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Socioeconomic and Geographic Barriers to Healthcare Access for Older Adults in Rural Bangladesh

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Abstract

The ageing demographic has emerged as a major public health challenge around the world as well as in Bangladesh, particularly in rural areas where there is poor access to healthcare services. Older adults experience numerous socioeconomic and geographic barriers to sufficient healthcare services. Hence, this study was conducted with the aim to explore the socioeconomically and geographical barriers affecting health care seeking behavior of elderly population in rural Bangladesh. A quantitative cross-sectional research design was used; data was collected from 400 respondents above the age of 60 years through a purposive-convenience sampling method by means of structured face-to-face interviews. Descriptive statistics, Pearson correlation analysis, one sample t-test and posterior distribution analysis were the methods of choice to process the aggregated data utilizing SPSS software. The results showed transport difficulties, distant health care facilities, expensive and time-consuming travel were the main barriers to accessing healthcare services. Respondents also only had access to nearby health facilities, accessible healthcare providers, older person-friendly services and core medicines in moderate levels. The study concludes that rural health infrastructure, transportation system and age-friendly healthcare organizations need to be improved so that older people in rural Bangladesh can access basic healthcare services, enhance healthcare access and ultimately better health outcomes.

Keywords: *Older Adults; Rural Bangladesh; Healthcare Access; Socioeconomic Barriers; Geographic Barriers*

1. Introduction

Population ageing is a universal phenomenon, the reason being low fertility rates and increasing life expectancy. People aged 65 years or over will outnumber children under five by 2050, and those aged over 60 is expected to more than double to 22%. This transition puts pressure on healthcare, social and economic systems with older adults increasingly at higher risk of chronic diseases, disabilities, mental health problems and social isolation. Caregiving and long-term care services often are inadequate, with

inequities by income, geography and race (Khan et al., 2024). The older population is growing, globally and in Bangladesh, as life expectancy continues to increase coupled with declining fertility rates and changing age structure. The growing population of Bangladesh aged 60 and above is posing new public health challenges. The advanced age, people have more probability of chronic diseases like diabetes, hypertension and other physic disability which increase the demand to use regular health services. On the other hand, numerous elderly individuals are hindered by obstacles such as expensive treatments, travel barriers, sub-standard healthcare facilities, and restricted access to affordable care (Sarker et al., 2023a). Rural areas tend to have comparatively fewer healthcare facilities and services which are not readily accessible in comparison to Urban. Rural folks experience health-care shortages, travel long distances to access health services and limited primary and specialist care. Consequently, rural people typically utilize lower levels of health services than urban counterparts with similar unmet needs and have much poorer health outcomes (Liepins et al., 2024). Key aspects of older adult healthcare access in Bangladesh associated with income poverty, education and financial dependency Public health care serves very low-income and poor seniors as a primary form of care, but they face long distances to public heath services, high out-of-pocket costs, and transportation barriers. Limited education lowers awareness and the ability to maneuver services and dependency on family members financially confine treatment and care. This is of particular concern in rural and remote areas where they are disproportionately affected, leading to increased levels of healthcare inequity amongst older adults (Ahmed et al., 2025). Distance, transport and access challenges between homes to health facilities in the remote riverine Char areas of Bangladesh were major barriers towards obtaining essential healthcare services. Numerous local people were compelled to travel countless long stretches of ocean and burn through huge wholes on transportation costs just to get into medical clinics or wellbeing focuses. People had little access to good transportation systems, boats were hard to find and healthcare structures were fragile; it discouraged them from getting treatment in the right time. Consequently, a large number of community members relied upon informal providers (such as village doctors and traditional healers) for health care provisioning (Sajib et al., 2025). The health and well-being of older adults is directly impacted by a lack of access to healthcare. Barriers, including poverty and social isolation, transportation and digital exclusion also limit timely access to healthcare services. As a result, most older adults have poor physical and mental health, higher morbidity and mortality rates, poorer functionality and decreased quality of life compared to those living in the rural areas and less privileged communities (Cabañero-Garcia et al., 2025). Therefore, the main aim of the study is to The main objective of this study is to investigate the socioeconomic and geographic barriers that limit healthcare access for older adults in rural Bangladesh.

2. Literature Review

Sarker et al.,(2023b) expressed that older people living in rural Bangladesh have inherently low socioeconomic status, coupled with geographical challenges to health-care access. Although many are afflicted with chronic diseases, including diabetes and hypertension, high treatment costs, difficulties in accessing transportation, long distances from treatment centers, and lack of adequate public health facilities restrict access to care. Many older people turn to private clinics, pharmacies, loans and even their family members or selling off some assets for medical expenses. We will be offering alternative healthcare infrastructure for elderly-friendly care, reducing out-of-pocket costs and further strengthening social protection across the life-course. Another study by Hossen et al., (2023) also expressed that there are barriers related to socioeconomic and geographic conditions that prevent older indigenous people from accessing health care services in the Chittagong Hill Tracts of Bangladesh. The health care access faced by them is significantly limited by poverty, remote hilly locations, lack of good transportation systems, expensive health treatments, limited availability of quality healthcare facilities and health literacy. Existing distrust in modern medical care fed by systemic racism–the inability to communicate with clinicians, reliance on traditional healing methods, behavior from hospital staff that are disparaging and discriminatory all create negative experiences where they do not feel that proper care or treatment is sought. The study highlighted that the challenges amplify the risk for older indigenous populations and

adversely impact their health and well-being. Matthews et al.,(2023) also stated that socio-economic and health care barriers limit adequate access of primary medical services for older types in rural Bangladesh. Health costs are limited, there is a shortage of qualified geriatric and mental health caregivers, and not enough health facilities to ensure continuity of treatment, especially in the rural areas. Older people face low incomes compounded by high out-of-pocket health care and weak social protection systems. The other significant findings indicated low awareness, inadequate government support as well as absence of specialized facilities for chronic illnesses and mental health, which pushed many elderly to rely on family care and at the same time drive them towards malnourishment and poor health due to poverty. Kabir et al., (2025) also stated that socioeconomic status, type of disease and geographic location are major determinants of healthcare access in rural Bangladesh. Many of the rural adults expressed health complaints, mainly NCDs (diabetes, hypertension). Although four out of five accessed some level of healthcare, many were reliant on informal or unqualified providers while one in five did not seek care altogether. Those living well-off and away from facilities, somehow accessed skilled healthcare services. Various barriers were reported: financial constraints, distance from the health care facility, ignorance and poor rural health services. Akter et al.,(2023) claimed that older women in rural Bangladesh are confronted with significant impediments to receiving healthcare due to economic poverty, low literacy levels, inadequate health system architecture, social disenfranchisement through lack of agency or autonomy and family member dependency. diabetes, liver diseases became the most common health problems among older women. Women with education levels higher than high school, strong family support, and large family networks were more likely to access health care. On the other hand, older women who lived alone or with relatives avoided seeking care. Increasing distances to health centers and poor rural health infrastructure limited access to healthcare again.

A few other studies in rural Bangladesh, suggest that economic and geographical factors prevent access to health services for older adults; poverty, illiteracy, long distance from facilities, lack of transport means and tendency to use informal care providers (Sarker et al., 2023b; Hossen et al., 2023; Matthews et al., 2023; Kabir et al., 2025; Akter et al., 2023; Ahmed et al., 2025). Yet in most studies, financial barriers were treated as a combined factor; satisfaction with healthcare was not quantified; and geographic or income factors were investigated in isolation or on small, specific subgroups. Not fully addressed were independent effects of specific financial constraints (cost of treatment, cost of medicines, cost of diagnosis, out-of-pocket payment), the comparative effects of geographic relative to economic steps in access and actual utilization and self-reported adequacy of elder-appropriate health services and essential medicines. Using a much larger and population-based national-level sample of 400 rural older adults, this study advances the literature by measuring barrier types (financial and geographic) quantitively rather than setting-specific, as well as perceived access to health facilities, providers or services for elderly people, which is assessed separately from satisfaction levels with health care facilities.

3. Objectives

Based on the background the objectives of the study are:

1. To identify the major financial challenges faced by older adults in accessing healthcare services in rural Bangladesh.
2. To examine how distance and transportation barriers affect healthcare utilization among rural elderly populations.
3. To assess the availability and accessibility of healthcare facilities for older adults in rural areas.
4. To explore the impact of socioeconomic status on the healthcare-seeking behavior of older adults in rural Bangladesh.

4. Theoretical Framework

This study is based on Andersen's Behavioral Model (1995) of Health Services Use , which explains the use of health services through three primary influences: predetermining factors, enabling factors, and need factors. It is a relevant model for the current study which explores how access to healthcare processes modified by socioeconomic and geographic barriers among older adults of rural Bangladesh. When it comes to predisposing factors, there are age, gender, education and health knowledge and also belief regarding health care. Such factors may affect older adults' awareness of illness and willingness to seek professional medical attention.

The concept of enabling factors includes income, treatment cost, medicine cost, transportation cost, family support for seeking care services, assistance to health facilities and availability of health services which is the major part of our study. These factors are directly related to its study objectives, which include financial hardships, distance and transport barriers, accessibility to health care facilities as well as socioeconomic status. Need factors identify health problems, real or perceived where chronic illness, disability, weakness and other disease (diabetes and hypertension) have added to older adult's demand for healthcare.

Andersen's model illustrates the factors that govern healthcare access among rural elderly people, which is not only related to illness but also affected by financial ability as well as transportation, facility availability and socio-economic condition. Therefore, this theory offers a robust framework for the understanding of healthcare-seeking behaviour in older adults in rural Bangladesh.

5. Research Methodology

This study used quantitative research methodology to examine the socio-economic and geographically related healthcare access barriers among older adults of rural Bangladesh. Data was collected at one point time using cross-sectional survey method from the respondents. The quantitative method was used since it allows the rational measurement and statistical analysis of barriers to health among the rural elderly. The study setting was the rural areas in Bangladesh where accessibility to healthcare facilities is poor, and older adults are known to have greater challenges related to transportation issues and costs of care. For the target population, older adults aged 60 years and above were included due to the fact that they are a vulnerable group, but also for male and female respondents to be equally represented so that an overall understanding could be gained. The study consisted of 400 respondents. A purposive-convenience sampling technique was arrived at based on age, rural residence and the willingness to take part in a survey. The Data were collected through a structured questionnaire including close-ended questions on different aspects of treatment costs (medication cost, transportation barriers, distance to health facilities, availability of health services), income level and education, family support as well as healthcare-seeking behavior. In the second step, data was collected through individual face-to-face interviews. SPSS software is used to analysis data. Moreover, inferential statistical methods: Pearson correlation analysis, one-sample t-test and posterior distribution were performed. To maintain the ethical considerations of this study, respondents were notified about the purpose of the research and invited to participate voluntarily with their information kept confidential. The study is a cross-sectional design, is limited to the selected study areas in Japan, and uses self-reported data that could include response or recall bias; thus, findings should be interpreted with caution.

6. Results

6.1 Demographic Information

Table 1 depicts the socio-demographic profile of respondents in terms of age, gender, marital status and monthly income. The sample is mostly evenly divided by gender, with men and women at equal levels.

Table 1: Demographic Information

		Frequency	Percentage
Age	60-64 years	113	28.25%
	65-69 years	98	24.5%
	70-74 years	89	22.25%
	75 -79 years	65	16.25%
	80+ years	35	8.75%
Gender	Female	200	50%
	Male	200	50%
Marital Status	Married	244	61%
	Widowed	116	29%
	Divorced	28	7%
	Unmarried	12	3%
Monthly Income	Low	91	22.75%
	Very Low	141	35.25%
	Moderate	100	25%
	High	47	11.75%
	Very High	21	5.25%

The survey was conducted on the 400 respondents with near equal gender representatives; where females and males accounted for 50% of the sample. The distribution of age indicated that younger seniors were more prominent than older ones, with 28.25% aged between 60–64 years, 24.5% aged between 65–69 years and 22.25% enrolled in the age range70–74 (Table2). The older age groups, those aged 75–79 years (16.25%) and ≥80 years (8.75%), made up a smaller proportion of the data. In terms of marital status, the respondents composed mostly married (61%), then widowed individuals (29%) and lone divorce especially 7% and single about 3%. The sample was skewed to lower monthly incomes with 35.25% reporting very low income, 22.75% low income, and 25% moderate income while smaller proportions reported high (11.75%) or very high income (5.25%). In summary, the respondents are mainly younger seniors living in a household (mostly married) and with limited financial means, indicating that there may potentially be socioeconomic and health-related characteristics of this segment of the population.

6.2 Major Financial Challenges

Table 2 presents the Pearson correlation analysis of treatment cost barrier, medicine cost barrier, diagnostic test cost barrier and out-of-pocket payment pressure as a design you need to pay off →. It is based on a sample size of 400 respondents. It broadly assesses the extent to which different healthcare cost-related barriers faced by respondents are interrelated.

Table 2: Correlations analysis of Healthcare Barriers

		Treatment Cost Barrier	Medicine Cost Barrier	Diagnostic Test Cost Barrier	Out-of-Pocket Payment Pressure
Treatment Cost Barrier	Pearson Correlation	1	.093	-.019	.031
	Sig. (2-tailed)		.064	.710	.541
	N	400	400	400	400
Medicine Cost Barrier	Pearson Correlation	.093	1	.083	.070
	Sig. (2-tailed)	.064		.098	.160

	N	400	400	400	400
Diagnostic Test Cost Barrier	Pearson Correlation	-.019	.083	1	.055
	Sig. (2-tailed)	.710	.098		.273
	N	400	400	400	400
Out-of-Pocket Payment Pressure	Pearson Correlation	.031	.070	.055	1
	Sig. (2-tailed)	.541	.160	.273	
	N	400	400	400	400

The correlations reveal very weak and statistically insignificant relationships among treatment cost barrier, medicine cost barrier, diagnostic test cost barrier and out-of-pocket payment pressure in the sample of 400 respondents. The correlation was highest between treatment cost barrier and medicine cost barrier (r =. 093, p =. 064], still an insignificant effect. Contextual and Statistical Analysis Utilities also demonstrated weak positive correlations between cost barrier to diagnostic tests (r =. 083, p =. 098) or out of pocket payment burden (r =. 070, p =. 160), and the treatment cost barrier was nearly uncorrelated with diagnostic test cost barrier (r = −. 019, p =. 710), and the specific influence of out-of-pocket have been explored (r =. 031, p =. 541). These data suggest that while cost-related barriers do exist, this does not entail a one side influence between them in this dataset. The finding both reinforces and contradicts previous studies when compared with the literature review. Sarker et al. (2023b), Hossen et al. (2023), Matthews et al. (2023), Kabir et al. (2025), and Akter et al., (2023) identified several factors contributing to major financial challenges among rural elderly in Bangladesh including high treatment costs, medicine and diagnostic costs, poverty and lack of social protection as well as out-of-pocket burden on health care. The current findings add to the literature by demonstrating that these financial barriers remain relevant in terms of healthcare access among older adults. In contrast to literature that presents financial hardship as related issues, however, correlation results suggest that each cost barrier might influence older adults separately. Based on our systematic findings, interventions should target treatment cost, medicine costs, diagnostic costs and out-of-pocket payment pressure as separate financial barriers.

6.3 Healthcare Facilities for Older Adults in Rural Areas

The results of the independent statistical test for some major geographic and accessibility-related barriers to accessing care are shown in Table 3. It analyzes factors like travel time, health facilities distance and availability for transport. The results assist with the statistical significance and discrepancies perceived.

Table 3: One Sample T -test of Healthcare Facilities

Variable	t	df	Sig. (2-tailed)	Mean Difference	95% CI Lower	95% CI Upper
Long Distance to Facility	61.91	399	.000	3.7125	3.5946	3.8304
Transport Availability Barrier	62.94	399	.000	3.7550	3.6377	3.8723
Transport Cost Barrier	63.97	399	.000	3.7000	3.5863	3.8137
Travel Time Barrier	61.29	399	.000	3.6475	3.5305	3.7645

Geographic and transportation-related barriers are significant issues facing older adults in accessing healthcare services, Comparison of means: One-sample t-test results. The sig. for all four variables were less than the 0.001 level of significance, hence they are statistically significant factors in establishing relationships with consumers. values were reported as. 000, meaning p <. 001. Of those barriers, the highest mean difference was for transport availability barrier (3.7550), long distance to facility (3.7125), transport cost barrier (3.7000) and travel time barrier (3.6475). These findings suggest that the problems older adults face are not merely because healthcare facilities are distant, but closer issues include lack of transport availability; costing travel and duration to reach appropriate healthcare centers. All variables also have confidence intervals strictly above zero, supporting the variable significance. Compared to the literature review, the results were more confirmed by previous studies. Sarker et al. Increased distance from treatment centers and transportation challenges among elderly in rural Bangladesh pose a major barrier to healthcare access (2023b). Hossen et al. Also, remote locations, lack of good transportation systems and healthcare facilities decrease the availability of care . Similarly, Kabir et al. (2025) in contrast, Akter et al. (2023) pointed out distance from health facilities and inadequate rural health services as major obstacles. Relatively few studies in the literature corroborate the present findings and demonstrate that distance, availability of transport, cost of transportation and travel time are significant geographic barriers to healthcare access in older adults' rural regions.

6.4 Distance and Transportation Barriers Affect

The table presents descriptive statistics for healthcare access-related variables based on 400 respondents. The mean values range from 2.95 to 3.05, indicating a moderate level of perceived access to health services. The low variance values suggest that respondents' opinions were relatively consistent across all four indicators.

Table 4: Posterior Distribution Characterization for One-Sample Mean

N	Variable	Mode	Mean	Variance	Lower Bound	Upper Bound
400	Nearby Health Facility Access	3.05	3.05	0.006	2.92	3.18
400	Qualified Healthcare Provider Availability	3.00	3.00	0.005	2.87	3.13
400	Elderly-Friendly Service Access	2.95	2.95	0.005	2.82	3.08
400	Essential Medicine Availability	3.02	3.02	0.006	2.88	3.16

The posterior distribution results also confirm that all access-related healthcare facility variables among the 400 respondents were often between average level of satisfaction. Nearby health facility access had a mean of 3.05 (lower bound, 2.92; upper bound, 3.18), suggesting respondents had only average access to nearby health facilities. Availability of qualified health provider similarly had a mean equal to 3.00, implying neutral or moderate perception on availability of providers (Table 2). Likewise, old people partaking services attract least score was 2.95, such magnitude exactly exhibit that services specially delivered to seniors activities were prefer idly below other factors of organization treatment vis with lower mean coefficient. Availability of essential medicines had a weighted mean score of 3.02, indicating moderate access to necessary drugs. Across the four variables, small variance values suggest the

respondents showed little variability in their responses. These results partly align with the literature review findings. Sarker et al. (2023b), Hossen et al. (2023), Matthews et al. (2023), Kabir et al. (2025), and Akter et al. Limited health facilities for older adults in rural Bangladesh, alongside a shortage of qualified providers, weak frontline health system infrastructure, limited access to medicines and lack of elder-friendly services2. Current results are also similar with literature as they are showing that the access of health care facility is also lacking. However, where literature typically points to such problems as major roadblocks to positive outcomes, the present results suggest that severity of this situation might be somewhat tempered in this sample. As such, the results suggest that rural older adults probably have limited access to life-saving facilities, providers and medicines, though quality delivery of services must still be improved in terms of availability and elder-friendliness.

6.5 Socioeconomic Status on Healthcare-seeking Behavior

This correlation table studies the influence of four major factors on healthcare behavior: Income Effect, Education Effect, Family Support and Healthcare Seeking Frequency (n = 400). The Pearson correlation coefficients reveal the strength and direction of linear relationships between these variables. The table also gives values of significance which lets us know if the observed correlations are statistically significant.

Table 5: Correlations of Healthcare-seeking behavior

Correlations		Income Effect	Education Effect	Family Support	Healthcare Seeking Frequency
Income Effect	Pearson Correlation	1	-.040	.049	-.019
	Sig. (2-tailed)		.424	.331	.700
	N	400	400	400	400
Education Effect	Pearson Correlation	-.040	1	.001	-.006
	Sig. (2-tailed)	.424		.983	.912
	N	400	400	400	400
Family Support	Pearson Correlation	.049	.001	1	-.023
	Sig. (2-tailed)	.331	.983		.653
	N	400	400	400	400
Healthcare Seeking Frequency	Pearson Correlation	-.019	-.006	-.023	1
	Sig. (2-tailed)	.700	.912	.653	
	N	400	400	400	400

The correlation table indicates that the associations among income effect, education effect, family support, and healthcare-seeking frequency were extremely weak and not statistically significant among the 400 respondents. Income effect showed a slight negative correlation with education effect ($r = -.040$, $p = .424$) and healthcare-seeking frequency ($r = -.019$, $p = .700$), while its relationship with family support was weakly positive ($r = .049$, $p = .331$). Education effect had almost no association with family support ($r = .001$, $p = .983$) or healthcare-seeking frequency ($r = -.006$, $p = .912$). Likewise, family support showed a very weak negative relationship with healthcare-seeking frequency ($r = -.023$, $p = .653$). Since all significance values were above 0.05, the findings suggest that income, education, and family support did not have a significant direct effect on healthcare-seeking frequency in this study. This result contrasts with previous studies. Ahmed et al. (2025) reported that income poverty, poor educational status, and financial dependence restrict older adults' access to healthcare. Matthews et al. (2023) also highlighted

that low income, high out-of-pocket expenses, and limited social protection create barriers to healthcare access. Similarly, Kabir et al. (2025) identified socioeconomic status as a key factor affecting healthcare use, while Akter et al. (2023) found that higher education and stronger family support improved healthcare access among older women. Thus, although earlier literature emphasized the importance of income, education, and family support, the present study found no significant relationship between these factors and healthcare-seeking frequency. This may suggest that barriers such as distance, transport cost, treatment expenses, and healthcare facility availability may be more influential in this sample.

7. Findings

The core findings are stated below:

1. The sample consisted of 400 older adults with equal gender distribution (50% male, 50% female). Most participants were younger seniors aged 60–74, married, and had low or very low monthly income, highlighting socioeconomic vulnerabilities in rural Bangladesh.
2. Correlation analysis of treatment cost, medicine cost, diagnostic test cost, and out-of-pocket payment pressure showed very weak and statistically insignificant relationships (all $p > 0.05$). Each financial barrier appears to impact older adults independently rather than collectively.
3. One-sample t-tests revealed that long distance to facilities, transport availability, transport cost, and travel time were statistically significant barriers ($p < 0.001$), with transport availability having the highest mean difference (3.7550). This indicates that both distance and accessibility significantly affect healthcare utilization.
4. Posterior distribution analysis indicated that older adults had moderate access to nearby health facilities (mean = 3.05), qualified healthcare providers (mean = 3.00), elderly-friendly services (mean = 2.95), and essential medicines (mean = 3.02), showing only average satisfaction with healthcare access.
5. Correlation analysis showed extremely weak and non-significant relationships between income, education, family support, and healthcare-seeking frequency (all $p > 0.05$), suggesting that in this rural sample, geographic and cost barriers may play a more decisive role than socioeconomic status in accessing healthcare.

8. Recommendations

Based on the findings the recommendations are given below:

1. Since long distance, transport availability, transport cost, and travel time were significant barriers, local government and health authorities should improve rural road networks, public transport access, and emergency transport services for older adults.
2. Transport cost was a major access barrier. Therefore, special transport vouchers, community ambulance services, or reduced-fare transport schemes should be introduced for elderly people, especially those from low-income households.
3. Older adults showed only moderate satisfaction with access to nearby facilities, qualified providers, elderly-friendly services, and essential medicines. Rural health centers should be upgraded with trained staff, regular medicine supply, diagnostic support, and geriatric-friendly service arrangements.
4. Health facilities should introduce separate service counters, priority queues, seating arrangements, respectful communication, and regular health check-up programs for older adults to make healthcare more accessible and comfortable.
5. Although financial barriers appeared to affect older adults independently, low income remains a major vulnerability. Government and NGOs should expand health insurance, free medicine programs, subsidized diagnostic tests, and social safety-net support for poor elderly people in rural Bangladesh.

9. Limitations

This study provides important insights into the socio-economic and geographical barriers that hinder older people in rural Bangladesh from accessing healthcare; however, it has some limitations. The first limitation is that the sample were 400 respondents based on certain rural divisions that may not represent older adults in all geographical and socioeconomic contexts of Bangladesh. Second, the use of self-administered surveys for data collection may lead to recall bias or social desirability bias that could compromise the validity of responses regarding healthcare utilization and barriers. Third, the study mainly examined quantitative measures — like income level, distance from hospitals, transport cost and availability of medical facilities — without taking into account qualitative dimensions of health care experiences — people that complain about low hospital return ratio or poor-quality services; cultural preferences for traditional versus modern medicine; attitudes of patients towards providers. Fourth, only financial barriers were studied independently; interactions between multiple cost-related factors and their combined impact on access to healthcare needs further exploration. Furthermore, the cross-sectional nature of this study does not allow us to establish causality between the identified barriers and health care-seeking behaviour. Finally, certain possible confounding factors such as digital competency, general mental health and attendance at informal caregiving networks were not addressed which may also affect healthcare access in rural areas by older adults.

10. Conclusion

This study explored the socioeconomic and geographic determinants of healthcare accessibility for older people in Bangladesh, particularly for rural dwellers. Conclusion: This study found that barriers to healthcare access among rural elderly people are multi-faceted with transportation issues, distances to health facilities or travel costs and availability of services. Geography barriers were also very significant, showing that physical accessibility remains one of the primary impediments for older adults finding timely medical care. It also indicates that access to nearby health facilities, availability of qualified health providers and elderly-friendly services as well as essential medicines are only moderate. Financial barriers like treatment cost, medicine cost, diagnostic expenses and out-of-pocket payments were major obstacles to access care; however, these same factors seemed to impact the ability to obtain health services individually rather than collectively. Also like its predecessors, this study found income and education level as well as family support to be statistically insignificant predictors of healthcare-seeking frequency; geographic and infrastructural barriers may influence rural settings significantly more. In conclusion, the findings from this qualitative study indicate that improved healthcare access for older adults in rural Bangladesh is impeded by inadequate rural healthcare infrastructure, transport limitations and lack of elderly-friendly services. Thus, addressing rural transport systems, upgrading healthcare infrastructure and human resources, ensuring the availability of essential medical supplies and medicines and establishing social protection linkage can surely help to mitigate existing barriers against healthcare accessibility as well as improve health outcomes among older individuals in rural communities.

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