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Research article

Dealing with Healthcare Costs: How Rising Prices Affect Medical Accessibility for Middle- and Lower-Class Households in South-Western Parts of Bangladesh

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ABSTRACT

Affordability of healthcare remains a prime concern in developing countries, disproportionately impacting lower- and middle-income households. In southwestern Bangladesh, high medical costs in the face of inflationary pressures of the economy keep small family units on the margins of forgoing or delaying needed medical care. This qualitative investigation centers on how such low-income families align their health requirements with their financial limitations. Using a two-stage sampling procedure emphasizing initially purposive sampling method followed by respondent-assisted and availability-based methods, 24 participants from the Khulna district were selected for in-depth interviews. These participants were selected from a diverse range of participants living in urban and rural areas. Data were analyzed thematically through NVivo 15 software. The findings point to the observation that financial hardship has pronounced health inequities, nudging many vulnerable families toward self-medication, traditional healing, or simply postponing treatment in the face of further indisposition. The exact methods included buying medicines directly from the pharmacy without prescriptions, avoiding diagnostic tests, and mistrust in public hospitals. The study calls for an intervention from the policymakers for subsidized healthcare provision, an improved health infrastructure in rural locations, and community programs to fill the gap in accessibility and affordability. The study emphasizes the urgent need for policy interventions such as the subsidizing of health services, improving rural health infrastructure, community-based programs, etc. The investigation contributes to other policy discussions on equitable healthcare by addressing affordability and accessibility gaps and offers pragmatic solutions for alleviating healthcare exclusion in low-resource settings.

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Introduction

Affordability of healthcare is a pressing global issue, chiefly in developing nations, where financial barriers restrict access to services deemed essential. In Bangladesh, specifically in the southwestern part, middle- and lower-income families find access to timely and affordable healthcare increasingly difficult as out-of-pocket expenditures swell and insurance cover remains low, with limited public support systems (Al-Worafi, 2023; Yenet et al., 2023). Healthcare expenses place a great financial burden on the poor and middle classes, who may delay seeking treatment or forgo it altogether (Akter & Kabir, 2023; A. T. M. S. Alam et al., 2025). Access to medical services, therefore, being so crucial to societal well-being, should steer our attention toward understanding how households cope with health needs amid the rising pressure of costs of daily necessities.

Earlier literature states that Bangladesh has made tremendous progress in the health sector over the years by adapting to advancements in medical technologies and healthcare infrastructures (Rodrigues da Silva et al., 2024; Wang, 2018). However, with the rise in medical costs, healthcare services have gradually become less affordable for common citizens (Kielb et al., 2017; Richard et al., 2018). Specifically, in southwestern Bangladesh, middle- and lower-class families find themselves most vulnerable, as they usually do not have health insurance and must rely on out-of-pocket payments (Adams et al., 2013; Joarder et al., 2019). Thus, inequities in health care based on wealth also equate to inequities in health; the wealthy can afford

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to get treatment while the poor are left with hardly anything (Biswas et al., 2016; Khatun et al., 2023).

The increased healthcare costs are highly attributable to inflation-the process of increasing prices of medical consultations, medicine, diagnostic tests, and hospital services (Dunn et al., 2018). The skyrocketing financial tolls on lower- and middle-income households are grossly worsened by negligible government subsidies, lack of social security systems (Ahmed et al., 2022; Mahumud et al., 2017). Different studies reveal that nearly 67% of the health expenditures in Bangladesh constitute out-of-pocket payments, one of the highest rates worldwide (Sarker et al., 2022; World Health Organization, 2023). Such a devious financial squeeze forces households to forgo treatment or borrow money, thereby increasing their vulnerability (Aminuddin et al., 2024; Flores et al., 2008). In certain cases, families liquidate assets or seek money as aid from relatives; however, these remedies are associated with severe socio-economic wounds and deepen the poverty cycle (K. Alam & Mahal, 2014; de Siqueira Filha et al., 2022).

The medical cost burden extends beyond the immediate financial aspect and brings in socio-economic consequences such as dwindling labor force participation, disrupted education, and poor quality of life (K. Alam & Mahal, 2014; de Siqueira Filha et al., 2022). Then, families that cannot pay their medical bills have to make even harder life choices, leaving them food, education levels, and shelter, while the health-related decisions stand in line behind all these needs (Dowhaniuk, 2021). Children may be unsupported by the medical bills needed for education, after which these youngsters give up secondary schooling, further economic instability. If the chief breadwinner suffers from long-term illness without treatment, the entire family will depend on one another and reduce family income and living standards in the process (Hassan et al., 2025; Kabir & Maitrot, 2018).

Moreover, informal healthcare services are widely sought balances for economic constraint. A good number of individuals from the extremely poor strata would rather trust traditional healers and unlicensed practitioners, given their cheaper cost compared to the formal institutions (Agarwal et al., 2017; Musich et al., 2016). Alternative medicine sometimes does offer relief, but this is severely undermined by the fact that many of the treatments have no scientific basis whatsoever, and in some cases, the unregulated practices can result in dire consequences (Bilinski et al., 2017; Lang et al., 2016; Moye-Holz et al., 2017). Hence, a lack of trust in government run healthcare facilities and the unaffordability of private healthcare are pushing households toward suboptimal healthcare choices, which could possibly carry grave implications for long-term health outcomes (Kelly & Barker, 2016; McGinnis et al., 2013).

A way out could be provided by policies and reforms. Along with subsidized health care services, local health insurance, and better health-care infrastructure could be the president's promise toward protecting the most vulnerable groups from enormous financial burdens imposed by their medical costs (de Siqueira Filha et al., 2022; Joarder et al., 2019). The larger number of beneficiaries would be brought under the ambit of health coverage if countries promote universal health coverage schemes and reinforce primary health-care services in the countryside too (Ahmed et al., 2022; World Health Organization, 2023). Health departments of states may also organize awareness campaigns on preventive health interventions to reduce avoidable expensive health conditions and thus lodge the load on the country's health system (Adams et al., 2013; Moye-Holz et al., 2017).

Apart from state-facilitated mechanisms, NGOs and international funding programs constitute an important axis for improving access to healthcare for marginalized communities. Different health NGOs have been operating for health care of the poor either at no cost or on a sliding scale basis, often limited by their lack of resources (Dowhaniuk, 2021; Sarker et al., 2022). In strengthening the coordination between the government, private healthcare providers, and international organizations can bridge gaps in healthcare service delivery to ensure marginalized populations are adequately taken care of by qualified health professionals (Hassan et al., 2025; Sarker et al., 2022; Yenet et al., 2023).

This study deals with the increasing healthcare costs affecting medical accessibility for middle- and lower-income households in southwestern Bangladesh. It studies the financial coping mechanisms, utilization of informal care, and the policies for recording the right to healthcare access. An understanding of these issues is relevant in order to propose policy interventions that would make healthcare access equitable, improve health outcomes, and reduce socio-economic disparities across the region.

Materials and Methods

Study Design

The study adopts a qualitative research design studying how middle- and lower-class households in southwestern Bangladesh deal with rising prices of healthcare. The decision to choose the qualitative approach stems from its rigor in capturing in-depth, contextualized understandings of an individual's lived experiences and socio-economic behaviors, particularly pertinent to health-seeking practices, financial coping mechanisms, and perceived barriers to formal medical care (Marvasti, 2004). In many cases, people from these socio-economic strata often refuse to seek higher-end healthcare due to high costs; they tend instead toward self-medication, traditional remedies, or just procrastination until their health suffers critically. Based on real-life experiences of the participants at the household level, the study tried to explore the insights into how healthcare decisions are taken according to intersecting socio-economic, cultural, and policy factors. The qualitative method, in this regard, accommodated an in-depth look at the psychological barriers and economic constraints isolating people from formalized healthcare, providing grounded insight into those impoverished conditions of access and the survival tactics implemented by these communities with increasing medical costs (Ela et al., 2021; Lune & Berg, 2017; Maxwell, 2012

Participant Recruitment and Study Area

A two-stage sampling technique was adopted so that participants would gain from having had the experiences potential participants. This sampling framework enables the researcher to select participants based on inclusion and exclusion criteria that are relevant to the study (Daniel, 2011). However, the inclusion criteria of the study are as follows (See Figure 1).

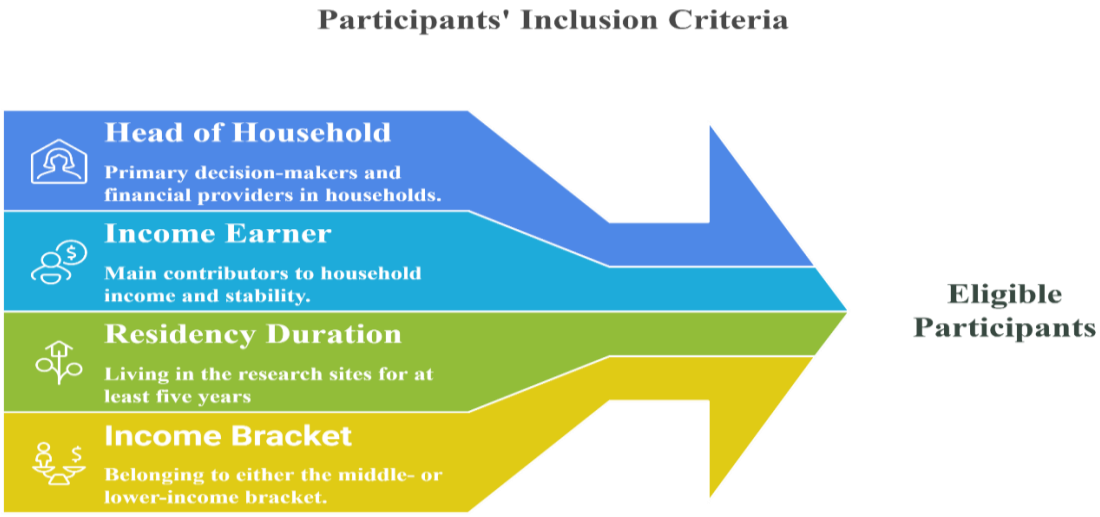

Figure 1: Participants' inclusion Criteria

Accordingly, income threshold was set as following –

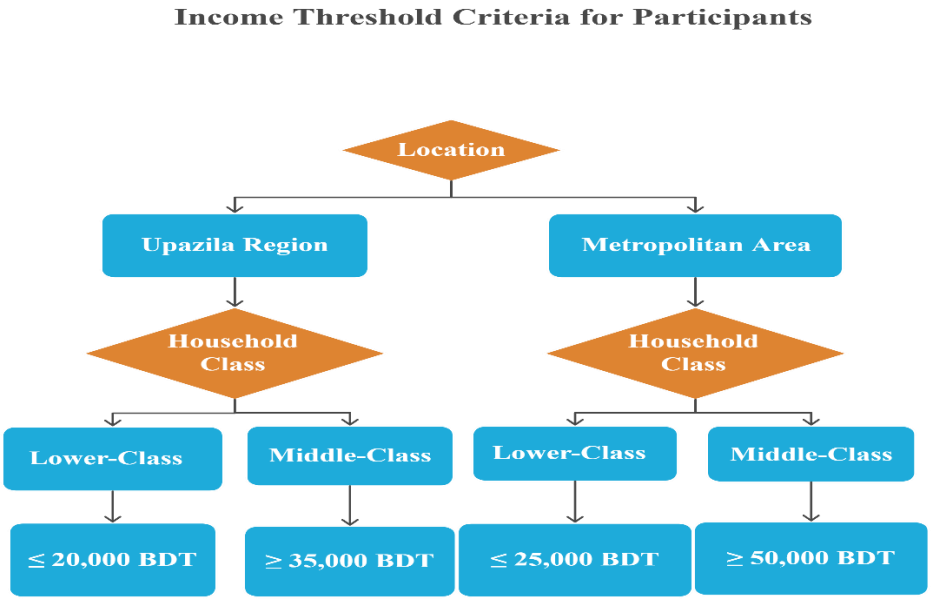

Figure 2: Participants' income threshold criteria

However, for the second phase, respondent-assisted sampling methods were utilized to select research participants during qualitative interviews. This sampling process allowed the researcher to find participants with relevant experiences within a broad spectrum of diverse cases from metropolitan, and upazila areas. Parallel to this, availability sampling was also employed for its capacity to select participants based on their accessibility and willingness to participate (Daniel, 2011).

In aggregate, 24 participants (See table 1) sampled from three different spots in the Khulna district (*Batiaghata* upazila, *Dumuria* upazila and Khulna Metropolitan City Area). It is noteworthy that in qualitative research, the main concern is not statistical generalization but rather in-depth understanding of the lived experiences of the participants, especially when these experiences are situated within contexts with socio-economic complexities, such as healthcare affordability. A sample size of 24 is methodologically appropriate in this study and is considered sufficient to explore the subtle effect of rising healthcare costs on access by middle- and lower-class households. Qualitative inquiry demands that the richness of data takes precedence over their breadth, emphasizing the intense engagement and contextual sensitivity that comes with having a relatively smaller but heterogeneous sample, to allow for the welfare of a trust

relationship between researcher and participants (Crouch & McKenzie, 2006; Bryman, 2012). Considering the socioeconomic heterogeneity within the study's target population, this sample size provided for reaching thematic saturation, at which point no new information was being gleaned from subsequent interviews; also, it ensured the sufficiency of experiences being represented (Guest et al., 2006; Patton, 2015). Therefore, the chosen sample theoretically supports the study's aim of registering healthcare struggles as lived realities of a locale burdened by economic constraints and structural disparities.

Table 1: Participants Information

Sl. No	**Participants**	**Living Location**	**Social Class (Based on Income)**	**Living Duration** in Research Locations **(Years)**
1	Participant 3	*Batiaghata*	Middle Class	25
2	Participant 8	*Batiaghata*	Middle Class	23
3	Participant 12	*Batiaghata*	Middle Class	21
4	Participant 14	*Batiaghata*	Middle Class	25
5	Participant 9	*Batiaghata*	Lower Class	20
6	Participant 18	*Batiaghata*	Lower Class	21
7	Participant 20	*Batiaghata*	Lower Class	25
8	Participant 22	*Batiaghata*	Lower Class	25
9	Participant 1	*Dumuria*	Middle Class	19
10	Participant 5	*Dumuria*	Middle Class	18
11	Participant 11	*Dumuria*	Middle Class	27
12	Participant 24	*Dumuria*	Middle Class	31
13	Participant 10	*Dumuria*	Lower Class	26
14	Participant 16	*Dumuria*	Lower Class	24
15	Participant 17	*Dumuria*	Lower Class	22
16	Participant 19	*Dumuria*	Lower Class	18
17	Participant 2	KMCA	Middle Class	24
18	Participant 4	KMCA	Middle Class	23
19	Participant 7	KMCA	Middle Class	29
20	Participant 13	KMCA	Middle Class	22
21	Participant 6	KMCA	Lower Class	26
22	Participant 15	KMCA	Lower Class	19
23	Participant 21	KMCA	Lower Class	20
24	Participant 23	KMCA	Lower Class	23

Data Collection Tools Development

The qualitative part of the study used semi-structured in-depth interviews to understand the implications of rising prices of essential goods on healthcare accessibility for middle- and lower-class households in south-western Bangladesh. The instrument sought to obtain rich, contextual information about the financial burdens of healthcare, the ability to undergo treatment, and coping strategies under economic distress.

The interview guide draws upon a thorough literature review on health care cost and affordability and socio-economic disparities in health access (Adams et al., 2013; Ahmed et al., 2022; Kabir & Maitrot, 2018; Sarker et al., 2022; Alam & Mahal, 2014). These sources guided the identification of thematic areas central to the objectives of the present research. The interview guide contained open-ended questions grouped into core themes relevant in understanding issues around medical accessibility in the face of economic hardship. The interviews were conducted in Bengali language to indicate contextual sensitivity and ensure that the participants clearly understand the questions put to them.

The set of questions sought to see how participants described their experiences of securing payments for medical treatment in times of price hikes, impediments to accessing health care, changes in treatment-seeking behavior, and cost implications. Examples of questions included simplified adaptations of the following:

1. *Had you or any members of your family faced difficulties in visiting doctors or managing treatment costs amidst price hikes?*
2. *During severe illness, were you able to provide required medical treatment?*
3. *What are the differences in medical and medicine costs before and after the surge in prices of daily necessities?*

These thematic areas are summarized (See table 2) in the following table:

Table 2: Data Collection Tool (IDI) Initiating Themes

Data Collection Themes	**Data Collection Theme Identification Sources**
Access to Medical Care During Inflation	Ahmed et al. (2022); Adams et al. (2013); Kabir & Maitrot (2018)
Out-of-Pocket Health Expenditures	Sarker et al. (2022); Alam & Mahal (2014)
Affordability and Cost Variation	Bilinski et al. (2017); Dunn et al. (2018); Zapata (2025)
Coping Mechanisms and Social Support	Kabir & Maitrot (2018); Aminuddin et al. (2024)

Ethical Issues

The ethical clearance for the study has been obtained from Khulna university's Research and Innovation Center under the reference number: KUECC-2025/03/20. The participants provided informed consent before the commencement of the interview. Accordingly, participants' acts of data confidentiality, anonymity, and impartiality were strictly maintained throughout the research process. All data were anonymized, stored in encrypted digital folders, and accessed only by the research team.

Data Collection

The qualitative data were collected via one-on-one in-depth interviews conducted face to face, using a semi-structured interview guide. This approach was premeditated to strike a balance between iterability among interviews and the ability to probe into the complex and often deeply emotional issues surrounding the affordability of health care (Guest et al., 2012). The semi-structured interview allowed the investigation of key issues, such as increased out-of-pocket payments for health services, public and private health services access, coping mechanisms, and health-seeking behaviors; however, it gave the study participants the freedom to voice their lived experiences in their own language. The interview guide was prepared after a thorough review of related literature and reached discussions with some public health and social research experts, who sensitized the researcher to both general and site-specific attributes of the issue.

Participants became aware of the research intent and proceedings a good while before the interview began. Ethical considerations came to play at this point; consent was specifically sought from the participants, and they had to be assured that they could withdraw from the study at any point in time if they wished without giving any reason for the same. Interviews were carried out in Bangla (the mother tongue) so that the participants could engage in conversations naturally and comfortably on sensitive issues especially related to financial hardship and deferred medical treatment. All the sessions took about 40-50 minutes to complete, although the exact time was altered according to the elaborateness of participants' responses and willingness to recount their experiences.

The interviews were audio-recorded with the consent of the participants to allow for verbatim transcription and offer the best possible interpretation of the data in the analysis stage. Audio recordings also helped guard against loss of precious information, including tone and emotional subtext. Meanwhile, the researcher remained ethical, nonjudgmental, and empathetic throughout all processes of data collection. Considerable effort was put into establishing a safe, respectful, and supportive attitude-complementary to trust. The participants were reminded from time to time that they had the guarantee of their confidentiality, could reject answering any question, or could walk away from the interview at any time without any reprisal.

Such an ethical and methodical approach provided the researcher with an opportunity to gather rich, credible, and meaningful narratives from representatives of several middle- and lower-income backgrounds (Bryman, 2012). These perspectives illuminate the day-to-day struggles occasioned by accessing health care in the face of escalating costs and provide a steppingstone to the understanding of the bigger structural constraints in the health system of South-Western Bangladesh.

Data Analysis

Data analysis, being systematic and rigorous, ensured both the accuracy and analytical depth of the findings. Each of the interviews was transcribed verbatim by the researcher in Bengali. To keep linguistic integrity intact and accurate meanings, the transcripts were then translated into English through a back-translation process. The researcher arranged for a professional bilingual translator, not connected with the data collection process, to retranslate the English version back into Bengali. Comparing the original and back-translated texts served to verify semantic equivalence to ensure consistency between the two language versions. If there arise any difference regarding any phrasing or meaning would then be discussed by the researcher and the translator to remove that discrepancies in order to ensure the integrity of the participants' responses.

NVivo 15 software was used to organize, code and handle the textual data during the analysis of qualitative data. The interpretation of the data took place through thematic analysis, employing the six-phase procedure laid out by Braun and Clarke (2006). In the **first phase**, the researcher immersed himself within the data by reading and rereading all the transcripts to get a broad understanding of what is contained in them. In the **second phase**, initial codes were produced systematically from the data to define and highlight features of the data that were of interest and relevant to the research questions such as affordability, coping mechanisms, delays in access, and prioritizing healthcare. The **third phase** consisted of searching for themes amongst patterns in the coded data; these preliminary themes involved identifying recurring meanings and relationships within and across participant accounts. The **fourth phase** consisted of reviewing themes relating to the coded data and the whole data set to make sure of coherency and internal distinction. The **fifth phase** involved defining and naming themes, with deliberation on how each theme signified a genuine core of his or her participant's experience and how they linked with greater social and structural challenges in healthcare. The **sixth phase** was about writing the report as a descriptive account with illustrative quotations referring to the research questions.

Special focus was put on the emic and etic perspectives throughout the entire analysis. An emic conclusion was drawn from participant interplay and represented the participant's actual lived experience, their priorities, and local interpretation of the health-care system. These insider perspectives thus entered into theme construction for a grounded understanding of economic and emotional costing of healthcare. By contrast, etic insights would be employed during the interpretive phase, drawing from existing literature and theory around health access and socio-economic vulnerability. For instance, while a participant stated that tests were avoided because they were just "costly tests," the etic level would analyze this as a behavior arising from a broader structural issue of

how people are affected by out-of-pocket payments and the failure of public health infrastructure to satisfy their needs.

The quest for trustworthiness took several directions in the analytical process. Thus, established peer debriefings with experts in qualitative research about coding categories, questioning assumptions, and sharpening thematic definitions. Throughout the entire analysis, an audit trail was kept elaborating on the decisions taken at every stage, thus ensuring transparency and replicability. Another approach was triangulation- that is, data comparisons across different participants and socio-economic sub-groups to ensure that the thematic framework was not built on isolated accounts but reflected commonalities across the whole sample.

Carrying out such in-depth and ethical approaches gave the researcher a basis to arrive at credible and nuanced conclusions reflecting the complex realities of middle- and lower-income households as they negotiate increasing healthcare costs in South-Western Bangladesh.

Findings

Following the increase in the price of daily needs, participating lower- and middle-income earners attributed that they could not bear medical expenses to be part of additional expenses. As delivery of health care services became expensive these families could barely afford to set aside some money for this sector amidst increased costs for food, education and other necessities. Many of the participants in the study could rarely afford their medical needs, thus postponing or neglecting proper healthcare because of lack of available cash-for basics, food and shelter come first. The middle-class also found themselves struggling to afford regular check-ups and emergencies were particularly tough to manage.

Theme 1: Scenario of Medical cost after price hike and its Effects on Lower- and Middle-Class Participant

Matrix Coding Table 1.1: Scenario of Medical cost after price hike and its Effects on Lower- and Middle-Class Participant

Social Class	Location	Response		Ability to Bear Such Expense		
		3000 to 4000 BDT	Over 4000 BDT	Yes	No	Moderate
Lower-Class	*Batiaghata*	1	0	0	3	1
	Dumuria	1	0	0	4	0
	Khulna Metropolitan City Area	0	1	0	2	2
Middle-Class	*Dumuria*	2	1	1	0	3
	Batiaghata	1	1	3	0	1
	Khulna Metropolitan City Area	3	1	1	0	3

The matrix coding table 1.1 provides a comparative overview between lower- and middle-class participants from different locations regarding their ability to bear medical expenses after the price hike. The summary and analytical observation are as follows:

Table: 1.2: Summary Observations from Matrix Coding Table 1.1

Class	Location	Medical Expense Range	Ability to Bear Expenses	Observations
Lower Class	***Batiaghata***	3000 to 4000 BDT	1 Moderate, 3 Unable	Most participants could not bear expenses; only one managed moderately.
	Dumuria	3000 to 4000 BDT	0 Moderate, 4 Unable	No participants could bear medical expenses, indicating the highest financial strain.
	Khulna City	Over 4000 BDT	2 Moderate, 2 Unable	Slightly better affordability compared to rural areas, but majority still struggled to bear any extra medical expense.
Middle Class	***Batiaghata***	3000 to 4000 BDT & Over 4000 BDT	1 Moderate, 3 Able	Better resilience with most participants managing costs fully or moderately.
	Dumuria	3000 to 4000 BDT & Over 4000 BDT	3 Moderate, 1 Able	Partial affordability dominated, reflecting financial strain in rural areas.
	Khulna City	Over 4000 BDT	3 Moderate, 1 Able	Partial affordability to bear expenses among all locations, reflecting better income stability.

Key Insights from Table 1.2:

Lower Class: All the participants across three different locations face challenges with medical costs; few indicated that they had reasonable access to medical facilities, which was more prevalent in the urban area of Khulna City.

Middle Class: More capable of bearing medical cost that they were able to manage medical costs either fully or moderately according to the findings.

Location-Based Differences: In *Dumuria* and *Batiaghata* participants of both classes faced higher financial pressure while Khulna City seemed more affordable.

Theme 2: Scenario of Visiting Doctor if Needed before and after Price Hike:

Health concerns take precedence over financial constraints; thus, people of all socioeconomic classes see physicians when they need to. People from poorer socioeconomic backgrounds nevertheless seek medical attention when serious health problems arise, even if they may put off visits because of cost concerns. Even middle-class families, who are somewhat better off, nonetheless put a premium on going to the doctor for necessary checkups. When people's health is in jeopardy, the requirement for medical treatment takes precedence above all other concerns. The following matrix coding table provides a scenario of visiting doctor if needed before and after price hike situation –

Matrix Coding Table 2.1: Scenario of Visiting Doctor if Needed before and after Price Hike

		Visit Doctor Regularly Before Price Hike		Visit Doctor Regularly after Price Hike		
Social Class	**Location**	**No**	**Yes**	**Yes**	**No**	**Sometimes**
Lower-Class	*Batiaghata*	2	1	0	4	0
	Dumuria	3	1	0	4	0
	Khulna Metropolitan City Area	0	2	0	3	1
Middle-Class	*Dumuria*	0	3	3	1	0
	Batiaghata	0	4	3	1	0
	Khulna Metropolitan City Area	0	4	3	1	0

Matrix coding table 2.1 illustrates that low-income people who previously struggled to afford regular medical visits now find them either completely unaffordable or only attending for emergencies after the price rise. Meanwhile, middle-class participants showed more financial resilience; the majority continued to visit doctors often despite price increases, but a minority had difficulty affording it. However, Findings from the location-based trends indicate that healthcare was somewhat more accessible in Khulna City than in the rural areas of *Batiaghata* and *Dumuria*; nonetheless, cost remained an issue for the lower class universally.

Theme 3: Reasons Prevent Participants to Think to Visit Doctor:

Matrix Coding Table 3.1: Reasons Prevent Participants to Think to Visit Doctor

Social Class	**Location**	**Too much Medical Test**	**Large Part of Income Spends on Groceries**	**Thinking Regarding Child's Educational Cost**	**Cannot Afford the Cost**
Lower-Class	*Batiaghata*	2	0	0	1
	Dumuria	2	0	0	2
	Khulna Metropolitan City Area	3	0	0	0
Middle-Class	*Dumuria*	1	0	0	0
	Batiaghata	1	0	0	0
	Khulna Metropolitan City Area	0	0	0	1

Information on the matrix coding table 3.1 depicts that lower-class participants in *Dumuria* and *Batiaghata* avoided going to the doctor because they believed that they could not afford medical expenses charged by the doctor and were afraid of having expensive tests to be done. Meanwhile, in metropolitan areas like Khulna City, participants from the middle class were more likely to be financially stable, and they were less likely to cite affordability or medical test fees as obstacles. Meanwhile, location Based Observation from Matrix Coding Table 3.1 illustrates that the middle-class people from Urban (Khulna City) are in less hesitation to pay doctors' bill. On the contrary, the lower-class participants in *Dumuria* and *Batiaghata* are more likely to be financially stressed and afraid about paying for medical bills.

Theme 4: In Case of Not Visiting Doctor; Alternative way of Managing Health:

If the costs of consulting a doctor are high, such people try to seek alternatives to treat their health problems. Many resort to home remedies, traditional medicine, or over-the-counter drugs without any proper guidance. Some take advice from friends, family, or the Internet in ways that may not be accurate or safe. Others postpone treatment until the condition gets worse, leading to avoidable health problems in the long run. Not only does this avoidable cycle endanger their health, but it will also accrue higher costs when emergencies arise. However, the matrix coding table 4 provide an overall scenario regarding people's AlterNet initiative to manage their health issues in absences of not visiting doctor on a regular basis –

Matrix Coding Table 4.1: In Case of Not Visiting Doctor; Alternative way of Managing Health

In Case of Not Visiting Doctor; AlterNet way of Managing Health					
Social Class	**Location**	**Not Visiting Doctors in Normal Case**	**Avoiding Diagnostic Test**	**Buying Medicine from Pharmacy**	**Observations**
Lower-Class	*Batiaghata*	1	0	3	Heavy reliance on pharmacies; few avoided visiting doctors in normal case of sickness.
	Dumuria	0	0	4	Most participants relied on self-medication.
	Khulna Metropolitan City Area	2	0	2	Participants avoided doctors in normal cases and relied moderately on pharmacies.
Middle-Class	*Dumuria*	1	1	1	Avoided tests but did not heavily rely on pharmacies as well as visit doctor in normal case of sickness.
	Batiaghata	1	0	0	Rare use of alternative methods; minor participants likely consulted doctors when needed.
	Khulna Metropolitan City Area	1	1	1	Some participants used pharmacies or avoided tests to manage costs; others consulted doctors.

The results from matrix coding table 4.1 show that following the price rise, there are clear regional differences in the ways that lower- and middle-class individuals take care of their health on their own.

Lower-Class Participants:
People from lower-class backgrounds in rural regions like *Batiaghata* and *Dumuria* relied heavily on pharmacies to self-medicate. This was particularly true in *Dumuria*, where the majority of participants preferred to purchase medicine from pharmacies rather than see physicians. In *Batiaghata*, most people still used pharmacies as their main option to physicians when they were unwell, however a small number of people did not. Some individuals from lower socioeconomic backgrounds in Khulna Metropolitan City completely avoided medical appointments, while others relied considerably on pharmacies. There is a very small number of indications that they are trying to avoid diagnostic testing, which suggests that budgetary concerns are the fundamental motivator driving these cost-cutting choices.

Middle-Class Participants:
Those from the middle class showed more financial resilience by seeing physicians more often and relying less on pharmacies. *Batiaghata* people tended to prefer to see doctors when they were sick, since they seldom used other means like self-medication or skipping diagnostic tests. Some *Dumurians* avoided testing yet continued to see their physicians for prescriptions, illustrating the diversity of behavior witnessed there. The middle-class participants in Khulna City showed a mixed bag when it came to managing healthcare expenditures; some emphasized seeing physicians when needed, while others relied on pharmacies or avoided testing altogether.

Comparative Insights from matrix coding table 4.1:
Class-based Patterns:
Self-medication and pharmacies were the most cost-effective options used by lower-class participants in rural areas, a trend seen across all locations. Meanwhile, although middle-class people may make compromises, such as forgoing tests, they nonetheless maintain convenient access to medical professionals and healthcare facilities.

Patterns Determined by Location:
Participants in areas like *Batiaghata* and *Dumuria*, particularly from the lowest socioeconomic strata, demonstrated an increased dependence on pharmacies due to constrained financial resources and restricted access to healthcare services. Both groups exhibited a blend of cost-reduction strategies and access to specialized medical care in metropolitan areas like Khulna City, suggesting a more equitable approach.

Discussion
The study elucidates the fact that the soaring prices of essential commodities have severely restricted access to medical care among lower- and middle-income households. This results in delayed or forgone medico static interventions that prevent health improvements. Exhibits of such differentials are encountered in earlier research findings whereby direct payments pose barriers for timely care-seeking and health inequities for populations living in poverty (Galvani et al., 2020; Qin et al., 2018). Such financial barriers point to the conceptual framework of medical poverty and force a household into choosing health, which in turn increases their vulnerability over time.

Another variant to the same theme of affordability emerges from this study, which finds that in *Batiaghata* and *Dumuria*, health costs discriminate especially against the weaker, poorer rural households. Middle-income respondents, when faced with price hikes, seemed to be resilient enough to continue their routine doctor visits; meanwhile, low-income participants postponed care altogether. Given this, those results echoed studies by Lagarde and Palmer (2011), Mills (2024), and Zapata (2025), who argue that since the rise in healthcare costs restrict mostly access to services by economically underprivileged populations, thus deepening health, inequalities.

Regardless of financial hardship, health remains a paramount concern in all categories of respondents. Respondents sought care regardless of heavy solicitation

of debts or bonds when health disorders reached an acute and life-threatening stage. This coping behavior finds resonance in discussions documented elsewhere, such as in the United States, where nearly 23% of the population reports incurring great financial hardships due to the cost of medical services (Chernew et al., 2021; de Siqueira Filha et al., 2022).

Another recurring theme was that of the divergence in coping strategies. Poor folks living in upazila settings would often eschew any doctor consultation due to the cost of the visit or diagnostic tests. The more common way was to self-medicate by buying medicines over the counter in local pharmacies; a method that was also followed by some middle-class participants who were unable to afford formal treatment. Probably the choice for the pharmacy stems from the feeling that such treatment is more affordable and accessible in comparison to formal treatments where distance and price become deterrents. On the other hand, middle-income individuals were able to attend formal consultations more readily, although, still, with some difficulty from a financial perspective. Behaviorally, these adaptations point to differences in access caused by locational and class characteristics. These findings coincide with more general national trends. One study on self-medication among indigenous communities in the Chittagong Hill Tracts revealed that economic and financial factors promote self-medication because patients cannot pay doctors' fees and usually resort to pharmacies nearby for treatment (Saha et al., 2022).

Meanwhile, a study regarding the health-seeking behaviors of rickshaw pullers states that rickshaw pullers might want to opt for local pharmacies more than any other option because they can avail themselves of the minor or major services with less cost and time (Q. M. Rahman et al., 2022). Lastly, another study on access to health care in Rural Bangladesh stated that many of the rural residents live in poverty and cannot afford the cost of health care services, rendering the people to seek more accessible and cheap substitutes (M. Rahman, 2024).

Such findings point to the need for immediate policy-level interventions in direct relation to the affordability problems. These could include reducing user charges, stimulating the implementation of universal health coverage through prepayment mechanisms, with the expansion of insurance-based or tax-funded health systems that may alleviate the discriminatory out-of-pocket effect of healthcare services. As supported by the studies of Mills (2024), National Health Council (2021), and Sobotko (2024) highlight, such reforms are urgently needed to improve access to healthcare services and reduce inequity in low and middle-income countries such as Bangladesh.

Qualitative comparisons in terms of other Lower Middle-Income Countries (LMICs) would show that the challenges related to healthcare affordability are not unique to Bangladesh. For example, studies from India and Nigeria reveal similar trends as the rural poor and middle-income urban populations are both financially strapped due to out-of-pocket expenses and lack of kept insurance cover (Alam & Mahal, 2014; de Siqueira Filha et al., 2022). Because urban middle-class families have stable incomes, they are often considered to be saved from any great financial trauma caused by healthcare; indeed, such assumption continues because this class depends less on free public health facilities and more on costlier private health. In Khulna City, the situation is replicated, with middle-class participants yet to face some issues of affordability, highlighting that income is not the panacea to medical insecurity (Mills, 2024). Other factors that are brought into the picture include the unregulated price of private healthcare, lack of prevention-oriented care utilization, and medical inflation creeping up-these are common with most LMICs (Mills, 2024; Moye-Holz et al., 2017). In that light, this research thereby reflects the universal storyline of unaffordability in healthcare systems irrespective of income levels or geographical settings and sets the context for local answers.

Notwithstanding, given the existing limitations of the current study, it is apparent that certain voices were not explicitly present, such as those from elderly-only households, those with chronic illnesses, and persons with disabilities groups whose barriers are likely even more severe. Furthermore, the study draws on self-reported data, and one must, therefore, consider the theoretical possibility of recall bias or social desirability bias, especially where delicate issues such as borrowing money or delaying care are concerned. So, future research needs to probe on these sub-groups and triangulate their results with records led from the clinic or administration for a more enriched view.

Conclusions

This study highlights three main findings: **First**, healthcare expenditures have inflicted severe economic constraints on middle- and lower-class households in Bangladesh's south-western region. **Second**, incrementing prices of medical services and essential drugs disproportionately affect these households and usually force them to focus on immediate survival rather than their future well-being. **Third**, and while informal networks do provide some degrees of support, such relief rarely offsets structural problems hindering access to formal healthcare.

The implication of these findings is that barriers to healthcare are widening and, in the long run, will further exacerbate existing socioeconomic inequalities. The absence of targeted policy interventions is bound to aggravate the situation specifically for those families who are already at the edge economically disruption.

The study has some drawbacks such as limiting itself to a specific geographic and socioeconomic context, and so further studies may wish to enlarge the scope to comparative regional data or longitudinal tracking. Further research should also explore the coping strategies in detail to build a foundation for sustainable support systems.

This study therefore calls upon the Ministry of Health, local government authorities, pharmaceutical firms, and community-based NGOs to unite against the prohibitive cost of healthcare. This will include subsidizing essential drugs, expanding public healthcare infrastructure into unserved areas, and factoring grassroots supports into formal policy planning.

Recommendations

In light of our findings, some core recommendations have been provided into short-term priorities and medium-to-long-term reforms from the perspective of improving healthcare accessibility for the lower and middle strata of south-western Bangladesh:

Short-Term Priorities

1. **Establishing a Drug Price Regulation Mechanism:** In the Directorate General Drug Administration (DGDA) under the regime of price control of essential medicines giving preference to less affluent areas.

2. **Subsidize the prices of essential medicines for vulnerable groups:** The syndicate may initiate pilot programs for subsidies for essential medicines in select district hospitals and community clinics along with some NGOs such as BRAC.

3. **Build community awareness campaigns:** Health workers, schools, and mosques should promote knowledge on preventive care with the help of local NGOs and mass media.

Medium-to-Long-Term Reforms

1. **Establish a Medium-to-Long-Term Reform: Scaling Up Pilot Programs of Urban Health Center (UHC):** On a scale basis, expansion of the government's existing UHC programs has been proposed in rural Upazila health complexes under the monitoring of the Ministry of Health and Family Welfare.

2. **Improve Access to Health Insurance for Informal Sector Workers:** Develop contributory micro-insurance schemes promoted by public-private partnerships targeting informal workers.

3. **Enhancing Public Health Infrastructure in Rural Areas:** Investment in diagnostics and emergency treatment at the district and Upazila levels must be made through the national development budgets.
4. **Develop Telemedicine Networks for Remote Areas:** Promote low-cost telemedicine services in conjunction with private startups and mobile operators to overcome barriers to travel and consultations.

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Competing Interest
The author report that there are no competing interests to declare.

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