: Health care seeking experience of a stroke victim

A 60 year old male, Shofiq, had been suffering from diabetes for some years. One day during Ramadan, while fasting he felt dizzy, his head was spinning and he lost his balance. He could not understand what was going on. Early morning he prayed as usual, and went to sleep; however, he woke up feeling that he couldn't move the left side of his body. In his words, "*I could not move my left side, it was senseless, and my left side was totally paralysed*".

The next morning, Shofiq's brother took him to a doctor who gave him medicine and asked him to take blood and urine tests as well as take an X-ray. After examining the results, the doctor informed him: "*You have had a stroke, from cold weather, blood pressure and diabetes…*". The doctor gave him medication for two months during which time he was totally bed-ridden. As his situation did not get better, he went to see another doctor and was given more medication. In order to manage his treatment expenses, he sold most of his belongings and capital assets, including his cows. One of his nephews helped him with some money as well. The hospital treatment cost him around Taka 5,000. After five months, his condition remained unchanged. His brother-in-law suggested to seek treatment from a *kabiraj* who gave him some medicine and ointment to massage. It cost him Taka 1,200 but he felt a bit better. He visited another *kabiraj* who gave a holy bracelet which cost another Taka 420, and following his advice, he bought some tonic which did not work. He is still following any advice he gets from his neighbours and often tries new forms of treatment. So far he has spent about Taka 20,000 and feels very depressed that he can't get well.

If the older person gets better at this point, they try to recover the financial losses and liabilities over a period of time. If the initial treatment does not work and the elderly patients are referred or advised to seek specialized treatment, they go through the same decision-making process. The families with available means and connections (i.e. children living in cities and having jobs) provide assistance. Sometimes even the

neighbours help with some money, as an 80 year old male respondent said,

> …My sons are poor and they have their own families to take care of, so they can't help me… my neighbours helped me, gave me some money for treatment....

An illness may leave a longer term financial burden on older people, moving from the comfort of having some savings to carrying a debt, as one of the 62 year old male respondent stated,

> …I had some savings, I spent that for my treatment, then I sold my wife's ornaments and used up the business capital... finally I had to take a loan from the cooperatives... my illness cost me Taka 2500 and now I am paying Taka 300 per week to repay my debt.

Poorer families face yet more liabilities and very often resign themselves to their ill fate. At this point they do not seek any health care services and are forced to cope with increasing discomfort as described by the case in Box 2.

Conclusions

The changing demographic structure in many low-income countries has resulted in the rapid increase of the elderly population. This is followed by an epidemiologic transition from communicable diseases to non-communicable and chronic conditions (Kinsella & Philips 2005). Research from Bangladesh indicate a high proportion of elderly people reporting health problems (Kabir et al. 2003), yet the health care system in the country does not explicitly cater to this population (HelpAge International 2000).

This study uses qualitative data to describe the complex nature of health-seeking behaviour of older people. Most significantly, old age is found to be an accepted explanation of ill health and the decisions taken to seek health care are influenced by factors such as perception of severity of illness, familiarity and accessibility to health care providers, and financing of health care. In the absence of specialized knowledge in geriatric health care, multiple sources of health care, such as allopathic care, *kabiraji* and homeopathic care are sought by the elderly people as

also reported in an earlier survey on health-seeking behaviour of adults in rural Bangladesh (Ahmed et al. 2005).

The qualitative data of this study suggest that, in general, respondents use "old age" and "ill-health" as inseparable entities. A study from the United States has also shown that older people expressed lower expectation regarding physical and mental health with ageing, as a result placing less importance on seeking health care (Sarkisian et al. 2002). Respondents in the current study were resigned to the belief that illness in old age was not completely curable and sometimes even incurable when their illnesses did not respond to treatments.

Multiple factors influence elderly people's choice and use of health care services. The perceived severity of old people's health problems is a key factor affecting health-seeking behaviour. As in many countries, self-care including self-treatment (or treatment by family members) is common when severity of illness is perceived to be low (Stoller & Forster 1992, Stevenson et al. 2003, Tuan et al. 2005). Data from the present study indicates that sudden deterioration of a "regular" health problem is considered severe, particularly if it affects the ability to work, to be physically independent and/or necessitates care from a family member. Once the level of severity is defined, a course of action is taken—more severe cases taken to the formal health care system, less severe cases treated traditionally or at home. Stoller et al. (1993) also report that depending on the degree of pain or discomfort caused by the problems and whether or not it interferes with their activities, older people decide upon the action to be taken regarding their health problems.

Family members in this study are reported to play an important role in the dynamics of seeking health care by the elderly individuals. Elderly women in particular in rural Bangladesh are reported to be in a vulnerable situation due to their dependence on the male family members (Rahman 2000). In the present study, in some cases, family members and even friends play an additional role in facilitating the treatment process of the older persons through their acquaintanceships with the health care providers. This is done in terms of financial help or in terms of the health care provider showing respect and consideration towards the elderly patient. Personal relationships with the health care providers, even through generations, play a very important role.

However, when there is no positive outcome from a certain treatment option, the explanation is often centred on fate.

Empirical evidence from Bangladesh and elsewhere indicates that socio-economic status is a strong determinant of health-seeking behaviour (Khe et al. 2002, Ahmed et al. 2003), even among the elderly (Ahmed et al. 2005). Similarly in this study, financing health care for an elderly individual is found to be one of the crucial deciding factors of whether or not to seek treatment, and what type of treatment to seek. The high cost of formally trained allopathic physicians is normally the reason to avoid them unless high severity demands it as also indicated by other studies from Bangladesh (Ahmed et al. 2003, Ahmed et al. 2005). Qualitative data from the present study shows that flexibility of the health care provider in receiving payment is, in fact, the most important factor deciding upon the kind of health care to seek. A service provider who is flexible about the cost of treatment and payment options is more attractive to the respondent than those who require immediate cash payment. Strategies of paying for health care include the use of savings, help from adult children, sale of livestock and poultry or other assets, and loan from friends and relatives.

Findings from this study provide a unique insight into the rationale behind health-seeking behaviour and the strategies employed by the elderly people in seeking health care in a rural area in Bangladesh. Financial factors play a crucial role in seeking health care in the backdrop of poverty of the elderly individuals and their families. However, flexibility within the informal health care system in rural Bangladesh in terms of payment provides a minor but insufficient recourse to the elderly patients. As treatment of even curable illnesses is forcibly discontinued due to financial constraints, the elderly persons resign themselves to the erroneous notion that ill-health is inevitable in old age.

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