

What resources do elderly people choose for managing their symptoms? Clarification of rural older people's choices of help-seeking behaviors in Japan

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Abstract

Background

Appropriate help-seeking behavior (HSB) that involves lay and professional care may moderate the usage of medical resources and promote good health, especially among the rural elderly. However, there is little evidence regarding the rural elderly's HSB choices for mild symptoms. Therefore, this study attempts to bridge this gap.

Methods

The participants were patients living in rural areas and over the age of 65, who attended Japanese clinics and general hospitals. In Phase 1, monthly diaries and one-on-one interviews about their mild symptoms and HSB were used to establish checklist items and assess content validity. Content analysis helped determine the items. In Phase 2, participants were asked to complete the checklist to measure HSB. The checklist answers and HSB mentioned in the diaries were compared to evaluate construct validity. Retests were conducted to examine the content's reliability and test-retest reliability.

Results

Phase 1 included 267 participants (average age = 75.1 years, standard deviation [SD] = 4.3; 50.1% male). The diary collection rate was 97.6%. Of the participants, 70.4% used lay care and 25.4% used professional care. Content analysis identified eight types of lay care and four types of professional care. Phase 2 included 315 participants (average age = 77.7 years, SD = 8.27; 46.0% male). In terms of validity, the results of the checklists and the diaries were correlated (Spearman ρ 0.704; $p < 0.001$). The most common behavior with mild symptoms was consulting with primary care physicians, followed by self-care and using home medicine. The test-retest reliability for mild symptoms found kappa values of 0.836 for lay care and 0.808 for professional care.

Conclusions

The list of rural older people's choices of HSB for mild symptoms had high validity and reliability. Therefore, it can be used to assess the relationships between HSB and health conditions and the effectiveness of health promotion on HSB among rural elderly people.

Introduction

Help-seeking behavior (HSB) is a human behavior that sustains health and involves seeking treatment for symptoms. It is an essential behavior for maintaining peoples' health, and ideally each person should have appropriate HSB. This requires people to assess their symptom and its severity, use lay care to

manage these symptoms, followed by professional care as needed [1]. Suitable HSB can connect people with appropriate care and enhance peoples' health in ways such as better quality of life [2]. A balance of lay care and professional care is important for appropriate HSB [3]. Lay care is care provided by lay people, or those who have received no formal training and are not paid, such as self-care and care from relatives, friends, and self-help groups, while professional care refers to care provided by trained paid professionals, usually in a formal setting [4]. The efficient usage of lay and professional care can reduce people's inappropriate HSB [5, 6].

HSB varies relative to healthcare resources. In urban areas, there are many medical resources, allowing for choice between various medical and healthcare professionals [1]. However, citizens in rural areas lack adequate resources for medical care, leading to inappropriate HSB such as usage of medical care for mild symptoms [7]. Limited education among people living in rural areas may also affect HSB [8–10]. In addition, rural HSB needs to be improved by providing information and educational interventions of HSB from multiple perspectives as these people may also lack information about medical issues [7, 11]. Although the Internet and social media have advanced, they are primarily used by young and middle-aged people. The elderly tend to obtain information from television and newspapers [12, 13]. A lack of information may lead to inappropriate HSB especially for mild symptoms [14]. Furthermore, it results in excessive usage of medical resources and undesirable results for citizens' health [2].

Rural older people's HSB for mild symptoms can be improved by continuously providing them with accurate information about their symptoms and healthcare [15]. Therefore, it is crucial to assess their HSB for mild symptoms to suggest modifications. Thus, comprehensive checklist of rural older people's HSB choices, that is reliable and valid evaluating the rural older people's HSB for mild symptoms should be constructed [16]. Also, HSB for mild symptoms can be assessed in terms of the relationship with their demographic. Currently, no research has clarified comprehensive checklist of rural older people's HSB choices, that is reliable and valid, regarding rural older people's HSB for mild symptoms. Therefore, this study aimed to create comprehensive choices that can accurately assess rural older people's HSB for mild symptoms.

Methods

Setting

Unan City, located in southeast Shimane Prefecture, Japan, is primarily covered by forest and is one of the most rural cities in Japan. A 2017 survey revealed the total population was 38,882 (consisting of 18,720 males and 20,162 females) and that the percentage of people over the age of 65 was 37.82%; this is estimated to reach 50% by 2025. Kakeya and Tai Clinic are rural clinics in Kakeya and Yoshida Town, the towns situated in the most northern part of Unnan City. Both clinics are about 30 km from Unnan City Hospital, the only general hospital in the city. Kakeya Clinic has five registered physicians, two nurses, and no admission facilities. Tai Clinic has three registered physicians, two nurses, and no admission facilities. All the physicians in both clinics are family medicine specialists. At the time of this study, Unnan City

Hospital had 281 beds comprising 160 acute care beds, 43 comprehensive care beds, 30 rehabilitation beds, and 48 chronic care beds. There were 14 medical specialties, and the nurse-to-patient ratio was 1:10 in acute care, 1:13 in comprehensive care, 1:15 in rehabilitation, and 1:25 in chronic care.

Participants

The participants in this study were patients over 65 years who attended Kakeya and Tai Clinic and Unnan City Hospital for regular health checkups. All participants lived in Unnan City. They were informed about this study via advertisements, and an explanation of the purpose of the research was included in the list and monthly health diary. Patients who could not read, write, or hear properly and patients with dementia were excluded from this study.

Phase 1: Instrument development

Monthly health-check diary

The diaries consisted of a space for noting the date, patient's blood pressure, existence of symptoms, kinds of symptoms, and how they managed the symptoms (i.e., HSB). The participants checked whether they had symptoms at the end of each day for one month. The clinic nurses collected the diary pages when the participants visited the clinic one month later. If there were unclear terms in their diary, the clinic nurses checked their symptoms and their approach to the symptoms in depth and wrote this on the diary page in red ink.

One-on-one interviews and a review of previous studies to confirm the content validity: To create a valid HSB list, participants' HSB was first transcribed based on the diaries. Next, purposive sampling was used to choose 39 participants (20 from the clinics and 19 from the hospital) to be interviewed about their potential HSB for mild symptoms to confirm content validity, in line with previous studies [16, 17]. The interview guides consisted of four questions based on the previous HSB research: "What kind of symptoms do you have in your usual lives?" "How do you act when you have mild bodily symptoms?" "Why do you act so?" and "Please describe your concrete experiences[18]." To define mild symptoms, previous research was referred to regarding HSB. Based on these findings, participants were shown examples of mild symptoms: mild fatigue, flu-like symptoms, joint pain, back pain, and mild headache [16]. The contents of the interviews were then recorded and transcribed verbatim so the first and second authors could review the interview and diary transcriptions based on the content analysis method [19]. Through this process, the list of options of potential HSB was finally constructed.

Phase 2: Testing the validity and reliability of the HSB list

The participants were given the constructed list of options of their potential HSB. Multiple answers were allowed for each question. By comparing the answers on the list and the results for the HSB in the monthly diaries, the validity of the list was assessed. Lists were completed in the waiting room at the clinic and then collected by nurses. To confirm the reliability of the HSB list, all participants were provided with the constructed HSB list twice, ensuring test-retest reliability. The interval between the two rounds of list completion was one month. The participants' data were also extracted from the clinic's electronic

medical record and a questionnaire including age, sex, work conditions, exercise habits, eating habits, sleeping habits, smoking, habitual alcohol drinking, educational level, living conditions, social support [16], social capital (using a 10-point Likert scale: can rely on neighbors in communities to completely not rely on neighbors in communities) [20], socio-economic state and health literacy (HLS-14) [21], and diseases.

Data Analysis

The first and second authors performed the content analysis [19]. Initially, the authors individually read the contents of the interview transcripts in depth while referring to the contents of the health-check diaries. After reading them, they generated the content regarding the HSB from the scripts. They discussed the HSB content until reaching an agreement, leading to the final HSB content. Parametric data were analyzed using Student's t-test, and categorical data were analyzed using the chi-squared test. Symptoms from the health-check diaries were categorized based on the International Classification of Primary Care-2. Their real HSB based on their diaries and the HSB based on the constructed questionnaire were categorized into two groups based on a previous study: lay care and professional care. Regarding lay care, whether or not the patients' real and potential HSB were correlated was analyzed using the chi-squared test and Spearman r, and statistical significance was set with $p = 0.05$. Regarding professional care, the participants' real HSBs could be affected by their symptoms' duration and severity, and the participants with only self-limited symptoms may not use professional care [18]. Hence, correlation between patients' real and potential HSBs was revealed by the percentage agreement between the results of the lists and diaries. The results of the repetition of the HSB list for lay and professional care were analyzed using Cohen's kappa statistic. The other independent variables were categorized binomially: sex (male = 1, female = 0), work (in employment = 1, not employed = 0), smoking (yes = 1, no = 0), alcohol drinking (yes = 1, no = 0), higher educational level (more than graduation from high school = 1, no = 0), living conditions (with family = 1, living alone = 0), higher social support (having or relative having = 1, not relatively having or not having = 0), higher social capital (high [10 to 6] = 1, low [5 to 1] = 0), and higher socioeconomical state (high [rich, relatively rich, or not poor] = 1, low [relatively poor or poor] = 0). Regarding HLS-14, the participants were divided into two groups according to a total HLS of above or below the median. This time, the median was 49. Based on kinds of diseases, a Charlson Comorbidity Index score was calculated for each participant. This index measures the severity of patients' medical conditions as it relates to the possibility of admissions and mortality [22].

Ethical considerations

Participants were informed that the data collected in this study would be used only for research purposes. They were also informed about the aims of this research, how the data would be disclosed, and that their personal information would be protected. Thereafter, they provided written informed consent.

Ethics approval:

The study was conducted in accordance with the principles of the Declaration of Helsinki and approved by Unnan City Hospital's Clinical Ethics Committee (approval number: 20190033).

Results

Phase 1: Instrument development

There were 267 participants (121 from the clinics and 146 from the hospital) in Phase 1. The participants' average age was 79.3 years (standard deviation [SD] = 6.8), and 38.2% were male. The collection rate of the diaries was 98.1% (262/267). A total of 214 participants had experienced symptoms. The total number of symptoms was 262. The most common was joint pain (L20), followed by headache (N01) and fatigue (A04) (Table 1). Of the participants, 86.3% (226/262) used lay care and 13.7% (36/262) used professional care to address these symptoms. Eighty-four codes were derived for the approaches from the diary sheets, and the most common code found was self-care (132/262), followed by self-medication (72/262), using primary care (32/262), and using complementary medicine (21/262). In the content analysis, eight subcategories of lay care and four for professional care were created. The lay care category consisted of doing nothing, self-care (changing lifestyles, sleeping, resting, and taking a bath), seeking information, consulting family and friends, consulting community members, using complementary medicine, using home medicine, and buying over-the-counter drugs. The category of professional care included consulting pharmacists, consulting primary care physicians, visiting medical institutions (other than primary care physicians), and visiting general hospital emergency rooms (including calling for an ambulance) (Table 2).

Table 1
**Codes of the symptoms and classification using the
 International Classification of Primary Care-2**

Ranking	Code number	Category	ICPC-2
1	53	Joint pain	L20
2	45	Headache	N1
3	36	Fatigue	A4
3	26	Itchiness	S2
4	20	Muscle pain	L18
4	16	Diarrhea	D11
5	15	Back pain	L3
5	14	Vertigo	N17
6	7	Numbness	N5
7	6	Abdominal pain	D6
7	6	Insomnia	P6
7	5	Common cold	R74
8	13	Others	
ICPC-2 = International Classification of Primary Care-2.			

Table 2
Items of the help-seeking behavior list and definition of each item

Category	HSB	Definition
Lay care	Doing nothing	No action
	Self-care (sleeping, resting, taking a bath)	Moderating symptoms by changing usual behaviors
	Seeking information	Collecting information about symptoms
	Consulting family and friends	Asking for help from family and friends
	Consulting community members	Asking for help from community members
	Using complementary medicine	Using chiropractic treatment or osteopathy
	Using home medicine	Using medicine that is present in the home
	Using OTC drugs	Buying OTC drugs in drug stores
Professional care	Consulting pharmacists	Asking pharmacists for treatment
	Consulting primary care physicians	Visiting primary care physicians for treatment
	Visiting medical institutions other than primary care physicians	Visiting medical institutions excluding primary care physicians for treatment
	Visiting the emergency room of general hospitals (including calling for an ambulance)	Going to emergency rooms of general hospitals for treatment
HSB = help-seeking behavior; OTC = over-the-counter.		

Phase 2: Testing the validity and reliability of the HSB list

The number of participants who responded to the HSB list was 315 (169 from the clinics and 146 from the hospital) with a 100% collection rate. The participants' average age was 77.7 years (SD = 8.2), and 46.0% were male. The Charlson Comorbidity Index scores for 33.9% (107/315) of the participants were greater than 5 (Table 3). In terms of validity, the results of the list and the diaries were correlated (Spearman ρ 0.704; $p < 0.001$). The most common behavior with mild symptoms, during this phase, was consulting with primary care physicians, followed by self-care and using home medicine (Table 4). The test-retest reliability for mild symptoms found kappa values of 0.836 for lay care and 0.808 for professional care.

Table 3
Demographic characteristics of the participants

Variable	N= 315
Age (years), mean (<i>SD</i>)	77.71 (8.27)
Sex (males), %	46.0
Smoking, %	40 (12.7)
Work, %	140 (54.4)
Living alone, %	41 (13.0)
Higher education, %	149 (47.3)
Higher social capital, %	168 (53.3)
Higher social support, %	229 (72.7)
Higher SES, %	259 (82.2)
Higher HL, %	159 (50.4)
Charlson Comorbidity Index, number (%)	
Score = 2	48 (15.2)
Score = 3	62 (19.7)
Score = 4	98 (31.1)
Score = 5	67 (21.3)
Score = 6	24 (7.6)
Score = 7	12 (3.8)
Score = 8	4 (1.3)
Diseases, number (%)	
Hypertension	293 (95.2)
Dyslipidemia	254 (80.6)
Diabetes mellitus	53 (16.8)
Chronic kidney disease	60 (19.0)
Heart failure	31 (9.8)
Cerebral vascular disease	21 (6.7)

SD = standard deviation; COPD = chronic obstructive pulmonary disease; SES = socioeconomic state; HL = health literacy

Variable	N= 315
Cancer	19 (6.0)
Hepatic disease	15 (4.8)
COPD	13 (4.1)
Asthma	12 (3.8)
Myocardial infarction	8 (2.5)
<i>SD</i> = standard deviation; COPD = chronic obstructive pulmonary disease; SES = socioeconomic state; HL = health literacy	

Table 4
Prevalence of help-seeking behavior for mild symptoms

HSB	Mild symptoms	
	N	Percentage
Doing nothing	10	3.1
Self-care (changing lifestyles, sleeping, resting, taking a bath)	146	46.3
Seeking information	42	13.3
Consulting family and friends	126	40.0
Consulting community members	10	3.2
Using complementary medicine	27	8.6
Using home medicine	129	41.0
Using OTC drugs	97	30.8
Consulting pharmacists	15	4.8
Consulting primary care physicians	227	72.1
Visiting medical institutions other than primary care physicians	19	6.0
Visiting the emergency room of general hospitals (including calling for an ambulance)	17	5.4
HSB = help-seeking behavior; OTC = over-the-counter.		

Discussion

This is the first study to develop a list for assessing the trend in choosing lay and professional care in HSB and verifying its validity and reliability. The two phases of the study were designed to confirm

content validity through various forms of data collection and testing. This list can provide a stepping-stone for further research regarding HSB of individuals and health outcomes.

Content validity of the list was examined through diaries of symptoms, review of previous studies, and one-to-one interviews. Content validity is vital for lists because it ensures the list accurately evaluates what the study intends to measure, which this study accomplished through a survey assessing patients' real HSB, providing real situational evidence to various HSB choices [16, 17]. Existing studies were also used when developing list items because they discuss the categorization and concepts of the severity of symptoms [16, 17]. Furthermore, the one-to-one semi-structured interviews deepened the understanding of the behaviors, allowed for further inquiry into possible behaviors, and confirmed behaviors suggested in the analysis of the diaries and research reviews.

The analysis exemplified the list's high construct validity and reliability by comparing the real activities and results of the checklist and test-retest. Through this comparison, a strong correlation was found between the two; therefore, the list has high validity [17]. As the participants were allowed to simultaneously choose multiple items in the list, the correlation and test-retest were performed for both lay and professional care, and high reliability and validity in both categories were found [23].

The patients' symptoms in this study were similar to those in previous studies, but the rate of using primary care physicians was higher and the rate of self-care was lower than other studies [16, 24, 25]. This finding may be due to the medical conditions of older patients in developed countries, especially rural Japan [15]. Older patients tend to have a variety of symptoms and may have difficulties managing those symptoms [14]. In addition, as many older people are isolated and live only with their partners without enough help, this can lead to a trend of depending on medicine. Oppositely, the rate of self-care and self-medication with mild symptoms (using home medicine and over-the-counter medicine) was high [1]. This finding may reflect the trend of older people changing their behaviors and being more motivated to take care of their health. This may be because older people can have vague/irregular symptoms in combination with aging, meaning that there are unavoidable symptoms accompanied by prejudices [24, 26, 27, 28]. However, there has been no study on the relationship between HSB and health outcomes, as well as aging [29, 30]. Future research should investigate this relationship and interventions for improving older people's HSB should be developed.

There are several limitations to this study. Regarding validity, although the content validity was clarified, the construct validity for professional care with mild symptoms was not clarified. The various presentations of mild symptoms, such as durations and timing, affect HSBs, making identifying real HSBs difficult. HSB can depend on the individual's situation. Living environment can change HSB in terms of three factors: accessibility, availability, and affordability [31, 32]. The setting of this study was rural, so these three elements may have been low, potentially causing minimal use of primary care and other medical institutions. As the list is comprehensive and contains various behaviors, it can be used in different settings, clarifying multiple types of HSB. Another limitation is the difference in health insurance between countries. Japan's medical system is a free access system; thus, Japanese people can access

medical institutions anytime and anywhere [33]. When applying this list to other countries' settings, other possible behaviors should be considered based on the local medical systems.

Conclusions

This study clarified rural older people's choices of HSB for mild symptoms. The HSB list for mild symptoms developed in this study has high validity and reliability in the Japanese context and can be used in various contexts to assess people's HSB for mild symptoms.

Abbreviations

HSB: help-seeking behavior

Declarations

Declarations

Not applicable

Ethics approval and consent to participate

Participants were informed that the data collected in this study would be used only for research purposes. They were also informed about the aims of this research, how the data would be disclosed, and that their personal information would be protected. Thereafter, they provided written informed consent.

The study was conducted in accordance with the principles of the Declaration of Helsinki and approved by Unnan City Hospital's Clinical Ethics Committee (approval number: 20190033).

Consent for publication

Not applicable

Availability of data and materials

All data generated or analyzed during this study are included in this published article.

Competing interests

The authors have no competing interests to declare.

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The authors declare that no financial support was received for this research.

Authors' contributions

RO designed, collected and analysed data, and prepared and revised the manuscript. MS conceptualized, designed study, analysed data and prepared the manuscript. YR designed, collected and analysed data. TM analysed and revised the manuscript. CS analysed and revised the manuscript. All authors read and approved the final manuscript.

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References

1. Cornally N, McCarthy G. Help-seeking behaviour: a concept analysis. *Int J Nurs Pract*. 2011;17(3):280-288. <https://doi.org/10.1111/j.1440-172X.2011.01936.x>
2. Fox A, Reeves S. Interprofessional collaborative patient-centred care: a critical exploration of two related discourses. *J Interprof Care*. 2015;29(2):113-118. <https://doi.org/10.3109/13561820.2014.954284>
3. Sirri L, Fava GA, Sonino N. The unifying concept of illness behavior. *Psychother Psychosom*. 2013;82(2):74- <https://doi.org/10.1159/000343508>
4. Morikawa M. Towards community-based integrated care: trends and issues in Japan's long-term care policy. *Int J Integr Care*. 2014;14(1). <http://doi.org/10.5334/ijic.1066>
5. Campbell SM, Roland MO, Buetow SA. Defining quality of care. *Soc Sci Med*. 2000;51(11):1611-1625. [https://doi.org/10.1016/S0277-9536\(00\)00057-5](https://doi.org/10.1016/S0277-9536(00)00057-5)
6. Wereta T, Betemariam W, Karim AM, et al. Effects of a participatory community quality improvement strategy on improving household and provider health care behaviors and practices: a propensity score analysis. *BMC Pregnancy Childbirth*. 2018; 18(1):364. <https://doi.org/10.1186/s12884-018-1977-9>
7. Song C, et al. Spatial and Temporal Impacts of Socioeconomic and Environmental Factors on Healthcare Resources: A County-Level Bayesian Local Spatiotemporal Regression Modeling Study of Hospital Beds in Southwest China. *Int J Environ Res Public Health*. 2020;17(16). <https://doi.org/10.3390/ijerph17165890>
8. Ohta R, Ryu Y, Katsube T. Challenges for Japanese rural home care workers in interprofessional collaboration: a qualitative study. *Home Health Care Serv Q*. 2018;37(4):1-12. <https://doi.org/10.1080/01621424.2018.1525462>
9. Ohta R, Ryu Y, Katsube T. Care managers in rural Japan: Challenges to interprofessional collaboration. *Home Health Care Serv Q*. 2019;38(4):1-16. <https://doi.org/10.1080/01621424.2019.1673867>
10. Ohta R, Ryu Y, Otani J. Rural physicians' perceptions about the challenges of participating in interprofessional collaboration: Insights from a focus group study. *J Interprof Educ Pract*. 2020;20:100345. <https://doi.org/10.1016/j.xjep.2020.100345>

11. Willems S, Peersman W, De Maeyer P, Buylaert W, De Maeseneer J, De Paepe P. The impact of neighborhood deprivation on patients' unscheduled out-of-hours healthcare seeking behavior: a cross-sectional study. *BMC Fam Pract.*2013; 14(1):136. <https://doi.org/10.1186/1471-2296-14-136>
12. Habtu Y, Yohannes S, Laelago T. Health seeking behavior and its determinants for cervical cancer among women of childbearing age in Hossana Town, Hadiya zone, Southern Ethiopia: community based cross sectional study. *BMC Cancer.*2018;18(1):298. <https://doi.org/10.1186/s12885-018-4203-2>
13. Yamaguchi M, Yoshida T, Yamada Y, et al. Sociodemographic and physical predictors of non-participation in community based physical checkup among older neighbors: a case-control study from the Kyoto-Kameoka longitudinal study, Japan. *BMC Public Health.*2018;18(1):568. <https://doi.org/10.1186/s12889-018-5426-5>
14. Agrawal G, Keshri K. Morbidity patterns and health care seeking behavior among older widows in India. *PLoS One.* 2014;9(4):e94295. <https://doi.org/10.1371/journal.pone.0094295>
15. Ohta R, Ryu Y, Kitayuguchi J, Gomi T, Katsube T. Challenges and solutions in the continuity of home care for rural older people: a thematic analysis. *Home Health Care Serv Q.* 2020;39(2):126-139. <https://doi.org/10.1080/01621424.2020.1739185>
16. Elliott AM, McAteer A, Hannaford PC. Revisiting the symptom iceberg in today's primary care: results from a UK population survey. *BMC Fam Pract.*2011;12(1):16. <https://doi.org/10.1186/1471-2296-12-16>
17. Downing SM. Validity: on the meaningful interpretation of assessment data. *Med Educ.* 2003;37(9):830-837. <https://doi.org/10.1046/j.1365-2923.2003.01594.x>
18. Shaw C, Brittain K, Tansey R, Williams K. How people decide to seek health care: a qualitative study. *Int J Nurs Stud.*2008;45(10):1516-1524. <https://doi.org/10.1016/j.ijnurstu.2007.11.005>
19. Hsieh H-F, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res.*2005;15(9):1277- <https://doi.org/10.1177/1049732305276687>
20. Nilsson J, Masud Rana AKM, Kabir ZN. Social capital and quality of life in old age: results from a cross-sectional study in rural Bangladesh. *J Aging Health.* 2006; 18(3):419-434. <https://doi.org/10.1177/0898264306286198>
21. Suka M, Odajima T, Kasai M, et al. The 14-item health literacy scale for Japanese adults (HLS-14). *Environ Health Prev Med.* 2013;18(5):407-415. <https://doi.org/10.1007/s12199-013-0340-z>
22. Charlson M, Szatrowski TP, Peterson J, Gold J. Validation of a combined comorbidity index. *J Clin Epidemiol.*1994;47(11):1245-1251. [https://doi.org/10.1016/0895-4356\(94\)90129-5](https://doi.org/10.1016/0895-4356(94)90129-5)
23. Lam SSK. Test-retest reliability and factor structures of organizational citizenship behavior for Hong Kong workers. *Psychol Rep.*2001;88(1):262-264. <https://doi.org/10.2466/pr0.2001.88.1.262>
24. Takahashi O, Ohde S. The ecology of medical care in Japan revisited. *Value Health.* 2014;17(7):A434. <https://doi.org/10.1016/j.jval.2014.08.1115>
25. Fukui T, Rahman M, Ohde S, et al. Reassessing the ecology of medical care in Japan. *J Community Health.* 2017;42(5):935-941. <https://doi.org/10.1007/s10900-017-0337-4>

26. Khan S, Ali SA. Exploratory study into awareness of heart disease and health care seeking behavior among Emirati women (UAE) - cross sectional descriptive study. *BMC Womens Health*. 2017;17(1):88. <https://doi.org/10.1186/s12905-017-0445-4>
27. Zock E, Kerkhoff H, Kleyweg RP, et al. Help seeking behavior and onset-to-alarm time in patients with acute stroke: sub-study of the preventive antibiotics in stroke study. *BMC Neurol*. 2016;16(1):241. <https://doi.org/10.1186/s12883-016-0749-2>
28. Sargent-Cox K. Ageism: we are our own worst enemy. *Int Psychogeriatr*. 2017;29(1):1-8. <https://doi.org/10.1017/s1041610216001939>
29. Barcham R, Silas E, Irie J. Health promotion and empowerment in Henganofi District, Papua New Guinea. *Rural Remote Health*. 2016;16:3553. Available: rrh.org.au/journal/article/3553.
30. Ford JA, Turley R, Porter T, et al. Access to primary care for socio-economically disadvantaged older people in rural areas: a qualitative study. *PloS One*. 2018;13(3). <https://doi.org/10.1371/journal.pone.0193952>
31. Zou X, Fitzgerald R, Nie JB. "Unworthy of Care and Treatment": Cultural Devaluation and Structural Constraints to Healthcare-Seeking for Older People in Rural China. *Int J Environ Res Public Health*. 2020;17(6). <https://doi.org/10.3390/ijerph17062132>
32. Liu Y, Chen Y, Cheng X, Zhang Y. Performance and Sociodemographic Determinants of Excess Outpatient Demand of Rural Residents in China: A Cross-Sectional Study. *J. Environ. Res. Public Health*. 2020;17:5963. <https://doi.org/10.3390/ijerph17165963>
33. Kaneko M, Motomura K, Mori H, et al. Gatekeeping function of primary care physicians under Japan's free-access system: a prospective open cohort study involving 14 isolated islands. *Fam Pract*. 2019;36(4):452-459. <https://doi.org/10.1093/fampra/cmz084>