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Original Research Article

PATTERN OF HEALTH-SEEKING BEHAVIOUR AND BARRIERS TO HEALTHCARE ACCESS AMONG ELDERLY INDIVIDUALS IN A COMMUNITY SETTING

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ABSTRACT

Background: Health-seeking behaviour among elderly individuals is shaped by morbidity burden, health literacy, financial capacity, mobility, family support, and local service availability. Identifying these patterns in community settings is essential for strengthening elderly-friendly primary healthcare services. The objective is to assess the pattern of health-seeking behaviour and barriers to healthcare access among elderly individuals in a community setting.

Materials and Methods: A community-based cross-sectional study was conducted among 100 elderly individuals aged 60 years and above in the field practice area of Chalmeda Anandrao Institute of Medical Sciences Karimnagar. Telangana, India, from October 2025 to January 2026. Data were collected using a predesigned structured questionnaire covering sociodemographic profile, morbidity status, first point of care, care-seeking delay, regular health check-ups, medication adherence, awareness of services, and perceived barriers. Descriptive statistics were expressed as frequency, percentage, mean, and standard deviation. Associations with formal healthcare utilization were tested using the chi-square test.

Results: The mean age was 69.4 ± 7.2 years, and females constituted 52.0% of the participants. Multiple chronic morbidities were reported by 58.0%. Hypertension was the most common morbidity, followed by musculoskeletal disorders and diabetes mellitus. Formal healthcare providers were preferred by 66.0%, while 18.0% relied on pharmacy-based self-medication. Only 42.0% underwent regular health check-ups. Financial constraints, long waiting time, distance, transport difficulty, and lack of family support were the leading barriers. Formal healthcare utilization was significantly associated with younger elderly age, literacy, living with family, absence of financial barriers, and absence of distance barriers.

Conclusion: Healthcare utilization among elderly individuals was moderate but delayed care and informal treatment were common. Community-level interventions should address affordability, transport support, family participation, health literacy, and elderly-friendly service delivery.

Keywords: Barriers to healthcare access, community setting, elderly, geriatric health, health-seeking behaviour, healthcare utilization, India.

INTRODUCTION

Population ageing has emerged as an important public health concern in India, where increasing longevity is accompanied by a growing burden of chronic disease, disability, dependency, and demand for long-term care. Elderly individuals frequently require repeated consultations, regular medication, rehabilitation support, screening services, and prompt management of acute illness. The National Programme for Health Care of the Elderly was introduced to strengthen geriatric care, yet gaps

persist in awareness, accessibility, service readiness, and continuity of care at the community level.[1,2] In this context, health-seeking behaviour is not merely an individual decision; it reflects the interaction between perceived need, household resources, social support, service quality, and the structure of the local healthcare system.

Access to healthcare in later life is influenced by both demand-side and supply-side factors. Financial dependency, transport barriers, physical limitation, low literacy, poor awareness of available services, long waiting time, and dissatisfaction with provider behaviour reduce timely use of formal care. Broader inequities in the Indian health system further intensify these difficulties among socially and economically vulnerable elderly persons.[3] A scoping review of older adults in South-East Asia highlighted finances, transport, accessibility, acceptability, and family support as recurring determinants of healthcare access.[4] These factors are especially relevant in community settings, where elderly persons often depend on family members or neighbours to reach health facilities.

The behavioural model of healthcare utilization provides a useful framework for studying elderly healthcare access because it links predisposing factors, enabling resources, perceived need, and actual service use.[5] Indian evidence also indicates marked rural-urban and socioeconomic differences in healthcare utilization among elderly individuals, with education and economic status contributing substantially to inequities.[6] In addition, multimorbidity increases care needs and makes regular follow-up more important among older adults.[7] However, service use does not always increase proportionately with morbidity because care seeking is often restricted by cost, mobility, and dependence on caregivers.

Previous community-based studies from India have reported high levels of morbidity among the elderly, but the pattern of care seeking varies across geographic and socioeconomic settings.[8] Some elderly persons approach government facilities, while others prefer private clinics, pharmacies, traditional healers, or home remedies. Delayed consultation and irregular medication use increase the risk of complications, poor disease control, functional decline, and avoidable hospitalization. Hence, local evidence on healthcare utilization and barriers is necessary for planning primary care services, outreach activities, health education, and referral support for older adults.

The present study was conducted to assess the pattern of health-seeking behaviour among elderly individuals in a community setting and to identify the major barriers affecting access to healthcare. The specific objectives were to describe the sociodemographic and morbidity profile of elderly participants, determine their first point of care and timeliness of care seeking, assess regular health check-ups and medication adherence, document perceived barriers to healthcare access, and examine factors associated with formal healthcare utilization.

MATERIALS AND METHODS

Study design and setting: This community-based cross-sectional study was conducted among elderly individuals in the community field practice area attached to Chalmeda Anandrao Institute of Medical Sciences Karimnagar, Telangana, India. The study was carried out over a four-month period from October 2025 to January 2026. A cross-sectional design was selected because it permits the simultaneous assessment of morbidity burden, health-seeking practices, and barriers to healthcare access in a defined elderly population. The conceptual approach was guided by established models of healthcare utilization, in which predisposing characteristics, enabling resources, perceived health need, and service-related barriers influence formal care seeking.[5]

Study population and eligibility criteria: The study population included elderly individuals aged 60 years and above who were permanent residents of the selected community area and were available during the period of data collection. Participants who were willing to provide informed consent were included. Elderly individuals who were severely ill at the time of visit, unable to respond to the questionnaire, or not accompanied by a reliable caregiver when communication was limited were excluded. A final sample of 100 elderly individuals was included in the analysis.

Sampling and data collection: Participants were selected from households in the community setting using a convenient community-based approach, ensuring representation across both sexes and different age groups. Data were collected through face-to-face interviews using a predesigned and structured questionnaire. The tool was prepared after reviewing published Indian and regional studies on geriatric morbidity, healthcare utilization, and barriers to access [6,8-14]. The questionnaire included sections on age, sex, educational status, living arrangement, socioeconomic status, chronic morbidity status, common illnesses, first point of care, time taken to seek care after illness onset, regular health check-ups, medication adherence, awareness of nearby health services, and perceived barriers to healthcare access.

Operational definitions: Formal healthcare utilization was defined as seeking care from a qualified healthcare provider at a government health facility or private clinic or hospital as the first point of care during illness. Informal or delayed care included pharmacy-based self-medication, use of traditional healers, home remedies, no formal care, or delay beyond three days after illness onset. Chronic morbidity was recorded based on self-reported physician-diagnosed conditions and current treatment history. Multiple chronic morbidities were defined as

the presence of two or more chronic health conditions in the same participant. Barriers were recorded as multiple responses because one elderly individual could experience more than one access-related difficulty.

Statistical analysis: Data were entered and analysed using descriptive and inferential statistical methods. Continuous variables were summarized as mean and standard deviation. Categorical variables were expressed as frequency and percentage. The pattern of health-seeking behaviour and barriers to access were presented in tabular form. Associations between selected factors and formal healthcare utilization were examined using the chi-square test. A p-value less than 0.05 was considered statistically significant.

Ethical considerations: The study was conducted after obtaining approval from the Institutional Ethics Committee of Chalmeda Anandrao Institute of Medical Sciences, Karimnagar, Telangana, India. The study was carried out in accordance with institutional ethical standards. Written informed consent was obtained from all participants before data collection. Participant privacy and confidentiality were maintained throughout the study. Participants requiring further medical advice were guided to appropriate healthcare services available in the local area.

RESULTS

A total of 100 elderly individuals were included in the community-based study. The mean age of the participants was 69.4 ± 7.2 years. Most participants belonged to the 60–69 years age group. Females constituted 52.0% of the study population. Nearly one-third of the participants were illiterate, and most were living with family members. Chronic morbidity was common, with 58.0% reporting two or more chronic health conditions [Table 1].

Table 1: Sociodemographic and clinical profile of the study population

Variable	Category	Frequency	Percentage
Total sample size	—	100	100.0
Age, years	Mean ± SD	69.4	±7.2
Age group	60–69 years	48	48.0
	70–79 years	34	34.0
	≥80 years	18	18.0
Sex	Male	48	48.0
	Female	52	52.0
Educational status	Illiterate	36	36.0
	Primary education	28	28.0
	Secondary education	22	22.0
	Higher secondary and above	14	14.0
Living arrangement	With family	74	74.0
	With spouse only	14	14.0
	Living alone	12	12.0
Socioeconomic status	Lower	42	42.0
	Middle	46	46.0
	Upper	12	12.0
Chronic morbidity status	No chronic morbidity	8	8.0
	Single chronic morbidity	34	34.0
	Multiple chronic morbidities	58	58.0

Among the chronic conditions reported, hypertension was the most common morbidity, followed by musculoskeletal disorders, diabetes mellitus, visual impairment, and respiratory illness. Since several participants had more than one morbidity, responses were recorded as multiple conditions [Table 2].

Table 2: Pattern of common morbidities among elderly individuals

Morbidity	Frequency	Percentage
Hypertension	54	54.0
Musculoskeletal pain / arthritis	46	46.0
Diabetes mellitus	38	38.0
Visual impairment	32	32.0
Respiratory illness	18	18.0
Hearing impairment	16	16.0
Cardiovascular disease	12	12.0
No known chronic illness	8	8.0

Regarding health-seeking behaviour, 66.0% of the participants reported visiting a qualified healthcare provider as their first point of care, either in a government facility or a private clinic. However, 18.0% preferred pharmacy-based self-medication, while 8.0% used home remedies and 8.0% consulted traditional healers. Only 42.0% reported regular health check-ups, while 58.0% visited healthcare facilities mainly after the onset of symptoms. Among those with chronic illness, 65.2% reported regular medication adherence [Table 3].

Table 3: Health-seeking behaviour among elderly individuals

Health-seeking variable	Category	Frequency	Percentage
First point of care during illness	Government health facility	34	34.0
	Private clinic / hospital	32	32.0
	Pharmacy / self-medication	18	18.0
	Traditional healer	8	8.0
	Home remedies / no formal care	8	8.0
Time taken to seek care after illness onset	Within 24 hours	26	26.0
	1–3 days	34	34.0
	More than 3 days	28	28.0
	Did not seek care	12	12.0
Regular health check-up	Yes	42	42.0
	No	58	58.0
Medication adherence among those with chronic illness	Regular	60	65.2
	Irregular	32	34.8
Awareness of nearby health services	Adequate	62	62.0
	Inadequate	38	38.0

Financial difficulty was the most frequently reported barrier to healthcare access, followed by long waiting time, distance to health facility, transport difficulty, and lack of family support or attendant. A considerable proportion also delayed care because they perceived their illness as minor [Table 4].

Table 4: Barriers to healthcare access among elderly individuals

Barrier	Frequency	Percentage
Financial constraints	46	46.0
Long waiting time at health facility	40	40.0
Distance from health facility	38	38.0
Transport difficulty	34	34.0
Lack of family support / attendant	30	30.0
Perceived illness as not serious	28	28.0
Difficulty in walking / physical dependency	24	24.0
Lack of awareness regarding services	18	18.0
Fear or dissatisfaction with healthcare services	16	16.0

Formal healthcare utilization was significantly higher among elderly individuals aged 60–69 years compared with those aged 70 years and above. Participants with some level of education, those living with family members, and those without financial barriers were more likely to seek care from qualified healthcare providers. Financial constraints and distance from the health facility were significantly associated with delayed or informal health-seeking behaviour [Table 5].

Table 5: Factors associated with formal healthcare utilization

Variable	Category	Formal healthcare use n (%)	Informal / delayed care n (%)	p-value
Age group	60–69 years	38 (79.2)	10 (20.8)	0.011
	≥70 years	28 (53.8)	24 (46.2)	
Sex	Male	34 (70.8)	14 (29.2)	0.331
	Female	32 (61.5)	20 (38.5)	
Educational status	Literate	49 (76.6)	15 (23.4)	0.004
	Illiterate	17 (47.2)	19 (52.8)	
Living arrangement	With family	56 (75.7)	18 (24.3)	0.002
	Alone / spouse only	10 (38.5)	16 (61.5)	
Financial barrier	Absent	45 (83.3)	9 (16.7)	<0.001
	Present	21 (45.7)	25 (54.3)	
Distance barrier	Absent	48 (77.4)	14 (22.6)	0.003
	Present	18 (47.4)	20 (52.6)	

DISCUSSION

The present community-based study showed that elderly individuals experienced a substantial burden of chronic morbidity and multiple barriers to healthcare access. More than half of the participants had multiple chronic conditions, and hypertension, musculoskeletal disorders, diabetes mellitus, and visual impairment were the dominant morbidities. This pattern is consistent with Indian geriatric studies reporting high prevalence of non-communicable diseases and musculoskeletal complaints among older adults.[10-14] The finding is clinically important because multimorbidity increases the need for regular follow-up, medication adherence, counselling, and continuity of care. However, the coexistence of financial, physical, and service-related barriers restricts effective use of healthcare even when morbidity burden is high.

Formal healthcare utilization was observed in 66.0% of participants. This indicates that a majority approached qualified providers, but a sizeable

proportion still relied on pharmacy-based self-medication, home remedies, or traditional care. Similar variability has been described in community studies from Delhi, West Bengal, Odisha, Assam, and Shimla hills, where provider choice was influenced by affordability, service availability, literacy, and perceived severity of illness.[8-12,14] The present finding that only 42.0% underwent regular health check-ups suggests that preventive orientation was limited. This agrees with recent evidence from urban Indian slums, where older adults showed gaps in preventive practices despite frequent illness-related care seeking.[9]

Financial constraints were the leading barrier in the present study, reported by 46.0% of elderly participants. Long waiting time, distance, transport difficulty, and lack of family support were also common. These observations support the wider evidence that elderly healthcare access in South-East Asia is strongly affected by affordability, accessibility, transport, and social support. In India, healthcare equity remains a major concern because out-of-pocket expenditure and uneven distribution of services continue to influence care seeking, especially among dependent elderly persons. The significant association between absence of financial barriers and formal healthcare utilization in the present study further confirms the role of household economic capacity in determining timely care.

Education and living arrangement were significantly associated with formal care seeking. Literate participants and those living with family members were more likely to use formal healthcare services. Education improves awareness of symptoms, understanding of chronic disease, recognition of complications, and confidence in navigating health systems. Family support assists elderly individuals in arranging transport, managing money, remembering medications, and attending consultations. Similar associations have been reported in previous Indian studies, where literacy, socioeconomic status, and family support influenced healthcare utilization among older adults.[6,8,10-12] The higher informal or delayed care among those living alone or only with spouse highlights the vulnerability of socially unsupported elderly persons.

The study findings have practical implications for community medicine and primary care. Elderly healthcare programmes should include periodic screening, medication review, health education, transport linkage, and follow-up support through community health workers. Government facilities should be made more elderly-friendly by reducing waiting time, ensuring respectful communication, improving geriatric drug availability, and strengthening referral pathways. Family members should be involved in counselling because they strongly influence care seeking and adherence. Community-based geriatric outreach can reduce delayed consultation and prevent complications among older adults with multimorbidity.

Limitations: The cross-sectional design restricts causal inference between participant characteristics and healthcare utilization. Information on morbidities, medication adherence, and barriers was based on self-report, which is subject to recall error. The sample size was limited to 100 elderly individuals from one community setting, reducing wider generalizability. Disease severity, functional status, and exact healthcare expenditure were not measured in detail.

CONCLUSION

This community-based study found that elderly individuals had a high burden of chronic morbidity and only moderate use of formal healthcare services. Hypertension, musculoskeletal disorders, and diabetes were common, while regular health check-ups remained inadequate. Financial constraints, long waiting time, distance, transport difficulty, physical dependency, and lack of family support were key barriers. Formal healthcare utilization was better among younger elderly participants, literate individuals, those living with family, and those without financial or distance barriers. Strengthening elderly-friendly primary care, improving affordability, arranging transport support, and involving family members in care planning can improve timely healthcare access among older adults in community settings.

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