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Ageism as a Barrier:
understanding healthcare-seeking among rural older adults in China

By

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ABSTRUCT

Healthcare is closely linked to well-being in later life. Considering the context of population aging in China, and the disadvantaged position of rural older adults in accessing healthcare, it is important to examine the factors influencing their healthcare-seeking behavior. However, existing research pays insufficient attention to cultural factors, particularly the role of ageism. The study aims to explore in what ways do social constraints and cultural factors affect the healthcare-seeking of Chinese older adults living in rural areas from the perspective of ageism. The study draws on semi-structured interviews with 11 older adults living in rural China.

The study shows that older adults exhibit both positive and negative attitudes towards seeking healthcare. These attitudes are shaped by the association of aging with physical decline and concerns about becoming a burden on their families. Very few participants reported experiencing external age discrimination, nor did they express unmet needs for healthcare services. In addition, the study reveals that rural older adults heavily rely on their children when making healthcare-related decisions. This marginalization in healthcare decision-making may be related to their limited social network and restricted access to informational resources.

INTRODUCTION

Since transitioning into an aging society in the late 20th century, China has experienced growth in both the size and proportion of older population and has become the country with the largest older population worldwide. At the end of 2023, individuals aged 60 and above made up 21.1% of the total population, and individuals aged 65 and above made up 15.4% of the total population (NHC of the PRC 2024). In the context of aging, healthcare has demonstrated an important role in the quality of later lives of older adults. Adequate healthcare can reduce disability rates, cognitive impairment, as well as all-cause mortality among older adults (Zhang et al. 2017). Although the overall life expectancy has been increasing, the number of years older adults living with illness has not decreased. According to the *World Health Statistics 2024* by the World Health Organization, China's life expectancy in 2021 was 77.6 years, but the healthy life expectancy was only 68.6 years (World Health Organization 2024). Chinese older population is expected to spend almost eight years living with illness, making care in later life and medical treatment inseparable.

As older migrant workers gradually return to rural areas, while young generations in rural areas move into cities for study and work and settle in cities, the degree of aging in the countryside becomes more pronounced (Zhu 2023). According to the data from the Seventh National Population Census in 2020, the rural population aged 60 and above exceeded 121 million, accounting for 23.81% of the total rural population. And the proportion was 5.1 percent higher than the national average (National Bureau of Statistics of China 2021). Correspondingly, the demands of addressing the barriers in healthcare-seeking and promoting positive healthcare-seeking behavior are more pressing in rural areas because of the urban-rural inversion of aging in China.

The accessibility of healthcare for older adults is not universal among all older populations and rural older adults face greater challenges in obtaining the healthcare they need. Since the 1950s and 1960s, China has gradually established and improved a three-tier healthcare system that spans both urban and rural areas, aiming to optimize resource allocation. The system consists of primary-level institutions, like community health service centers, secondary-level hospitals, like county and city hospitals, and tertiary-level hospitals, like comprehensive provincial hospitals. Currently, according to regional administrative divisions, the rural older population's access to healthcare follows a hierarchical structure from the grassroots level upwards, encompassing village clinics, township public hospitals and private clinics, county-level public hospitals and private specialized hospitals, and prefecture-level city hospitals and provincial capital hospitals (Zhu 2023). Despite the continuous improvement of the healthcare system, there are still significant disparities between urban and rural older people in terms of utilization of healthcare services and healthcare-seeking behavior. The older rural population still faces challenges in terms of both the accessibility and actual use of medical services.

Previous research showed that the proportion of rural older adults with inadequate access to health services is much higher than that of urban older adults (Zhang et al. 2017). Compared to urban areas, the link between inadequate healthcare access and higher rates of disability, cognitive impairment, and mortality was significantly stronger among older adults in rural areas, even after controlling relevant covariates (Zhang et al. 2017). Rural older residents demonstrate significantly lower rates of healthcare utilization than urban older residents (Liu et al. 2007; Zeng et al. 2021). Rural and urban older adults also exhibit different preferences in their choice of healthcare institutions. Rural older adults typically default to primary healthcare institutions, while urban older adults are more inclined to seek healthcare at public healthcare institutions and

higher-level hospitals (Zeng et al. 2021). In addition, the older population in general tends to utilize healthcare resources less than the younger population in certain circumstances. A German study revealed that although older patients have more frequent episodes of dizziness, more falls, and similar levels of distress due to dizziness compared to younger patients, younger patients are more likely and more frequently to seek healthcare help including medication, physical therapy, and psychological therapies (Prell, Finn, and Axer 2022).

Existing research has demonstrated significant disparities in healthcare access and utilization among older adults in China, with older population in rural areas experiencing limited access to healthcare services. But studies investigating the factors influencing and contributing to the disparities have focused primarily on structural and economic dimensions, such as affordability, healthcare costs and accessibility of health care services (Liu et al. 2018). And previous research has mainly employed quantitative methods to examine the impact of quantifiable factors, including income, health insurance coverage, self-assessed health status, etc. (Zeng et al. 2021). Nevertheless, limited attention has been paid to the influence of cultural factors, especially age itself, on healthcare-seeking behaviors of Chinese older adults.

This study will be conducted with the hope of answering the question: In what ways do social constraints and cultural factors affect the healthcare-seeking of Chinese older adults living in rural areas from the perspective of ageism? The objective of current research is to close the gap in the literature on how cultural factors, specifically ageism, contribute to inadequate healthcare access among rural older adults in China and inequal healthcare services. Additionally, applying qualitative methods, this research aims to obtain a further understanding of health and age through the subjective perspective of rural older people and attempts to further reveal the mechanisms of age as a structure of inequality. In addition, the study provides

critical insights for promoting comprehensive healthcare access in an aging society and plays an important role in improving the well-being in the later life of rural older adults, as well as fostering a more inclusive cultural environment.

LIETERATURE REVIEW

Healthcare

Healthcare-seeking behavior, also referred to as illness-related behavior or sick-term behavior, has been defined as any activities undertaken by individuals who perceive themselves to have health problems for the purpose of getting well (Kasl and Cobb 1966). The current study focuses specifically on healthcare-seeking behavior related to the purpose of treatment, excluding broader health-related practices aimed at maintaining health or preventing illness, such as routine health examinations. Medical sociologists view healthcare-seeking behavior as social behavior (Li et al. 2024). The decision-making process of seeking healthcare involves a series of factors, including personal characteristics, health beliefs, characteristics of healthcare providers, etc. During the process, individuals need to decide whether or not to seek medical care, whom to seek medical care from, and what types of treatment to pursue. Thus, individuals' demand for healthcare does not necessarily translate into actual utilization of healthcare services (Zeng et al. 2021). Healthcare-seeking is mediated by multiple factors at the individual, social, and structural levels.

Due to the complexity of factors influencing the choices of healthcare-seeking options, different populations exhibit varying patterns of healthcare utilization. In China, the utilization of healthcare services of the older population is characterized by a high demand but relatively low rates of actual utilization (Xu, Yuan, and Zhu 2010). Rural older adults, in particular, face compounded disadvantages in healthcare access. Despite the fact that urban older residents in China tend to have higher healthcare needs than their rural counterparts, the problem of unmet healthcare needs is more severe among rural older adults (Ma and Xu 2015).

To better understand the healthcare-seeking behavior of rural older adults and healthcare disparities among the older population, scholars have proposed different explanatory frameworks Long and Li proposed in their study that research on the difference in healthcare-seeking behaviors of Chinese urban and rural older adults often draws on two perspectives: structural and cultural (2015). Studies based on a structural perspective focus on measuring the socioeconomic status of individuals and employing structural discrepancies in economic, organization and policy to explain the discrepancies among rural and urban older adults.

Existing research consistently shows that rural older adults face greater financial obstacles in accessing healthcare services compared to their urban counterparts. The majority of rural older adults indicate that financial barriers were the main reason for difficulties in accessing health-care resources, while a relatively low percentage of urban older adults express the same opinion (Zhang et al. 2017). The key financial factors influencing rural older adults' healthcare related decision include lower pensions, lower personal incomes and a high percentage of self-payment (Zeng et al. 2021; Hou and Ke 2015). Despite the high level of health insurance coverage in rural areas, the health insurance system in rural areas is not as beneficial as it is in urban areas (Zhang et al. 2017). According to Qiu and Wang's (2023) systematic review of the development of China's medical insurance system, China has gradually established a healthcare insurance system comprising the Urban Employee Basic Medical Insurance (UEBMI), Urban Resident Basic Medical Insurance (URBMI), and New Rural Cooperative Medical Scheme (NECMS), respectively for urban employees, unemployed urban residents, and rural residents. However, evidence from a study examining how health insurance affects healthcare utilization among older adults in Zhejiang and Gansu Province in China revealed that NECMS did not significantly improve rural older adults' access to healthcare services or reduce out-of-pocket

payments (Li and Zhang 2013). In order to address the dualistic between urban and rural healthcare and improve equity, China began to integrate NECMS and URBMI since 2016. Nevertheless, there is still an uneven distribution of healthcare resources between urban and rural areas, making it harder for rural residents to make healthcare decisions or receive compensation for health insurance benefits (Qiu and Wang 2023). Beyond the limitations of insurance system, rural older adults' choice of healthcare providers is also shaped by economic factors. Rural older adults are more likely to seek healthcare at primary-level facilities due to cost and convenience considerations, while urban older adults tend to choose public hospitals or higher tier medical services (Zeng et al. 2021). Utilization of outpatient care in China is constrained by economic level, while inequality is higher for inpatient care because it is generally more expensive. Preventive health care may reduce the need for hospitalization, yet the main factor influencing health awareness and prevention is the level of education (Fu, Fang, and Dong 2022).

Studies based on cultural perspective pay more attention on more micro contextual factors in explaining healthcare-seeking behaviors among the rural older population in China. On the one hand, some scholars have discussed the impact on older adults of Chinese culture of filial piety and Confucianism, as well as family intimacy. Filial piety, a traditional social and cultural characteristic of China, requires children to provide for their parents financially and emotionally, and places families the primary moral responsibility of caring for the older population (Anon 2020). The large number of young and middle-aged people working outside rural areas has created a variety of family structures that differ from the traditional ones, which has led the younger generation to become increasingly detached from parental authority and to focus on their individual interests. Resources are more skewed towards the younger generation, leaving the rural older population with fewer resources to rely on family as support for health care (Yan

2016; Zou and Nie 2021). On the other hand, people may define rural residents as second-class citizens, and the rank of rural elders in the collective may influence their healthcare-seeking behavior (Long and Li 2016). Meanwhile, age itself prevents older adults from obtaining necessary healthcare. Age is not just a biological concept, but a socially constructed category that determines how different ages are treated and perceived. This led to a broader issue of ageism, but its effect on healthcare-seeking behaviors of rural older adults in China remains understudied.

Ageism

Robert Butler first introduced the concept of ageism in 1969 and defined it as "prejudge by one age group toward other age groups". He specifically characterized ageism as discrimination by middle-aged groups who hold the resources of society against younger and older groups who are seen as dependent (Butler 1969). In his later work, Butler drew comparisons between ageism, sexism, and racism, and argued that ageism is manifested in the form of attitudes, behaviors, and institutionalized policies targeting the older population (1980). Despite that age is a widely used demographic variable in social science research, the structural inequalities it provokes have still not received sufficient consideration.

To more systematically reveal how age constitutes a mechanism of social inequality, Anne E. Barrett (2022) presents a theoretical framework of age inequality. The sociology of age framework argues that ageism is not a stereotype or a negative attitude against older populations at an individual level. In contrast, Barrett reflects age as a social determinant and contends that age is the central axis of a system of inequality, just like gender, race and other factors of concern to sociology. This framework develops three dimensions centered on age inequality: age as institution, age as performance, and age as identity. It also further elaborates on essential

elements of age inequality, including age position, age ideology, and age norms. Focusing on the key dimensions and elements, the framework shows that social norms and social expectations construct age hierarchy, privilege some age groups over others, restrict people's behaviors and thoughts to societal narratives about age, and perpetuate this systemic inequality (Barrett 2022). This study employs Barrett's framework to analyze how ageism influences healthcare-seeking behaviors among rural older adults in China, with particular attention to how changes in social roes and interactions, and age identity affect their decision to seek medical care.

Numerous existing studies align with the idea in the sociology of age framework, demonstrating that age is a structural problem rooted in society. First of all, physical appearances, as a visible symbol of aging, is a basic construction of "older identity". Higgs and Gilleard (2022) argues that the corporeality of the aging body reflects both old age and age's negative social status. The association between aging and physical decline leads society to construct older people's social identities primarily through the lens of health deterioration and disability. In this context, older adults are more likely to be linked with negative characteristics like frailty, vulnerability and incompetence compared to younger people (Bugental and Hehman 2007; Bennett and Gaines 2010). In addition to perception, age also influences how older adults are valued and treated in society. The hierarchy within age position plays a significant role in the disparity in resource allocation, as society assigns resources, opportunities and social values based on age (Barrett 2022; Clarke and Griffin 2008). Yan introduces a tendency in Chinese society to use the term "descending familism" which means the attention and resources at both spiritual level and material levels flow from the older generation to the younger generation (Yan 2018). Ageism leads some older people to accept negative impressions of older people from

younger people and to accept them as conforming to their identity as older people (Macrae 2018).

Building upon the understanding of ageism as a structural inequality, existing research has also demonstrated its significant influence on older adults' access and utilization of healthcare services. Age hierarchy affects healthcare resource allocation, making policies and practices disadvantageous to older populations. During the CPVID-19 pandemic, the sharp contrast between rising medical demand and limited resources brought ageism into the framework of healthcare resource allocation, such as distributing ventilators and hospital beds based on age, implicitly reflecting the notion that older adults' lives are less valuable (White and Lo 2020; Swift and Chasteen 2021). Ageism in the healthcare industry is also directly reflected in how healthcare providers treat older patients. Healthcare workers favor young people and display condescending and dismissive attitudes toward older people and are more inclined to work with young patients rather than older patients (Macrae 2018; Helton and Pathman 2008). Doctors are less trusting when working with older patients, partly due to assumptions about their ability or willingness to follow medical advice. Stereotypes in aging may also lead health professionals to attribute diseases and injuries to advancing age, resulting in less thorough diagnoses or less proactive treatment. These negative attitudes may in turn discourage older adults from seeking or adhering to healthcare (Chrisler, Barney, and Palatino 2016). Beyond the healthcare system, family attitudes toward health care for older adults and the role they play in the process also garnered great discussions. A study targeting rural families in China found that the expectations of the majority of rural older adults are ignored since that they are totally dependent on their families for the financial and material support necessary to access health care services. A study targeting rural families in China found that the expectations of the majority of

rural older adults are ignored since that they are totally dependent on their families for the financial and material support necessary to access health care services. Older adults, in most of the households interviewed in the study, were deprived of the authority and autonomy to make decisions about medical care and treatment. And some older adults choose not to participate in health care to voluntarily avoid becoming a constant burden on their families (Zou, Fitzgerald, and Nie 2020).

Previous research consistently demonstrates the inequality of healthcare resources between urban and rural older adults, as well as the inadequacy of healthcare access for older adults in rural areas. However, most of the existing studies use quantitative methods to quantify broad trends in healthcare resource disparities and analyze them from a macro perspective, and limited studies examine this issue from the cultural perspective. There have been few studies attempting to systematically explain the impact of ageism on healthcare-seeking behaviors among older populations, particularly among rural older adults, who have been marginalized in accessing healthcare. Moreover, most of the existing research has remained at the phenomenal level, focusing on the impact of ageism on individuals, such as older people's negative perceptions of their own health and healthcare-seeking, but there has been inadequate discussion of the structural issues behind this phenomenon. Therefore, this study examines how age function as a structural inequality affecting the healthcare-seeking behaviors of Chinese older adults in rural areas. Adopting a qualitative approach, this study will explore the cultural barriers and social constraints that older people experience, particular how age shapes their access to healthcare and their behaviors, from the perspective of their own subjective experience. The paper aims to fill the gap in the discussion of age inequality mechanisms in existing research.

METHODS

This study adopts a qualitative research design employing semi-structured interviews. A qualitative research approach is particularly well-suited for capturing the complexity of human experience as it could combine the construction of social reality with positivist-empiricist methods to enhance the collection and use of data for multidimensional interpretations. And qualitative methods focus not only on observable external behaviors, but also on the intentions of individuals and the meaning behind their social behaviors (Chen 2021). Since the current study aims to explore how cultural factors and social constraints affect healthcare access of rural older population, particularly through the lens of ageism, which involves various factors that could not be quantified, such as subjective feelings and interpersonal interactions, a qualitative method is appropriate for revealing the subtle links between behaviors, perception, and the surrounding social environment. Semi-structured interviews were designed to guide the discussion toward the cultural and family influence on older adults' healthcare-related decisions, while allowing participants the flexibility to elaborate on their opinions and experiences.

All the participants were recruited from multiple rural areas of Inner Mongolia, a vast autonomous region in Northern China. In light of the study's focus on healthcare access among rural older adults, Inner Mongolia is a suitable region as the research site. From the perspective of the aging background, the older people in Inner Mongolia are characterized by diversified religious beliefs, a high proportion of senior citizens, lower educational attainment, and unbalanced social security. Inner Mongolia, with its distinctive demographic characteristics and social service landscape, provides an appropriate site for examining the interaction of aging, cultural factors and healthcare access. Additionally, the researcher's previous familiarity with the

local context could contribute to a more effective participation in recruitment and supported cultural sensitivity throughout the interviews.

Prior to data collection, the research protocol, including recruitment procedures, interview guide, informed consent process, and data protection and storage methods, were reviewed and approved by the Institutional Review Board (IRB) at the University of Chicago (ID: IRB24-2152). All of the following methods have been approved by the IRB.

Following the IRB approval, I conducted 11 semi-structured interviews in Chinese. And the interviews were then transcribed verbatim in Chinese. The study targeted on older adults aged 60 and above living in rural China, who are eligible to be interviewed independently. Recruitment did not include specific requirements regarding gender, age group, health status, etc. The 11 participants ranged in age from sixty to ninety years old, with 6 males and 5 females. Recruitment was carried out through multiple strategies. Most of the participants are married and live with a partner, a few live alone, and one participant lived with his daughter. The majority of participants do not work currently. The initial participants were recruited through informal referrals, including personal networks and introductions from local staff. To better facilitate access to older adults, I contacted a local staff member who works in the village council in Keyouqianqi, Inner Mongolia, to assist in the participants recruitment. The staff member helped identify eligible older residents in the villages and contacted them. His familiarity with the community helped build trust and facilitated outreach. After the initial introduction, I followed up with participants to schedule interviews and conduct the interviews. The subsequent recruitment was carried out using snowball sampling, asking the initial participants if they knew other eligible participants who may be interested in participating in the study.

All interviews were conducted remotely one-on-one via Tencent Meeting, a widely used video conferencing platform in China. I chose the Tencent Meeting because it is a safe and reliable platform, which could protect participants' privacy and data security. The meetings were password-protected so that only participants who have an invitation link with a password can apply to join the meeting. To protect participants' privacy and to encourage them to feel more comfortable expressing their views, all interviews were conducted on a one-on-one basis between the participants and me. All participants were informed in advance to make sure that they could be alone or in a separate room during the interviews. Each interview lasted approximately 40 to 60 minutes and was conducted in Chinese.

Informed consent was obtained from all participants prior to the formal interview. I sent the consent form to each participant a few days ahead of the interview after each interview was scheduled. Participants were informed about the purpose of the research, the voluntary nature of their participation, the confidentiality, and their right to withdraw. For participants who had difficulties with reading the form, the consent process was explained verbally before the interviews to ensure they fully understood the study and their rights. Ensuring the anonymity of participants was essential for ethical consideration. Accordingly, no personally identifiable information was collected or retained during the study. The participants were informed in advance that they did not need to show their real names when joining the meeting. Instead, pseudonyms were used in the transcripts, allowing specific details to be referenced in the paper while preserving participant anonymity.

To ensure the accuracy of data and facilitate later transcription and data analysis, with participants' consent, both audio and video were recorded in the interviews on the Tencent Meeting Platform. Because of the technical limitation of the platform, video was recorded along

with audio, as Tencent Meeting does not support audio-only recording. However, only the audio recordings were retained for transcription and analysis, and the visual recordings were immediately deleted after the interview, as visual data were not necessary for the research.

The interview guide was divided into two sections. The first section focused on participants' daily lives and general perceptions of their age. The section was designed to build rapport, and provide cultural and contextual background of participants' life, helping to better understand their subsequent responses. It included questions such as "What does a typical day of you look like?", "What do you usually do when interacting with people around you, like neighbors and friends?", and "Have you ever heard something about what the older people 'should' or 'should not' do when interacting with others?

The second section aimed to unravel the medical experience, willingness to seek health care, and the motivations or the deterrence behind participants' healthcare-related decisions. The questions basically started by asking about the personal experiences of the participants and then pursuing their attitudes toward medical decisions and personal health conditions based on the experiences or events they described. Some example questions include "Can you describe your experience the last time you felt unwell and how you handled it?" "Could you walk me through how you decide whether or not to seek medical care and how you choose where to go?" "If you are feeling unwell, would you usually let your family know right away. Why or why not?", and "Thinking back on your past experience of seeking healthcare, have you ever felt that your age affects how you were treated?". The complete interview guide is included in the Appendix.

Data coding for this study followed an inductive coding approach, processing from open coding to focused coding using MAXQDA. During the open coding phase, a split coding approach was primarily employed. Given that the older participants sometimes faced difficulties

in clearly and accurately articulating their thoughts and experiences during interviews, a line-by-line coding strategy was adopted to help capture subtle details and implicit meanings embedded in their responses. There were other coding techniques that were also applied during the open coding phase, including descriptive coding, process coding, and in-vivo coding. Descriptive coding was particularly helpful for summarizing participants' narratives and identifying key themes while preserving the integrity of their experiences. In vivo coding was used to retain participants' original expressions, especially when culturally meaningful phrases, like proverbs or sayings, emerged. Finally, process coding was used to reflect some changes in attitude and behaviors.

FINDINGS

During the interviews, I found that some participants place a high value on health and seek medical care proactively, while others ignore illness and postpone treatment. The differences in their attitudes and healthcare-seeking behaviors are influenced by various factors including self-perceptions of aging, family, and access to resources. And my sample's healthcare-related decision demonstrated a high dependency on family members, especially adult children. This section will elaborate on the respondents' behavior towards healthcare and the factors influenced by age through the following four themes: Proactive Health-Seeking and the Value Placed on Well-being; Minor Illnesses Left Untreated as the Norm: Neglect and Avoidance; Marginalization of Older Adults in Healthcare Decisions; and Disconnected from Social Support and Informational Resources.

Proactive Health-Seeking and the Value Placed on Well-being

Although there is evidence showing that older adults in rural China face multiple challenges, including structural and cultural, in accessing healthcare, the majority of the interviewees expressed a willingness to take the initiative to seek healthcare, as well as a strong desire for longevity and healthy life. Qiang, a 60-year-old male, shared one of his experiences when he felt discomfort in his chest area. The actions in response to physical discomfort reflected a positive attitude towards seeking medical care and the willingness to follow the doctor's advice. When he was unwell reflected active Qiang recounted:

> "One time, I felt some discomfort in my heart, so I went to see the village doctor to have it checked. The village doctor said my heart didn't seem to be in good condition and gave me some pills. I felt better after taking them. Then he advised me to get a more thorough

examination. So, I went to the city, to a big hospital, and got an EKG. The result turned out there were some issues within my heart. But the doctor said it wasn't anything serious. I just needed to rest more and stop drinking alcohol."

This attitude was echoed by another participant Liang, a 60-year-old male, who described a similar pattern of timely action when experiencing physical discomfort. He also indicated a willingness to seek healthcare services beyond surrounding environments and go to city-level hospitals or more advanced medical facilities. He said: "I usually see the doctor pretty quickly. As soon as I feel something's wrong, I go to see the village doctor. And once I think the village doctor cannot figure out what is going on or the treatment won't be helpful, I'll go to the hospital in the city right away to get a CT scan or whatever is needed."

Qiang went on further to describe his belief that people at his age should pay closer attention to their health and be responsible for themselves. In the response, he criticized his friend with severe hypertension but did not take treatment seriously and still drunk heavily, describing this behavior as "irresponsible" and "messing around with his own life". Reflecting on the significance and urgency of timely healthcare, he said:

"You really have to take the initiative to see the doctor. We are already in our sixties. If you miss the chance (to check) this time, who knows if there will be another one next time. At our age, we have no idea how our health indicators are doing. Isn't it necessary to get things checked? You have got to at least have some ideas of which part of your body needs more attention."

The positive attitudes towards healthcare were also reflected in an age-related shift in health consciousness. Several participants reported they now take their health more seriously

than when they were younger. For instance, Lijuan, a 63-year-old female, said: “I didn’t take medication when I got cold or a fever when I was in my thirties or forties. But now it’s different. I take medication as soon as I feel unwell, and sometimes I even take it ahead. Like recently, there is a flu going around, so I took some cold medicine at home.” Similarly, Liang said that: “Now I really pay more attention to health. When I was younger, I didn’t take it seriously and just pushed through it when I got sick. But now I have to take the initiative to seek the doctor.”

This shift was mostly attributed to the growing awareness of bodily vulnerability. As an example of the reason for increasing attention placed on health, Lijuan indicated: “It’s because I’m older now. Some problems just show up without me even noticing. Getting older is like a bike that needs repairs. These physical conditions, as well as the thoughts, didn’t happen when I was younger.” In addition to health concerns, some participants viewed increased self-care awareness and proactive healthcare-seeking behaviors as ways to avoid burdening their family, especially children. Baoguo, an 89-year-old male, indicated that he now takes health much more seriously than when he was younger. He went on to explain that the main reason he pays attention to his health is to avoid causing trouble for his children. Baoguo said: “The reason I value my health much more than before is because I don’t want to bother my daughters. That’s the main reason. I’m already this old, it doesn’t really matter anymore to me.” Qiang also showed a change in health beliefs and healthcare-seeking behavior in his later life. When asked about the reason behind this change, he specifically explained that he did not want to cause his children financial strain:

> “If you get sick, aren’t you going to be a burden on our kids? Of course you are. Now my wife and I can still do some farm work as capable, and we can help our kids out whatever is left over. But if we become sick, forget about helping, they have to take care of us

instead. There is a big difference between how we are able to help our kids, and they have to take care of us."

Minor Illnesses Left Untreated as the Norm: Neglect and Avoidance

Not all participants demonstrated a willingness to seek healthcare and positive healthcare beliefs. On the contrary, some participants showed varying degrees of negative responses when facing health issues. They prefer not to seek professional medical assistance but tend to cope on their own or postpone treatment, reflecting a more casual approach to healthcare. Among these participants, a common practice was to rely on their own diagnosis and judgement to manage their physical discomfort. For instance, Yuzhen, a 77-year-old female, when asked about how she usually responds to physical discomfort and how she decides whether and where to seek healthcare, Yuzhen reported that she did not think minor problems need treatment or seek healthcare services. Yuzhen, instead, was accustomed to assessing her symptoms on her own and determining which medications to take:

> "I used to get sick a lot when I was younger, so I generally know what kind of medicine is suitable. If I have a minor illness, I usually just read the instructions and then take some medicine myself to resolve it. If my eyes don't feel right, and I think it may not problems with my liver, just too much phone time, and I'll go get some eye drops from the pharmacy. Most people in my age have digestive issues, so I keep some meds at home for that. If I feel something hurts, I'll just buy some medicine and handle myself."

Wenhai, a 62-year-old male, also shared the sentiment of handling less serious conditions through personal adjustment and self-diagnosis rather than seeking for medical treatment:

> "I don't go to the hospital unless I really have to. I know my body condition pretty well, and I also take account that I'm going through menopause. Men also have menopause after their sixties. I exercise, try not to be irritable, and keep a regular routine. I just deal with discomfort on my own, so I rarely go to the hospital. I sometimes take medicine based on my experience. If I feel it's not working very well, I might go to see the village doctor or to the nearby local hospital to check it out."

Some participants' perceptions of aging included how they responded to physical discomfort. Rather than viewing physical discomfort as a sign of illness that needs more attention or medical intervention, they interpreted such symptoms as natural and inevitable consequences of getting older. This belief led them to rationalize the degradation of health conditions, thus reducing the perceived necessity of seeking healthcare services. Wenhai expressed his feelings after describing his current physical condition:

> "After several times (experiencing dizziness and lightheaded) that felt like a rollercoaster, I was not so worried about it anymore. I think maybe it's not really an illness, but just some parts of the body have gotten degraded. Some parts of my body just don't function as well as before because I have gotten older. It's something beyond our control."

Other participants expressed similar views, emphasizing the normality of age-related physical discomfort and the need to accept it. When elaborating her choice of taking medication herself, Yuzhen said: "I think it's normal to feel uncomfortable in the body at this age. At our age, things like joint pain, or stomach issues are just typical age-related illnesses. So, we don't take them too seriously, and don't go to the hospital." Shulan, a 75-year-old female, said: "I'm getting old. I'm in my seventies. You know, heart, organs, the whole body, everything began to

fail. It's all declining. Honestly, there's no such thing as feeling good all the time. So, I'd get less trouble if I could get through it by myself."

Different from only a few participants who actively sought medical care and mentioned their children as a reason, the desire not to bother children and family was a common reason given by the participants who tended to minimize the significance of medical care and postpone treatment. Participants noted that their children were highly attentive to their health and would often insist on taking them to the hospital once they learned that their older family members are not feeling well. Nevertheless, because of this, some older adults are worried that taking them to the hospital would take up their children's time and disrupt their routines. As a result, they often choose not to tell family about their discomfort and handle minor issues themselves, unless the situation becomes truly serious. For instance, when talking about her family's attitude towards her when she was sick, Guiying, a 61-year-old female, said: "I don't want to tell them. I'm afraid of troubling them. They are busy enough." Yuzhen also described how, despite knowing that her sons did not support her taking medication on her own, she would choose to hide her illness and deal with illness herself to avoid troubling them:

> "If I tell my sons I'm sick, they will ask me to go to the hospital. They don't want me to take medicine on my own and often complain about this. They told me it would harm my health to take medication without seeing a doctor. So, I just lie and tell them I haven't taken medicine on my own this time and go to the hospital with them. But I would handle it on my own if it's something I can solve with medicine. I want to try to reduce the burden on my children as much as possible."

Marginalization of Older Adults in Healthcare Decisions

Regardless of whether older adults held a proactive or avoidant attitude towards their health and healthcare services, the dominance of their children in medical decision-making remained a recurring and influential factor. Despite the differences among individuals in health beliefs and willingness to seek healthcare, 7 of the 11 participants ultimately chose to rely on their children's arrangements when it comes to actual medical actions and health-related decisions. As mentioned above, most of the participants said that their children and other family members were highly concerned about their health. In these circumstances, the decision to seek healthcare sometimes did not reflect participants' own preference, but rather the opinions of their family. This pattern was exemplified by Qiang who shared: "When I felt something was wrong with my heart, my family told me I had to see the doctor. To be honest, I didn't want to go at first. But they told me you must do so, so I just listen." Similarly, Fang, a 62-year-old female who was diagnosed with stomach cancer a few years ago, narrated that she had no intention of getting a medical examination because she did not experience any obvious symptoms. It was only after her son repeatedly asked her that she agreed to get the examination. In retrospect, she acknowledged that without her son's insistence, she likely would not have gone for the check-up, and the cancer may not have been detected and treated in time:

> "I casually told my son I'd been a bit constipated. I didn't think it was a big deal, so I didn't tell him at first. He made an appointment for me to get checked after hearing about this. It turned out there was something serious. The local hospital said it would require major surgery. My son said we should go to Beijing. He thought Beijing's medical resources and doctors are better than that in the local hospital… My son and daughter-in-law always tell me to get regular checkups. I usually say, 'Why should I? Being sick is

already uncomfortable, finding out something will make me more worried.' My son told me to get checked or I wouldn't have known."

For some participants, healthcare decisions are almost fully reliant on their children. As Yuzhen said: "Important things in my family, like seeing a doctor or getting treatment, are all decided by my eldest son. After he makes a decision, he then talks it over with his younger brother. Now basically everything is up to my sons. They discuss what to do, and I don't really worry about it." Baoguo also pointed out that decision-making was gradually passed to his children after his retirement. He said: "It's all decided by my kids. They talk to each other about the decision, like which kind of treatment I should get or which hospital to go to…. I think the change started after I retired. After I retired, there wasn't much to do, and I didn't have many connections with the outside world. So, I just listened to my kids."

Some participants expressed clear acceptance of their children's dominant role in health-related decision-making. They did not resist the shift of power but considered it reasonable and necessary. Participants explained they felt less able to make good decisions about their own health and thought their younger family members were more qualified to deal with such issues. Listening to their children was not only reasonable from the practical perspective, but also natural order. For instance, Baoguo said: "The most important thing as an old man is to listen to my kids. Don't be stubborn. You don't know anything anymore. How can you still insist on doing things on your way?" Qiang referred to a common saying that describes this shift within the family, suggesting that children making decisions for their aging parents is as natural as parents doing so for their young children:

"I think it's totally fine. You don't have the ability anymore, why wouldn't you just follow what others arrange for you? There's a saying: 'Young child, old child.' When we

were little kids, our parents made decisions for us, like where we went and what to eat. Now that we're old, isn't it the kids' turn to decide for us? Parents are getting older, so they should be the ones in charge. Young child, old child."

Disconnected from Social Support and Informational Resources

While relying on their children in healthcare decision-making, participants also demonstrated a high level of dependence on their children throughout the entire healthcare-seeking process. This dependency was not only observed in decisions about whether to seek healthcare, but also in specific steps, including making appointments, communicating with healthcare professionals, using digital devices, etc. With the increasing medical procedures and the growing digitalization of healthcare services, older adults face challenges such as difficulties in operating digital tools and limited access to information, which makes them feel lost during medical visits, and even to avoid seeking healthcare services. In this situation, children often become older adults' essential support to navigate this process. Liang noted that he could complete the medical process smoothly only with the help of his children due to his unfamiliarity with technology: "They take us to the checkups. I just wait once we get to the hospital, and they handle every step. They know more than I do…. Technology has advanced a lot nowadays. We can make the appointment at home and see the doctor in time when we get there. Making the appointment can be done by phone, but it's my kids who do it. Using the phone is hard enough for me." Fang also expressed a strong sense of anxiety about going to the hospital without her children, and difficulties in using technology:

"I can't go without my kids. My kids took me to all the follow-up examinations in the past few years. If I go to the large hospital by myself, I'll get confused and can't find anywhere. I wouldn't want to go if I had to go by myself. I can't find anywhere and can't

figure out the procedures. I've been to that hospital many times. I got confused every time when I got there. I saw others making appointments on their phone and even don't need to go to the hospital. But I can't figure it out."

Baoguo expressed that he has been excluded from technological developments both in healthcare and in everyday life: "Kids took me to the hospital. I know nothing. It would be much easier when they went with me. Not to mention going to the hospital, it's hard for me to take a train on my own without my kids now. I don't know how to buy tickets or get through the station. I can't keep up with all the new technology, the (A)I, 5G and all that. I've been left behind by society."

When faced with difficulties related to health care, participants were unable to receive assistance from a broader social network beyond the family. Some participants indicated that they rarely engaged in social activities when talking about their daily lives, and most of their interaction was chatting with peers of a similar age. For instance, Yuzhen said: "My health isn't that great now. So, I rarely participate in group activities. I usually just go downstairs and take a walk, and chat with my older friends, and maybe play cards sometimes." Baoguo said: "There is not much going on in my daily life. My friends are all getting old as well. We just talk to each other on WeChat every day, sending each other some encouraging words." Liang also shared that he often was perceived as younger by others since he interacted with younger people frequently: "Most of the people I interact with are in their thirties or forties. Others often say I don't seem like 60 because I can still get along with younger folks. People my age usually just spend time with other older people."

Some participants found they have limited access to help when there are health problems, especially compared to younger populations who benefit from broader social networks. Weidong,

a 65-year-old male, said: “For some older people whose children are filial, health problems can be noticed and addressed in time. For those whose children are not filial or are not nearby, the problems ended up just can’t be addressed in time and are left to drag on.” And Jianhua, a 69-year-old male said when answering the difference of response to health problems among older people and young people: “Young people tend to go get checked in time when something is wrong. Their family is often close by, and even if they’re not, friends can also help. But once you get older, it’s different.”

DISCUSSION

Based on interviews with older adults in rural China, this study investigates how social constraints and cultural factors affect the healthcare-seeking of Chinese older adults living in rural areas from the perspective of ageism. It provides empirical insights into age as a structural mechanism of inequality in access to healthcare among rural older populations.

Consistent with what was observed in earlier research, this study finds a general tendency of passive healthcare-seeking behavior among older adults in rural areas, including the normalization of physical discomfort as a natural part of aging, delays or avoidance of healthcare services, and medication based on personal judgments (Liu et al. 2007; Long and Li 2016). Nevertheless, 6 older rural adults in my sample exhibited a proactive attitude toward seeking medical care and strongly emphasized the importance of maintaining physical well-being in later life. Although this phenomenon was also revealed in the study by Zou et al. in 2020, it is particularly evident in the current study. Furthermore, different from previous studies, the current study does not demonstrate that it is considered culturally unethical for rural older adults to actively request medical care.

It is worth noting that the study identified the two opposing attitudes towards healthcare-seeking were driven by similar underlying motivations. Regardless of whether they choose to seek healthcare services proactively or postpone it, older rural adults attribute the physical decline to the natural process of aging and express concerns about imposing burdens on their families. Many rural older adults perceive health decline as an inevitable consequence of aging (Sarkisian, Hays, and Mangione 2002; Bennett and Gaines 2010), and this perception may prevent them from seeking timely healthcare or adopting strategies that promote a healthy lifestyle and recovery (Wurm et al. 2013; Horton, Baker, and Deakin 2007). It indicated that

ageism influences the healthcare-seeking behaviors among rural older adults not through direct external discrimination, but through internalized stereotypes that subtly shape their beliefs about aging and their perceptions of health requirements. As presented by Levy (2001), ageism can operate in an implicit and unconscious way, manifesting through internalized stereotypes of aging or older individuals' beliefs about the older population. Even though the notion that growing older means declining physical well-being and reduced self-worth was generally accepted by most participants, it did not necessarily lead to negative healthcare-seeking behaviors. My sample demonstrated diverse understandings and behavioral responses toward this belief. The internalization of age-related stereotypes provides an explanatory framework for healthcare-seeking behaviors among the rural older populations. This framework, however, did not directly determine their actions**.** Instead, it may be embedded within other influencing factors, such as personal experiences or material conditions, and was interpreted and practiced in different ways by older individuals in rural areas.

The findings within the study indicate that very few participants reported experiencing explicit ageism from medical professionals or family members, such as being refused treatment or being belittled. A possible explanation for this might be that older adults in rural areas have a lower level of social participation with limited diversity of social activities (Vogelsang 2016; Wang, Li, and Fu 2021), and maintain closed social networks limited mainly to peers of similar age (Ye and Zhang 2019). In this context, rural older adults do not have many opportunities to be exposed to social expectations or social norms related to age. The construction of ageism and individual perception of ageism are shaped primarily through interpersonal interaction (Ayalon and Tesch-Römer 2018). Consequently, the limited social interactions may diminish their understanding or recognition of ageism. Another possible explanation for this is the influence of

Confucian culture, particularly the emphasis on filial piety. In cultural contexts that emphasize family ties and filial piety, older adults are more likely to be viewed positively and accorded higher social status (Taşdemir 2025), while adult children tend to view caring for their parents as a normative duty and responsibility (Liu, Wu, and Dong 2020). The cultural context may mitigate the manifestations of ageism in daily life. The findings, however, should be interpreted with caution. The absence of explicit reports of external age discrimination may not necessarily indicate that rural older people were unaffected by it. Considering their internalized view of aging as naturally associated with physical deterioration, and the pervasiveness of this association in dominant ideology (Macrae 2018), it is possible that they have experienced ageism without being consciously aware of it.

Another important finding is that rural older adults are heavily marginalized in healthcare decision-making and are highly dependent on their children. Many participants in the study believed that they were less capable of making proper decisions or that they ought to defer to the decisions of their children. Therefore, the power of decision-making has shifted to the younger generation, and the rural older populations gradually lose their autonomy in healthcare decision-making. This dynamic could be interpreted through the notion of "ag as performance" proposed by Barrett (2022) within the sociology-of-age framework. This concept suggests individuals are expected to situate their behaviors within the age institution, encouraging them to act in ways that align with their age or conform to mainstream age norms. Negative stereotypes of aging could lead older adults to seek external help more frequently, thus increasing their dependency (Coudin and Alexopoulos 2010). In the process of making health-related decisions, rural older individuals perform in accordance with negative age stereotypes by relying on and deferring to younger family members. Additionally, this shift of decision-making power also reflects the fact

that ageism sometimes manifests in a well-intentioned form, whereby negative stereotypes of older population drive positive behaviors such as paternalism, assistance, or protection (Cuddy, Fiske, and Glick 2007). Older adults may feel overprotected, and their true opinions are ignored (Huang, Liang, and Shyu 2014; Ye, Gao, and Fu 2017).

The disconnection of rural older adults from broader social networks and informational resources further limits their healthcare-seeking behaviors and ability to make independent healthcare decisions. The larger scale of social networks could provide older individuals with more support both instrumentally and emotionally and frequent face-to-face interactions significantly increase the perceived adequacy of the support (Seeman and Berkman 1988). The social networks of rural older adults are primarily centered around their children, with daily interactions mostly confined within the family and limited contact or social engagement with others (Ye and Zhang 2019). Older adults in rural areas, compared to their urban counterparts, face great challenges in intergenerational support due to the migration of education and job opportunities to the urban areas (Guo, Aranda, and Silverstein 2009).

This study also demonstrated how the dependence and limited social assistance of rural older people are reflected in the increasingly digitalized healthcare environment. Digitization in healthcare processes reveals the lack of digital literacy among rural older adults and the negligence of this deficiency in the technical design of healthcare systems. There is a digital health divide between younger and older people. Older individuals, especially those with low income and living in rural areas have less access and ability to use digital healthcare services than younger individuals (Mace, Mattos, and Vranceanu 2022; Hall et al. 2015).

Finally, previous research has demonstrated that older adults in rural China experience significant barriers to accessing adequate healthcare services compared to their urban

counterparts. Nevertheless, the current study presents a contrasting observation. None of the participants reported experiencing a situation in which they required healthcare services but were unable to obtain them. Nor did they report that the frequency of seeking healthcare services has been influenced because of limited medical resources. This discrepancy could be understood by the specific characteristics of the study sample and the ways that medical needs are shaped and interpreted within specific social context. One possible explanation for this might be that the study sample disproportionately included rural older people who live with children or have their children living nearby. This living arrangement may facilitate access to healthcare since children can provide not only financial but emotional support for the older rural population. Financial support and daily care could lead to better psychological expectations and less financial pressure when rural older people become sick, which will increase their behavior in seeking healthcare service (Ren and Ren 2023; Zeng et al. 2021). In terms of emotional support, as presented above, rural older adults who have their children nearby tend to rely heavily on them when making healthcare decisions. On the one hand, participants who follow their children's suggestions in healthcare decision-making may not be fully aware of what kind of medical service they need or lack. On the other hand, the emotional support provided though children's presence or encouragement may also increase their likelihood of seeking medical care, thereby promoting more adequate utilization of healthcare services. Another possible explanation for this may lie in the methodological difference between the current study and the previous studies. Much of the existing literature relies on quantitative indicators to measure healthcare access, such as whether an individual received outpatient care in the past month or inpatient care in the past year. These indicators set clearer measurements for healthcare utilization. In contrast, this study used in-depth interviews to capture participants' subjective narratives. Without sufficient knowledge of

available treatment options or points of comparison, older adults may have difficulty recognizing or articulating unmet healthcare needs.

Although this research did not suggest that older rural adults lacked access to necessary healthcare, some participants did express a preference for informal healthcare. Prior research has shown that social support plays a significant role in shaping older adults' choice of medical institutions. Togonu-Bickersteth et al. (2019) found that older adults who received social support were more likely to seek care from formal healthcare facilities, while those without such support tended to rely on informal care. This phenomenon is particularly pronounced in the rural setting of this study, where older people rely primarily on family-based support systems. Therefore, studies are needed to further examine healthcare behaviors and demands under different family support structures, like empty-nested older adults and oldest-old living alone.

CONCLUTION

In conclusion, this study reveals that ageism implicitly affects healthcare-seeking behaviors among rural older adults in China mainly through the internalization of negative stereotypes of aging, but this effect does not necessarily lead to negative healthcare-seeking behavior. Most respondents did not perceive external discrimination regarding aging. The research has also shown that older adults in rural China demonstrated great dependency on family members in health-related decisions. Disconnections from social networks and information resources further deepen this dependency.

The study adopts a cultural perspective to provide additional evidence on the influence of age on healthcare-seeking behavior among older adults in rural China and further enriches the understanding of the internalization of ageism. Meanwhile, the study expands the current understanding of the mechanism of age as a structural inequality. The findings of the study may also help to promote a more inclusive healthcare environment as well as a social environment, highlighting the need for future policy interventions to pay more attention to implicit ageism, and to strengthen social support and healthcare accessibility for rural older adults.

There are some limitations in this study as follows. First of all, although I tried to maintain neutrality and minimize personal influence when developing the interview guide and conducting interviews, my identity as a young female researcher may inevitably influence the attitude of the participants and the way they responded to me in the interviews. During the field work, older participants tended to perceive me as a junior rather than a researcher. This perception may influence not only the degree of openness in their responses, but also the language they used. Potentially affecting the depth and authenticity of their responses. Secondly, China is a vast country with significant regional diversity in terms of economic development or

cultural context. The sample of this study was only selected from Inner Mongolia in northern China. The findings are shaped by specific geographical, economic, and cultural context of this region to a certain extent, which may fail to fully represent the experience of rural older adults in other parts of the country.

Further research could expand the sample to include older adults from various rural regions, in order to gain a more comprehensive understanding of how ageism manifests and impacts them across different cultural and economic backgrounds. In addition, the positive effects of age on the older population's health beliefs and behavior could be usefully explored in future research.

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APPENDIX

Section I. demographic

1. How older are you?
2. Where do you live?
    a. How long have you lived here?
3. Could you tell me about your family situation?
4. Who do you live with? (spouse, child, alone?)
5. Are you currently working?
    a. No
        i. Did you have a job before?
        ii. What kind of job was it?
        iii. When did you retire/stop working?
    b. Yes
        i. Is your current job a formal position, or something more flexible?
        ii. How do you typically manage your work schedule?

Section II. General life experience & Reflection on family and community

1. How do you usually spend your day?
    a. Can you walk me through what you did yesterday?
    b. (For participant lives with younger generation) Do you usually need to take care of your grandchildren?
2. What do you usually do when interacting with people around you, such as neighbors and friends?
3. Have you participated in any activities organized by your village or other local organizations recently?
    a. Yes
        i. Can you walk me through the process?
        ii. How did you learn about the activity, register, and participate?
        iii. How was your experience?
    b. No
        i. What are the main reasons you didn't participate?
4. What responsibilities do you usually have at home?
    a. What do you usually do with your family?
5. Who makes the important decisions in your household?
    a. Me
        i. How has your decision-making power changed compared to when you were younger? For example, were there things you used to decide on your own that now require others to do so?
        ii. Why do your family members are willing to listen to your decisions?

iii. Are there any matters that you need others to decide for you?

b. Others

i. Who used to make household decisions in the past? Is this person still the one making decisions now?

ii. Can you tell me how this change happened?

iii. Do your children still consult you when making decisions?

6. Have you ever heard something about what the older people "should" or "should not" do when interacting with others?
    a. Yes
        i. Do these statements align with what you personally want to do?
        ii. How do you feel when others say this?
        iii. Do you go along with their opinions, or do you stick to your own ideas?
    b. No
        i. Is there anything you wanted to do but were stopped by others because of your age? (Can you describe it in detail, including how you brought it up, how others reacted, and how you responded?)
        ii. In your own opinion, what should or shouldn't people at your age do?
7. Has anyone ever told you that you "don't seem like someone of your age"?
    a. What did you do that made them say that?
    b. How do you feel when you hear this kind of comment?
    c. How would you feel if someone said you were 'old'? Why?

Section III: Healthcare decisions and healthcare experience

1. How is your health currently?
2. What options do you have for seeking medical care? What kinds of healthcare resources are available to you?
    a. How long has the local clinic been there?
3. Can you describe your experience the last time you felt unwell and how you handled it?
4. When you do not feel well, how do you deal with it?
    a. How do you decide where to seek healthcare? For example, do you go to a local clinic or a hospital in the city? To what extent does it affect your daily life, and how does that influence your choice of healthcare facility?
    b. b. If you feel dizzy for a few days but it doesn't seriously affect your daily life, would you actively go to the hospital for a check-up?
5. Compared to before the age of 60, has the way you handle illness or discomfort changed?
    a. Can you recall a specific example?
    b. If yes, how do you think these changes are related to your age and others' expectations of you?
6. Can you tell me how you currently maintain your health?
7. How does your current physical condition compare to when you were younger? What are the most noticeable changes

    a. Can you tell me about a recent time when you wanted to do something but found it more difficult than before?
    b. Have you felt these changes affecting your daily life? Can you describe how you noticed them?
8. How do you feel when you notice these changes?
    a. Do you see them as a normal outcome of aging?
9. Would you tell your family right away when you feel unwell?
    a. Why or why not?
    b. How does your family usually react when they hear about it?
10. Who usually makes medical decisions for you—yourself or your family?
    a. Family
        i. How do you feel about your family making medical decisions for you?
        ii. What prevents you from making decisions on your own?
11. The last time you went to the doctor or felt unwell, did your family give you any advice or requests? For example, did they encourage you to go or suggest that you don't need to?
12. How does your family's attitude or suggestions influence how you approach illness now?
13. If your family didn't give their opinions, would you make any different choices about seeing a doctor or getting treatment?
14. Besides your family, how do you talk about your health with others, such as friends or neighbors?
    a. Have they ever given you any advice?
    b. How do your peers view their health and medical treatment?
15. Have you noticed any differences in how younger family members, such as your children, grandchildren, or other younger relatives, handle illness compared to you?
16. Some people believe that it is normal for older adults to feel unwell and that they should just endure it because seeing a doctor won't help much. What do you think about this?
17. Some older adults choose not to tell their children when they are sick because they don't want to burden them. What are your thoughts on this?
18. The last time you went to the hospital, were you accompanied by someone, or did you go alone?
19. Can you tell me the process about how the doctor communicated with you?
20. One last question—In your past medical experiences, have you ever been treated differently because of your age? For example, has a doctor mentioned your age and used it as a factor in making treatment decisions?
21. Is there anything else you would like to add regarding what we just discussed?