

Socio-Economic Determinants of Geriatric Healthcare Seeking Behavior in Lagos Nigeria

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Abstract: *This study is carried out to examine social and economic factors that determine the Healthcare Seeking Behaviour (HSB) of elderly in the Nigerian society. 200 elders purposively selected from Oshodi- Isolo and Ikeja Local Government Areas in Lagos State Nigeria, responded to Geriatrics Healthcare Seeking Behaviour Test (GHSBeT). Descriptive and inferential statistics were employed in data analysis. Observed patterns shows that 50% of caregivers are spouses; 45% of the geriatrics preferred to confide with their orthodox doctors on issues. Reported preferred therapeutic method are 76% orthodox medicine, 19% indigenous traditional medicine, 2% psychotherapy while 3% use home rest without treatment. Observed preferred healthcare service used range from 36% public hospitals to 9% faith healing. 40% cost of the geriatric medical treatments are borne by children. Significant inverse correlation was observed between age and healthcare seeking behaviour (HSB) of the elderly ($r_{xy} (200) = -.28, P < 0.05$). There was no observed significant gender difference ($t = -1.53, df = 198, P > 0.05$), significant marital status difference was observed ($f = (200) 4.80, P < 0.05$) and no significant annual income influence on geriatric HSB ($f = (200) 1.91, P > 0.05$). Geriatrics focused public enlightenment programmes on seeking medical care from trained professional practitioners alone should be made at the community levels. Geriatrics pension schemes, social security systems or health insurance policies funded at the national level and implemented at the local communities to improve medical facilities available for the elderly in the society. Development of Indigenous healthcare practices through researches efforts and funding are recommended.*

Keywords: Socio-economic, geriatric, healthcare seeking behavior

1. Introduction

Healthcare Seeking Behaviour (HSB) has been defined as any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding appropriate treatment (Olenja, 2003). Ward, Mertens, & Thomas (1996) defined HSB as the sequences of remedial actions that individuals undertake to rectify perceived ill health. Health is more than the absence of diseases. Rather it includes socio, psychological, and economic well-being. Thus HSB is a fundamental issue in every society. With a couple of exemptions, more individual in both low and high wage regions are living longer than any other time in the recent past. The net increase of older population world-wide is about one million every month two-thirds of them in the lower income countries (Gorman, 2002).

In recent years, as population aging has grown into a 'defining global issue' (HelpAge International 2002), concerns have emerged regarding policy intervention appropriate for older people (Gorman & Heslop 2002), especially in the aspect of elderly health care. Quality of life changes over time and health becomes one of the major concerns about old age, for both individuals and society. Hence, policy formulation for the health care service among the elderly in any country should be based on the knowledge of health seeking behaviour of the community and the factors influencing it. The factors determining trends in the health seeking behaviour may be seen in various contexts like demographic, socioeconomic and cultural. Most countries have diverse health systems according to the local circumstances, and a multi-level coordination is essential for better health profile of the nation. Features of the health facility and confidence in health care workers also play a major role in decision making about the choice of the health facility. Health seeking behaviour has been explored in

many international and its significant determinants included the physical, demographic, Socio-economic and cultural factors and the organization of healthcare system.

The United Nations (UN) defines elderly people as those people whose age is 60 years and above (UN, 2011). In 1980 the UN estimated that there were 378 million people in the world aged 60 years or above. That figure has risen to 759 million over the past three decades and is projected to jump to 2 billion by 2050 which will constitute 16 per cent of the global population (UN, 2011). Among 15 countries that currently have more than 10 million elderly people; seven are developing countries (Vikram & Martin 2001; United Nations 2013). In Nigeria, those aged 65 years and above make up about 4.3 percent of the total population which was put at 140,431,790 million according to 2006 population exercise (National Population Commission (NPC) 2009) The population of elderly (age 65 and above) in Nigeria is on the increase as the mortality rates are gradually reducing (NPC & Micro International USA, 1990, 2008). Policies that support people in later life such as pensions, free healthcare and treatment of chronic conditions have been slow to evolve in developing countries in comparison with the fast growth rate of the geriatric population (Gorman & Zaidi, 2013). The situation is not different in Nigeria (Abdulazeez, 2014; Poullier, Hernandez, & Kawabata 2003). Most elderly have no reliable income sources, no adequate public sector pension for employed (Abdulazeez, 2014) and absence/ lack of social security system among unemployed rural elderly people. This situation affects not only the income of the elderly population but also contributes to poor housing, ill health and personal insecurity (Anita, 2003; Population Reference Bureau (USA) 2006). It might also hinder appropriate health care seeking behaviour of elderly people such that they could be obliged to visit traditional medicine or healers than seeking modern health care (HelpAge International in Ethiopia, 2013). Many elderly in Nigeria

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retire into poverty, deprivation, and poor access to health care with little or no personal savings to meet their daily needs (Charton, & Rose, 2001; Kimokoti, & Hamer 2008). More often than not they are denied of their right to receive their pension which results in poor healthcare seeking behaviour. Few resources is devoted to health care of the geriatrics by the Nigerian government (Adebowale, Atte & Ayeni, 2012). In most developing countries as is with Nigeria, formal social security systems have only limited coverage and inadequate benefit payments (Bailey, 2000; Colin, Turner, Bailey & Latulippe 2000). Hence, older people depend on social support from family and friends (Van de Walle, 2006; Kaseke, 2004).

Despite the available resources, the healthcare delivery and utilization of the public healthcare services in Nigeria is way behind many other countries, and there is urgent need for studies explaining the factors influencing healthcare seeking behaviours of the citizenry. According to Pritti Biswas, Zarina Nahar Kabir, Jan Nilsson and Shahuduz Zamma (2005) "Health seeking behaviour of the elderly relies upon the view of health and ill-health, and this is based on specific health crisis of maturity diseases, for example, waterfalls, toothaches, gastric pain, body pain, arthritis, fever, uterine problems, loss of appetite and general weakness and there is a barely recognizable difference between the typical health status of a more seasoned individual and that of a more established individual experiencing a sick condition. High extents of individuals reporting health issues, yet the healthcare structure in the country do not really provide to this people. The aging of a populace referred to a raise in the percentage of the elderly vice-versa a decline in the amount of the adolescent.

1.1 Gender and healthcare seeking behavior

In developing countries there is still inadequate understanding of how gender influences health itself (Abou Zahr, Vlassoff, & Kumar, 1996; Goding & Howie, 1990; Nash & Gilbert, 1992), access to health information (Abou Zahr et al., 1996) and services (EQUINET Steering Committee, 1998; Nash Ojanuga & Gilbert, 1992; Vlassoff, 1994) health-seeking behaviour (Ahmed, Adams, Chowdhury, & Bhuiya, 2000; Puentes-Markides, 1992; Tanner & Vlassoff, 1998; Vlassoff & Garcia Moreno, 2002) and the use of services (Buor, 2003; Hjortsberg, 2003), treatment and attitudes of providers (Hartigan, 2001; Nare, Katz, & Tolley, 1997; Oliveira-Cruz, Hanson, & Mills, 2003; Puentes-Markides, 1992), and health outcomes (Abou Zahr et al., 1996; Ahmed et al., 2000; Hjortsberg, 2003). This is important because if we believe that health is genetically, biologically, ecologically, culturally and socially determined, then gender must be recognized as being one of these determinants as it is interconnected with biology and the socio-cultural factors that affect health (Vlassoff & Moreno, 2002). In some developing countries gender is reported to affect the utilization of health and medical services (Pillai et al., 2003; Ahmed, Tomson, Petzold, & Kabir, 2005). There is an association between gender and health seeking (Ahmed, 2001; Ahmed et al., 2000), and differences in seeking treatment for other family members, such as female and male children (Bhan, Bhandari, Taneja, Mazumder, & Bahl, 2005). For certain conditions, gender,

income and literacy determinants do not affect any delay in health care seeking (Dhingra, Rajpal, Taneja, Kalra, & Malhotra, 2002). Women in developing countries are frequently confronted with a countless of socio-cultural factors which negatively impinge upon physical well-being and accessibility to appropriate health care services (Nash Ojanuga & Gilbert, 1992).

According to Hartigan, (2001) some cultural practices that do not allow women to be seen in public during the day, as in many Muslim communities, negatively affect healthcare seeking. In Nepal, for general health issues gender has been shown not only to affect illness reporting, but also the decision to choose a health care provider and how much to spend on a sick child (Pokhrel et al., 2005). In terms of specific conditions such as tuberculosis, women were more likely to delay in seeking treatment than men (Yamasaki-Nakagawa et al., 2001), while perceptions of illness were found to be different between men and women (Pokhrel & Sauerborn, 2004). In Ghana, women are more likely to seek health care than men (Danso-Appiah, De Vlas, Bosompem, & Habbema, 2004), in Zambia, women with low level of education were more likely to delay in seeking treatment (Needham, Foster, Tomlinson, 2003).

1.2 Education and HSB of the Elderly

As a determinant of health care seeking behavior, literacy is intimately tied to gender, education level, and regular income and is considered an indicator of socio-economic status (Bharmal, 2000; Sudha et al., 2003). Male literacy levels are consistently higher than female, particularly in developing countries (Institute for Statistics Literacy and Non Formal Education Sector, 2002). Low literacy levels affect the ability to access health information presented in print form, to read labels and instructions for medications, or even safety advice. People with low levels of literacy are less likely to request care early on in their illness (Perrin, 1998). Low levels of literacy is an indicator of higher hospitalization rates (Arozullah et al., 2005), greater rates of malnutrition (Bharmal, 2000), and skin disease (Gibbs, 1996). A key socio-cultural determinant of health is education (Kickbusch, 2001). Available data in all countries points to the relationship between the risk of disease and lower levels of education (Mackenbach & Howden-Chapman, 2003). Occurrence of illness is significantly lower in groups with higher education, especially among men. Buor (2003) reports that in Ghana higher education results in higher utilization of health facilities. Education may be the single most important factor to influence women's health (Heiberg, 1996). In developed countries education level is a correlate of access to a national health service Cooper, (2002), and directly affect women's access to healthcare in developing countries (Nash Ojanuga & Gilbert, 1992) also education and economic status of the household are positively related with choosing to act and seek health care when ill in Zambia (Hjortsberg, 2003). Multiple studies around the world have also used female and maternal education levels as health indicators for everything from social problems in dealing with types of illnesses (Kumar et al., 2004) to utilization of hospitals, immunization levels (Shimouchi et al., 1994) and other health services (Bhan et al., 2005; Smith, 2004). Education increases the possibility

of health education and health literacy, but is not a guarantee (Tomlinson, 2003).

1.3 Income and HSB.

Income is a determinant of health care seeking behavior. It determines not just health seeking behaviour, but risk factors associated with health outcomes (Colin, Adair, & Popkin, 2004; Mackenbach & Howden-Chapman, 2003), barriers to seeking health care (Taffa & Chepngeno, 2005), types of treatment (Nyamongo, 2002) and delays in service use (Johansson, Long, Diwan, & Winkvist, 2000). According to Pillai et al., (2003) economic status is the most significant predictor of healthcare service use. Income affects the level to which health care facilities are sought and used (Buor, 2003). Decision to seek health care is often based upon the cost as compared to the perceived benefit (Hjortsberg, 2003). According to Buor (2003) the ability to pay determines the use of health services. A lack of finances affects health care seeking (Taffa & Chepngeno, 2005), willingness to pay for services and the means to do so (Foreit & Foreit, 2003). Low income is a barrier to health seeking (Gotsadze, Bennet, Ranson, & Gzirishvili, 2005). Low income limits health care seeking (Onwujekwe & Uzochukwu, 2005; Peterson et al., 2004; Soucat et al., 1997). In a study in Southeast Nigeria Onwujekwe & Uzochukwu, (2005), found that rural populations were less likely to pay the cost of health care treatment upfront and more likely to pay in installments. Most elderly Nigerian citizens live in poverty and this impact on their healthcare seeking behaviour.

1.4 Age and healthcare seeking behaviour

Age is a factor associated with health both in itself and in conjunction with other factors (Kaplan, Newsom, McFarland, & Lu, 2001; Mishra, Ball, Dobson, Byles, & Warner-Smith, 2002). The effects of age can be due to differences in socio-economic status as defined by employment, education and income (Mishra et al., 2002), as well as greater economic dependency, poor housing, loneliness and lowered self-esteem (Waweru, Kabiru, Mbithi, & Some, 2003). The elderly are often unable to access adequate health care which can contribute to their poor health status (Waweru et al., 2003). This can be a concern in developed countries (Wiet, 2005) and those less developed (Waweru et al., 2003). Examination of incomes, health status, social support of the elderly shows that there have been persistent inequalities related to age, gender and social class in terms of resources, access to informal and formal care and value accorded to later life. These inequalities are due to differences in status and resources. The elderly may be more likely to use informal health care, home and folk remedies, traditional healers and medicine (Eisenberg et al., 1998), and even faith healers (de-Graft Aikins, 2005) not just because of economic reasons (although often traditional medicine can be more expensive (Good & Kimani, 1980), but as likely out of habit (Kuo, Hawley, Weiss, Balkrishnan, & Volk, 2004), tradition (Good & Kimani, 1980; Sandhu & Heinrich, 2005), or personal beliefs and attitudes (Astin, 1998). Studies on the healthcare seeking behavior of the elderly in Nigeria is scanty in literature, hence this present study seeks to find out the

influence of age, gender, marital status and level of income on healthcare seeking behavior geriatrics in Lagos state Nigeria.

The objectives of this present study include to identify the patterns of issues associated with healthcare seeking behaviour of geriatrics in Lagos Nigeria such as caregiver, main confiders of the elderly on healthcare issue, patterns of preferred therapeutic methods, and healthcare consultant, financing therapies received by the elderly, frequency of seeking healthcare services and of illness and constraints in using orthodox medical services. The study also seek to observe the correlation between age and HSB, as well as the influences of gender, marital status and levels of income of the HSB of the elderly in Lagos Nigeria.

2. Methodology

Participants

A cross sectional survey design was employed in the study. The population comprised of the elderly citizens of 55 years and above residents in Ikeja and Oshodi-Isolo Local Government Areas of Lagos state Nigeria. A purposive sampling technique was used to select 200 geriatrics who participated in this study.

Instrument

A structured questionnaire tagged Geriatrics Healthcare Seeking Behaviour Test (GHSBeT). It is a 15 item instrument based on a self-reporting four points likert scale ranging from 1= strongly disagree to 4 = strongly agree GHSBeT has an observed acceptable reliability coefficient (Cronbach Alpha) of .78.

3. Results

Social demographic characteristics of participants

The overall the mean age of the 200 geriatric that participated in the study was 63 years, 92 (46.0%) are male and 108 (54.0%) are female. Their marital status revealed that 120(60.0%) are married, 35(17.5%) are divorced/separated while 45(22.5%) are widowed. Distribution by educational background showed that depicts that 11(5.5%) have not educational qualification, 24(12.0%) acquired Primary education, 41(20.5%) are SSCE/WAEC holders, 96(48.0%) are BSC/HND holders and 28 (14.0%) are M.Sc./PhD holders. 67(33.5%) of the participants have formal employment (white-collar jobs), 56(28.0%) are self-employed, and 77(38.5%) are retired. The source of income for majority 96(48.0%) of the participants is their current occupation, 70(35.0%) are financially supported by their families, 30(15%) is from investment/insurance, 2(1.0%) from Government/ pension and 2(1.0%) are from other sources. Distribution by annual income depicts that majority 101(50.5%) earn between Nigerian Naira (NGN) 100,000 to NGN 200,000 annually, 43(21.5%) earn between NGN 200,001 to NGN 300,000, 16(8%) earn between NGN 300,001 to NGN 400,000, 10(5%) earn between NGN 400,001 to NGN 500,000 and 30(15%) earn above NGN 500,000.

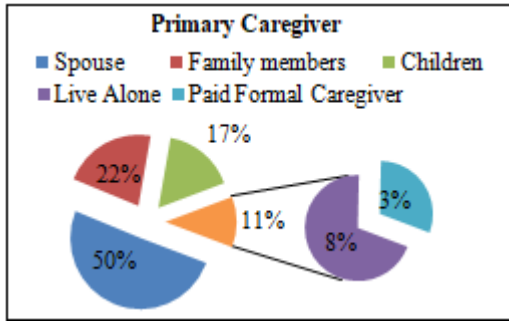


Figure 1: Pie chart showing Primary caregiver for the participants

The summary of the pie chart in figure 1 shows the participants' primary caregiver. 50% are cared for by their spouses, 21% receive care primarily from other family members excluding their spouses and children, 17% are cared for by their children, 8% live alone while 4% are attended by paid formal caregivers offering home services.

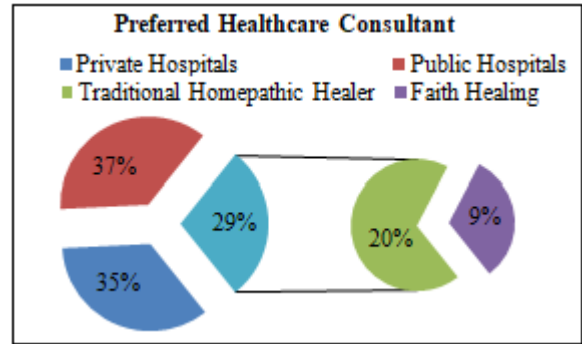


Figure 4: Showing the preferred healthcare consultants of geriatrics in Lagos Nigeria

Summary of the pie chart in fig.4 shows that 35% of the participants prefer consultants in private hospitals, 36% use the public owned orthodox hospitals, 20% prefer the traditional homeopathic healers while 9% of the geriatrics engages in faith healings practices.

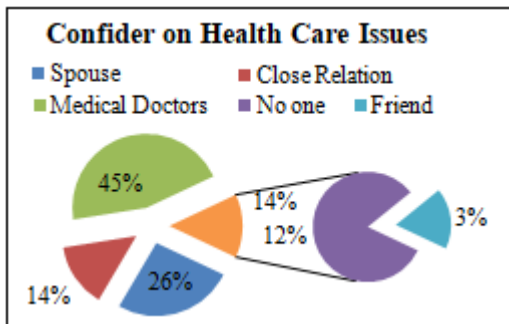


Figure 2: Showing the confiders of Geriatrics on health related Issues

Summary of fig. 2 shows the main individual the sampled elderly confide with on their health care issues. 45% discuss with their medical (orthodox) doctors, 26% confide with their spouses, 14% reports that they confide with close relations, 12% do not discuss their health issues with anyone while 3% said they confide with their friends.

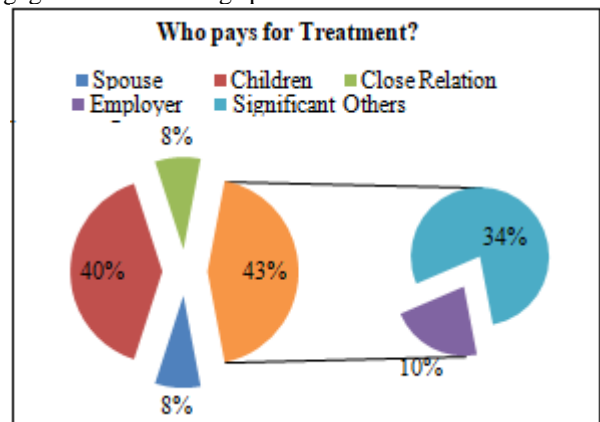


Figure 5: Showing those responsible for financing therapies of geriatrics in Lagos Nigeria

Summary of fig 5 shows that 40% of the medical treatment received by the elderly are paid for by their children, 35% by significant others, 9% by employers, and 8% each by spouses and close relations.

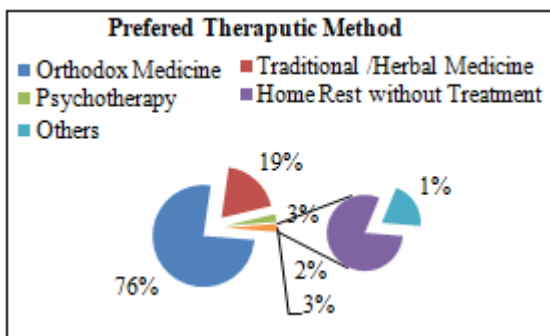


Figure 3: Showing the preferred therapeutic methods of geriatrics in Lagos Nigeria

Summary of pie chart in fig 3 shows the preferred therapeutic method of the geriatrics. 76% use orthodox medical facilities, 19% use the African traditional healing method, 2% use the psychotherapists on issues relating to mental health, 2% prefer to stay at home and rest while 1% use other method not specified.

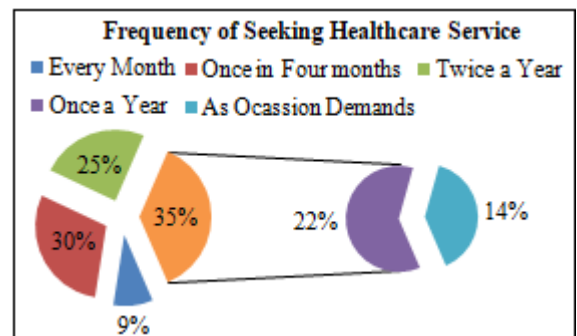


Figure 6: Showing the frequency of seeking healthcare services among the participants

Summary of figure 6 reveals the frequency of seeking healthcare services. 29% present at healthcare facilities once in four months, 25% visit therapists twice a year, 23% seek health care once a year, 15% said they use health care services as occasion demands while 9% visit health care facilities once a month.

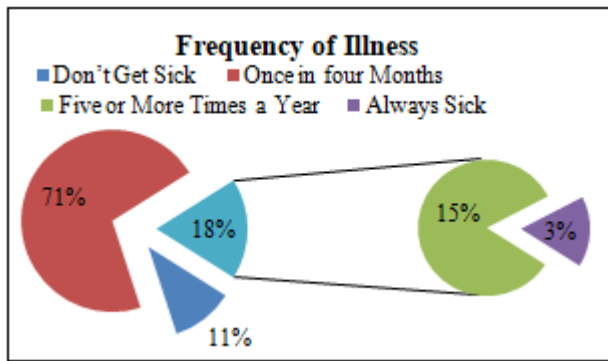


Figure 7: Showing frequency of illness among the participants.

Summary of fig7 above reveals that 71% of the geriatrics who participated in this study get ill once every four months, 15% report being ill five or more times in a year, 11% reported that they don't get ill, while 3% reported being always ill.

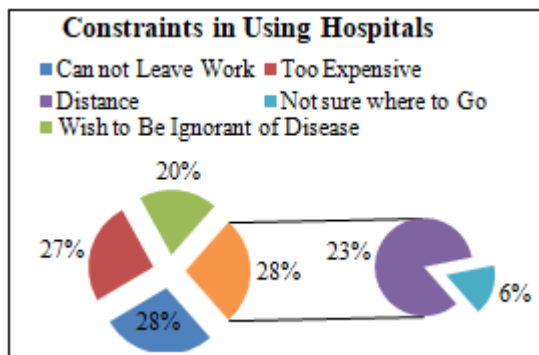


Figure 8: Showing the constrains experienced in using orthodox facilities.in Lagos Nigeria

Summary of pie chart in fig. 8 reveals that 28% do not use orthodox medical services due to work related issues such as inability to leave their work, 25% report that medical services in the hospitals are too expensive for them, 23% report that the distance to the health care services is their major constraints, 19% of the geriatrics don't use hospitals because they prefer to remain ignorant of the nature of their illness, while 5% said they were not sure where to go to for treatment.

Table 2: Correlation between age and geriatric healthcare seeking behavior

Variables	N	r	p
Age	200	-0.28	<0.05
Geriatric HSB	200		

Table 2 above reveals that there is a significant negative correlation between age and healthcare seeking behavior among the elderly ($r_{xy}(200) = -0.28, P < 0.05$). This implies that the lower the age the more the actions taken to seek healthcare. In other words younger people are more active in seeking healthcare than older ones.

Table 3: t-test of gender influence on geriatric healthcare seeking behavior

Gender	N	Mean	SD	df	t	P
Male	92	29.96	5.87	198	-1.53	>0.05
Female	108	31.35	6.87			

An independent sample t-test was carried out to determine the influence of gender on healthcare seeking behavior of geriatrics in Lagos Nigeria. The t-test scores showed that there were 92 males and 108 females while the mean (\pm SD) of healthcare seeking behavior were 29.96 ± 5.87 and 31.35 ± 6.87 respectively. The significant 2-tailed P value associated with this test was .000. The t-test reveals no statistically significantly reliable difference between the mean of the healthcare seeking behavior scores of the male and that of the female geriatrics ($t = (200) -1.53, P > 0.05$). It is therefore concluded that healthcare seeking behavior is not a function of gender.

Table 4: ANOVA of marital status influence on geriatric HSB

Marital Status	N	M	SD	F	P
Married	120	30.88	7.05		
Divorced / Separated	35	27.82	4.57	4.80	<0.05
Widowed	45	28.96	5.12		

A ONE way analysis of variance was carried out to determine the influence of marital status on Healthcare Seeking Behavior (HSB) of the participants. The f test score showed that 120 were married, 35 were divorced/separated while 45 were widowed. The mean (\pm SD) of the HSB were 30.88 ± 7.05 ; 27.82 ± 4.57 and 28.96 ± 5.12 respectively. The result revealed a statistically significant marital status influence on geriatric HSB ($f = (200), 4.80, p < 0.05$). It is concluded that health seeking behavior among the geriatric population is influenced by marital status.

Table 5: ANOVA of annual income on geriatric HSB

Annual Income (NGN'000)	N	M	SD	f	p
100 - 200	101	31.53	7.23		
201 - 300	43	28.51	3.76		
301 - 400	16	30.19	6.04	1.91	>0.05
401 - 500	10	32.50	8.02		
≥ 501	30	30.77	5.96		

A ONE way analysis of variance was carried out to determine the influence of annual income on HSB of the geriatrics. The f test score showed that 101 participants were on annual income of between N100,000 and N200,000; 43 participants earned between N201,000 to N300,000; 16 participants were on annual income of N301,000 to N400,000. Furthermore 10 participants were on income of N401 to N500,000 while 30 participants were on an annual income of above N500, 000. The result showed no significant annual income influence on geriatric healthcare seeking behavior ($f = (200), 1.91, P > 0.05$).

4. Discussions

The study returned that majority of geriatric population had their spouses as primary caregiver, while few had formal caregivers. This is an indicator that the use of formal caregivers is still very foreign to the Nigerian culture. The bound of the extended family is firmly entrenched in the African culture; hence the healthcare needs of most Nigerian geriatric population are born by family members. This finding is also consistent with some research finding which show that primary caregiver is family members (National

Alliance for Caregiving 2009; Weiss, Gonzalez, Kabeto, & Langa, 2005; Pinquart & Sorensen 2005).

This present study found that majority of the participants preferred to confide with their medical practitioners on issues of their health status. This reveals a high awareness on the part of the geriatric population in urban communities of the orthodox medicine option. It is also an indicator of the availability (proximity) of medical facilities in the cities, the case may however not be the same in rural areas where people may be subjected to several hours of transportation to get of hospitals or clinics. Furthermore majority of geriatric population have members of their families as caregivers and these group of people would prefer taking them for orthodox medical care. It is also worthy of note that a significantly high population (19%) among the participants still opt for the use of traditional herbal remedies. This is in agreement with research findings who found a high prevalence of use of traditional healing methods Mali, Ghana, Zambia and Nigeria(WHO, 2002b);South Africa (Lekotjolo, 2009) and Tanzania (Makundi, Malebo, Mhame, Kitua, & Warsame,2006). This study also reveals a significant difference in the preferred healthcare consultant. More than 79.5% prefer using the orthodox medical option as against 19.5% who make use the indigenous traditional medical care. This is also an indicator of the efficacy and popularity of the traditional medical among the aged in Nigeria. The study returned that the cost of treatment for most geriatric population was borne by members of their families. It shows the bound and strength of both nuclear and extended family structure among Nigerians. It also reveals a poor health insurance scheme in the nation. A vast majority of Nigerians do not have a health insurance (World Bank, 2008; Kannegiesser, 2009). Hence they choose the health care option affordable. The National Health Insurance Scheme (NHIS) was signed into law in 1999, yet did not become operational till 2005 (Kannegiesser, 2009). The efficacy of the scheme is however contested among the Nigerian populace. A World Bank (2008) survey carried out showed that only 0.8% of Nigerians were covered by the NHIS. It predicted further that it will take at least another 10 years before many low income persons would benefit from the scheme.

Despite the fact the majority of the respondents reported frequent illness, findings show that large majority of them sought orthodox medical care every four months, while minority visits once a month. This reveals that most of the aged population does not seek orthodox medical care regularly reflecting a negative healthcare seeking behavior. The cause of this attitude could be as varied as the inhibiting factors such as costs, cultural beliefs, motivations, severity of the illness, proximity to care facilities, past experiences, ignorance of the illness, not knowing where to go and so on.

A significant inverse correlation between age and healthcare seeking behaviour among the elderly was equally returned by this study. This implies that the lower the age the more the actions taken to seek healthcare. In other words younger people are more active in seeking healthcare than older ones. This is in agreement with previous findings which find age as a factor associated with health (Kaplan, Newsom,

McFarland, & Lu, 2001; Mishra, Ball, Dobson, Byles, & Warner-Smith, 2002).

This study returns no significant gender difference on geriatric healthcare seeking behavior. This is however contrary to some earlier findings which report significant gender differences on utilization of health and medical services especially in developing countries (Pillai et al., 2003; Ahmed, Tomson, Petzold, & Kabir, 2005). Some studies show association with gender and health seeking (Ahmed, 2001; Ahmed et al., 2000), including differences in seeking treatment for other family members, such as female and male children (Bhan, Bhandari, Taneja, Mazumder, & Bahl, 2005). The difference in the findings of this research could be as a result could indicate a different result unique to the geriatrics as compared to the general population. In other words when it comes to the geriatric population as against the general population, the gender influence in healthcare seeking behavior is similar.

A significant marital status influence on geriatric healthcare seeking behavior was returned by this study. Some prior work does suggest that there are differences in the types of health care the married receive different from singles or divorced. The married are more likely to have a primary care physician (Sox, Schwartz, Burstin, & Brennan, 1998). Report illnesses earlier and have better screening behavior, (Lannin et al., 1998; Iwashynaa & Christakis, 2003). The recently widowed may have more hospitalizations and have greater use of mental health services (Prigerson, Maciejewski, & Rosenheck, 1999). When hospitalized, the married have been found to have shorter lengths of stay (Chin & Goldman, 1997; Kuykendall, Ashton, Johnson, & Geraci, 1995). The married are less likely to use nursing homes (Freedman, 1996; Freedman, Berkman, Rapp, & Ostfeld, 1994; Iwashynaa & Christakis, 2003). In summary these studies suggest that the married may get better health care than the unmarried.

Finally the findings returned no significant annual income influence on geriatric healthcare seeking behaviour. This is however contrary to previous findings. A possible explanation is probably due to the spread income of the participants. Majority of them fall within low income group. Mackenbach & Howden- Chapman, (2003) affirmed that the effect of low income on health is not clear. Thus being within the same social economic status, little of no significant difference was observed with regards to income. Previous researches show that income is a determinant of health care seeking behavior. It determines not just health seeking behaviour, but risk factors associated with health outcomes (Colin, Adair, & Popkin, 2004; Mackenbach & Howden- Chapman, 2003), barriers to seeking health care (Taffa & Chepngeno, 2005), types of treatment (Nyamongo, 2002) and delays in service use (Johansson, Long, Diwan, & Winkvist, 2000). According to Pillai et al., (2003) economic status is the most significant predictor of service use. Income affects the level to which health care facilities are sought and used (Buor, 2003). Often the decision to seek health care is based upon the cost as compared to the perceived benefit (Hjortsberg, 2003). According to Buor (2003) the ability to pay determines the use of health services. A lack of finances seriously affects health care seeking (Taffa & Chepngeno,

2005), is a barrier to health seeking and creates overwhelming financial burden for some (Gotsadze, Bennet, Ranson, & Gzirishvili, 2005).

5. Conclusions

Majority of geriatric population had their spouses and family members as primary caregiver, while few had formal caregivers. This reflects the typical African traditional extended family system tradition where old folks depend on their children and immediate family members to care for them as they age. The formal care giving practice is thus alien to the vast majority of the Nigerian population. The cost of treatment for most geriatric population was borne by members of their families.

There is a high awareness among the Nigerian geriatric population especially in urban communities of the orthodox medicine option. Majority of this population preferred to confide issues of their health status with their orthodox medical practitioners as well as indicate a preference for the orthodox therapeutic option to other methods. This is a reflection of the accessibility and availability of this method of medical care in the cities. It is also worthy of note that more than 19% of geriatrics population still opt for the use of traditional herbal remedies, and some alternate between the herbal remedy as well as the orthodox option. This is also an indicator of the efficacy and popularity of the traditional medical among the aged in Nigeria. Despite the fact the majority of the respondents reported frequent illness, findings show that large majority of them sought orthodox medical care every four months, while minority visits once a month. This reveals that most of the aged population does not seek orthodox medical care regularly probably due to cost, location, belief and other factors. This is a reflection of a negative healthcare seeking behavior.

Age is significantly related to geriatric healthcare seeking behavior (HSB). Younger people have better attitude towards health care seeking. Some ailments are attached to aging. Hence some geriatric population may have a negative HSB due to an erroneous belief that their illness may be as a result of old age which cannot be helped through seeking healthcare. Marital status has a huge influence on geriatric healthcare seeking behavior. The married get better health care than the unmarried and divorced. This could be as a result of better income or a reflection of encouragement and support received from a spouse, which motivates a positive HSB. The findings returned no significant annual income influence on geriatric healthcare seeking behavior.

6. Recommendations

One of the major deterrence of usage of orthodox healthcare services (especially by the geriatric population) is affordability. The Federal Government through the ministry of health can provide some assistance through the health insurance scheme. The effectiveness of the Nigerian Health Insurance Scheme (NHIS), implemented in 2005, should be evaluated and reviewed and necessary adjustments made to subsidize cost of primary healthcare services to the elderly. Geriatrics focused public psycho-education programmes focused on importance of seeking medical care

from trained professional health care practitioners alone could be made through the mass media and public lectures in the communities. Also, Public and private sector initiatives should be encouraged to establish well equipped old peoples' home across the nation. Furthermore, as the geriatric population increases, so also would the proportion of that population that believes in and prefers the indigenous traditional healthcare option. Hence there is need for researches aimed at developing of the indigenous traditional medical methods so as to elevate the practice to international standard. Finally more research efforts of the health care seeking behavior of the geriatrics are needed

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