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Determinants of Healthcare Seeking Behaviour amongst Households In Nigeria

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ABSTRACT

The weak healthcare-seeking behaviour in Nigeria has been a major concern for both scholars and policy makers in recent years. This issue is also reinforced by international pressures on nations (Nigeria inclusive) to achieve the SDGs goal number 3 by 2030. Thus, this study assessed the key determinants of healthcare seeking behaviour among households in Nigeria. The study employeddatasets from NOIPolls-Afrobarometer national survey which sampled 3,200 participants residing in the urban and rural communities in Nigeria aged 18 years and above.A multivariate logistic regression,cross-tabulation and chi-squareanalytical tools were employed to analyze the data collected from the field. The research found thatundue financial extortions from patients seeking healthcare services by healthcare service providers, unfriendly attitudes of healthcare service providers to patients seeking medical attention, poor access to medical services, long waiting time, lack of medicines at the clinic, shortage of medical staff, poor condition of health facilities and households' lived poverty index had significant influence on healthcare seeking behaviour of households in Nigeria. This reveals that the healthcare-seeking behaviours of households in Nigeria are significantly related to the enabling, predisposing and need factors. It then suggests the strengthening of healthcare systems, and workforce development, including communication and counselling skills among healthcare service providers by the government, NGOs and stakeholders in the private sector in order to curb the unfriendly attitudes of healthcare providers to patients seeking healthcare services.The study also recommends that the government should set up monitoring and compliance mechanism agencies across all states in Nigeria, and ensure universal and sustainable healthcare coverage across the urban and rural communities in Nigeria.

Keywords:Determinants, Healthcare Seeking Behaviour, Households,Andersen'sBehavioural Model, Healthcare Service Utilization, Logit Model, NOIPolls, Afrobarometer, Nigeria.

JEL Classification Codes:H51, H52, H53, H75.

I. Introduction

The health seeking behaviour of households in urban and rural communities determines how health services are used and in turn the health outcomes of the population.As compared to other countries in Sub-Saharan Africa, Nigeria's healthcare system is characterized by unfriendly attitudes of healthcare service providers to patients seeking medical services, low financial protection and poor access to quality healthcare services (Popoola, 2021; Adepoju, Oladimeji&Sokoya, 2023). For instance, the National Bureau of Statistics (NBS, 2017, 2022) observed that the trend of inappropriate HSB in Nigeria (that is healthcare services from chemist, traditionalist, spiritualist, and self-medication) increase steadily from 46.7% in 2013 to 68.1% in 2019. In addition, 71% and 53% of rural and urban dwellers respectively, reported inappropriate HSB during their last illness episodein Oyo State (Latunji&Adeyemi, 2018).

According to World Health Organization (WHO, 2023), about 55% of households in Nigeria cannot obtain essential health services, and each year, large numbers of households are being pushed into poverty because they must pay for healthcare services out of their own pockets. Federal Ministry of Health (FMH, 2021) also reported that in Nigeria, more 800 people spend more than 10 percent of the households' incomes on health expenses for themselves, a sick child or other family member, for almost 100 million people these expenses are high enough to push them into extreme poverty, forcing them to survive on just $1.90 or less a day. In assessing the determinants of healthcare services seeking behaviour, the indicators often assessed include people's health status (morbidity and mortality) (Ahmed, Adams, Chowdhury &Bhuiya, 2018; Andersen, Davidson & Baumeister, 2018).However, low health seeking behaviour among households has been linked to negative health outcomes such as increased maternal and under-5 mortality rates and poorer health statistics in Nigeria (Federal Ministry of Health [FMH], 2020 & WHO, 2019).

The healthcare seeking behaviour of a society determines how they use health services. The utilization of health facilities in Nigeria can be influenced by undue financial extortions from patients seeking medical services by healthcare service providers, unfriendly attitudes of healthcare service providers to patients seeking healthcare services, poor access to medical services, long waiting time, lack of medicines at the clinic, shortage of medical staff, poor condition of health facilities, households' lived poverty index. These factors have the tendency of discouraging households' healthcare seeking behaviour in Nigeria. Also, households whose average income is below the poverty line are less likely to seek formal and appropriate medical care when they are ill compared to households whose incomes are above the poverty line. For instance, according to Transparency International (2022) 1 in 5 people in Nigeria reported that they have experienced undue financial extortions while seeking healthcare service in most public health facilities in Nigeria. It is estimated that 140,000 children die every year as a result of corruption in Nigeria's health system (WHO, 2021).

Globally, about 7 million under-five deaths were recorded in 2021, (WHO, 2021) while 41% of these deaths occurred in Sub-Saharan Africa, Nigeria inclusive, even though the vast majority of the deaths are preventable using public health interventions with increased healthcare seeking behaviour among households. World Bank(2020) reported that preventable deaths of under-five children remain very high in Sub-Saharan Africa due to poor healthcare service seeking behaviour among households. Despite the high potential that adequate health care interventions hold for the survival of young children, health care seeking behaviour has remained very low inNigeria. For instance, evidenced from National Bureau of Statistics (NBS, 2022) revealed that the percentage of male and female reported having an illness rose from 13.7% and 15.2% to 22.6% and 24.5% between 2016 and 2022, respectively; while those with appropriate health-seeking behaviour decreased from 27.9% to 17.9% for male and 28.3% to 19.1% for female between the periods.

According to National Bureau of Statistics (2022), 71% of rural residents reported inappropriate HSB during their most recent illness episode, compared to 53% of urban residents. Similar to this, Nigerian women were less likely to give birth in the presence of a skilled birth attendant in areas where the population to Primary Healthcare Center (PHC) ratio was high (more than 9,000:1) than they were in areas

where it was lower (less than 6,000:1). Due to this discrepancy, it is essential to for this study to identify the variables that affect HSB in various socio-economic subgroups in Nigeria. This is essential to guide policy formulation and implementation.

Consequently, poor health care service seeking behaviour presents a daunting challenge to the attainment of goal number 3 of the Sustainable Development Goals (SDGs) for a developing country like Nigeria. Hence, in view of the aforementioned problems, this studyseeks to provide answers to the research questions:

i. What is the relationship between households' socio-economic background and healthcare seeking behaviour in Nigeria?

ii. What are the major determinants of healthcare seeking behaviour among households in Nigeria?

Providing answers to these questions are considered important because a clear understanding of the aforementioned issues could help policy makers in formulating health policies that will reform the Nigerian health sector. Therefore, the objective of this research is to investigate the determinants of healthcare seeking behaviour among households in Nigeria.The study is organized as follows: next section is the literature review, followed by methodology for the research. Section four is the empirical findings and discussion of results, and the last section (section five) presents the conclusion and recommendations for policies formulation.

Ii. Literature Review

Conceptually, healthcare seeking behaviour (HSB) is any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy. It can also be referred to as illness behaviour or sick-term behaviour. Perhaps HSB of a society could determines how they use health services. Hence HSB can be situated within the broader concept of health behaviour, which encompasses activities undertaken to maintain good health, to prevent ill health, as well as dealing with any departure from a good state of health.

Theoretically, inappropriate HSB could pose devastating health, social and economic consequences for individuals, families and nation at large (Becker, 1964; Cai and Kalb, 2005). It is also linked to worse health outcomes, increased deaths and poorer health indicators (Popoola, 2021; Geldsetzer, Williams &Kirolos, 2021). However, studiesthat have attempted to assess factors that significantly influence healthcare seeking behaviour of households across international and domestic countries of the world can be broadly classified into two groups. The first group are studies which emphasized the utilization of the formal system, or the health careseeking behaviour of people. The studies that fall under the first category have developed models that describe the series of steps people take towards seeking healthcare. These models are sometimes referred to as 'pathway models' (Musinguzi, Anthierens, Wanyenze & Bastiaens, 2018; Patra& Das, 2018; Mackian, 2019; Geldsetzer, Williams &Kirolos, 2021).However, Burney, Alenezi, Hamada &Al-Musallam (2019), Geldsetzer, Williams, &Kirolos(2021) as well as Latunji&Akinyemi (2018) in an attempt to model the determinants of healthcare seeking behaviour of households in Ghana and Mauritania classified'pathway models' into Health Belief and Andersen's Health BehaviouralModels.

The second group comprises studies conducted by Quintussi, Van de Poel, Panda &Rutten (2018),Saah, Amu, Seidu & Bain(2021),Wellay, Gebreslassie, Mesele, Gebretinsae, Ayele, Tewelde & Zewedie(2018) as well as Zeng, Xu, Chen, Chen &Fang(2020) who model the determinants of healthcare seeking behaviour among households in Cyprus, Chile, Afghanistan and Kuwait. These studies found that households' decision to engage with a particular health facility is influenced byhouseholds' economic status, sex, age, social status, type of illness, access to services and perceived quality of healthcare service. In addition, studies conducted by Maiwada, Rahman, Rahman, Mamat &Baba(2016), Ibrahim, Sarah, Nabyonga, & Lawson (2019), Mackian (2019), Abuduxike, Aşut, Vaizoðlu, &Cali (2019), Babalola (2020), and Muzurura, (2018) also found geographical locations, cultural and organizational factors as significant factors influencing households' healthcare seeking behaviour in Malawi, Nigeria and Ivory coast.

According to Geldsetzer, Williams, & Kirolos (2021), Chauhan, Manikandan, Purty, Samuel, & Singh (2019), Mhlanga (2021), Mackian (2019),Wellay, Gebreslassie, Mesele, Gebretinsae, Ayele, Tewelde, &Zewedie (2018) access to health facilities, perceived quality of service were significant factors influencing healthcare seeking decisions of different population segments in Italy and Sierra Leone. To this end,the reviewed empirical studiesabove have described households' healthcare seeking behaviour within the context of various diseases episodes. Hence,to the best of our knowledge, empirical studies that have been documented on the determinants of healthcare seeking behaviour among households' inNigeria is very scanty, the studies reviewed in this researchhave also not empirically investigated the need, enabling and the predisposing factors influencing healthcare seeking behaviour among households in Nigeria as it is being examined in this study.

Iii. Methodology

This research employed quantitative research method to study the research problems across the six geo-political zones in Nigeria. A nationally representative survey dataset from NOIPolls and Afrobarometer national survey which sampled the opinionsof 3,200 participants about their healthcare seeking behaviourout of the total population of over 215.87 million households in Nigeria was used in validating the hypotheses in this research. Proportionate stratified random sampling technique was adoptedin selecting the sample size at the data collection stage.The study participants were stratified into geo-political zones, senatorial districts, state level and local governments areas across the country. This sampling methodology is actually in line with the sampling methodologies of Nigeria Demographic and Health Survey (NDHS, 2018) andthe Multiple Indicator Cluster Surveys (MICS, 2021).The justification for this sampling methodology is to ensure that the sample size is a true representative of the study population.

However, a questionnaire design was used in eliciting information from the respondents while Cronbach's Alpha was employed to test the reliability of the instrument used for the data collection and the reliability index obtained was 0.79 which indicates that the survey tool used for the data collection is reliable and consistent. Therefore, this study operationalized households' healthcare seeking behaviour (which denotes the dependent variable) by the rate at which respondents consult a qualified medical professional or seeking healthcare at orthodox health facilities such as private clinics, primary healthcare centres, and general hospitals during any illness episodes or any situation requiring medical attention.On the other hand, the determinants of healthcare seeking behaviour among households as operationalized in this research include:UFEPSHS = undue financial extortions from patients seeking healthcare services by healthcare service providers, UFAHSPP = unfriendly attitudes of healthcare service providers to patients seeking medical attention, PAMS = poor access to medical services, LWT = long waiting time, LMC = lack of medicines at the clinic, SMS = shortage of medical staff, PCHF = poor condition of health facilities and HLPI =households' lived poverty index.

III.1 Conceptual Framework

This research adapted Andersen's behavioural model ofhealthcareservice utilization propounded in 1968 to establish link among healthcare seeking behaviour, enabling and predisposing factors influencing households' healthcare seeking behaviour in Nigeria. The conceptualization of healthcare utilization by this model acts on the assumption that a person's use of health service is influenced by three key factors, namely, predisposing factors, enabling factors, and the need for care factors.

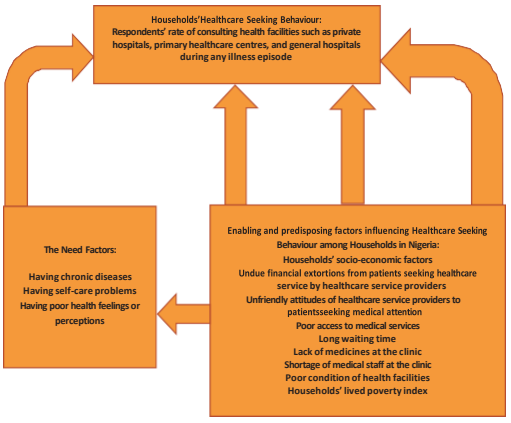

Figure 1: Andersen's Behavioural Model of Healthcare Service Utilization. Source: Adapted from Andersen and Davidson (2018)

Figure 1 indicated that there are three main tenets of this model, these are predisposing, enabling, and the need factors. The tenets adequately explain the various factors influencing healthcare seeking behaviour among various households in Nigeria.

Meanwhile, in this study, we hypothesized that households' socioeconomic factors such as age-group, education, place of residence, gender, and occupation form the enabling factors while undue financial extortions from patients seeking healthcare services by healthcare service providers, unfriendly attitudes of healthcare service providers to patients seeking medical attention, poor access to medical services, long waiting time, lack of medicines at the clinic, shortage of medical staff, poor condition of health facilities and households' lived poverty index form the predisposing factors influencing households' healthcare seeking behaviour in Nigeria while the need factors include having chronic diseases, having self-care problems and having poor health perceptions.

III.2. Model Specification

This study employed the multivariatelogistic regression model of Mohammed, Njiforti & Sanusi (2021) to examine the determinants of healthcare seeking behaviour among households in Nigeria. However, the model of Mohammed *et al.* (2021) differ from our model in this study in that their logit model analyzed the link between reproductive health outcomes and women's labour force participation in Nigeria while ours analyzes the determinants of healthcare seeking behaviour among households in Nigeria. Multivariate logistic regression model has been widely used in the literature and remain empirically handy in estimating economic relations whose dependent variables are dichotomous in nature. Hence, the dependent variable in this study is categorical in nature. However, for dependent variable **(Y)** in this research, a respondent was scored **1** if he/she had a contact with public or private health facility in the last twelve months and **0** if otherwise, we operationalized this with households' healthcare seeking behaviour. Therefore, dependent variable **Y = 1** if a respondent had contact with health facility and **Y = 0** if otherwise. Algebraically, this relation is defined as:

$$\lambda(Y = 1/X) = X; 1 - \lambda(Y = 0) = 0$$

$$X = \frac{e^{(\alpha+\beta_1 x_1+\beta_2 x_2+\ldots+\beta_n x_n)}}{1+e^{(\alpha+\beta_1 x_1+\beta_2 x_2+\ldots+\beta_n x_n)}} \quad (2)$$

In equation 1 , λ denotes the probability that a household had contact with public or private health facility in the last twelve months while *a* connotes the probability that a household did not have contact with public or private health facility in the last twelve months. In equation *2* represents the intercept term while *1* ß β_i denotes the regression coefficients to be estimated for variable vector X_i = 1,2,3.....n, which are the predictors of the outcome variable Y (Y = Households' Healthcare Seeking Behaviour [HHSB]) in the model.

However, thepredictor variables that are operationalized within the **X** vector in this study are:undue financial extortions from patients seeking healthcare services by healthcare service providers(UFEPSHS), unfriendly attitudes of healthcare service providers to patients seeking healthcare services (UFAHSPP,)poor access to medical services (PAMS), long waiting time (LWT), lack of medicines at the clinic (LMC),shortage of medical staff (SMS), poor condition of health facilities (PCHF) and households' lived poverty index (HLPI).

$e^{(\alpha \square \beta_1 x_1 \square \beta_2 x_2 \square \ldots \square \beta_n x_n)}$

Meanwhile, denotes the odds-ratios of the estimated parameters in the logit

model. In addition, the study also adopted cross-tabulation and chi-square analytical tools to analyze the association between respondents' healthcare seeking behaviours and households' socioeconomic characteristics.

Iv. Results And Discussion Of Findings

The socio-demographic characteristics of the respondents who participated in the NOIPolls-Afrobarometer national survey in Nigeria is presented in table 1. The socio-demographic characteristics of the respondents considered include gender, age-group, education, occupation and place of residence.

Table 1: Summary of Socio-Economic Characteristics of Respondents (*Obs=3,200*)

Socio-Economic Variables		N	%
Gender	Male	1660	52
	Female	1540	48
Age-Group	18 -25 years	942	29
	26 -35 years	988	31
	36 -45 years	656	20
	46 -55 years	328	10
	56 -65 years	206	6
	66 years and above	80	2
Education	No formal education	506	16
	Primary	566	18
	Secondary	1388	43
	Post-secondary	740	23
Occupation	Traders/hawkers/vendors/retailers	788	25
	Farming/Agriculture	674	21
	Unemployed	494	20
	Artisans or skilled manual workers (e.g. , Trades like electrician, mechanic, or skilled	450	14

	manufacturing workers)		
	Students	284	9
	Unskilled manual workers (e.g. , Cleaners, laborers, domestic help, unskilled manufacturing workers)	162	5
	Mid-level professionals (e.g., Teachers, nurse, mid-level government workers)	158	5
	Upper-level professionals (e. g., Bankers, doctors, lawyers, engineers, accountants, professors, senior-level government workers)	66	2
	Supervisors/Foreman/Senior Managers	54	2
	Clerical or secretarial	30	1
	Security services (Police, army, private security)	18	1
	Others	22	1
Residence	Urban Settlement	1370	43
	Rural Settlement	1830	57

Socio-Economic Variables

The findings from table 1indicatesthat 52% and 48% of the respondents who were interviewed during this survey were male and female while 29% and 33% were between the age-groups of 18-25 years and 26-35 years. On the other hand, 20% and 10% of the respondents fall within the age-bracket of 36-45 years and 46-55 years. Meanwhile, 6% and 2% of the respondents constituted the proportion of the population who were between 56-65 years as well as 66 years and above. Also, 16% of the respondents had no formal education while 18% had primary education, 43% had secondary education and 23% had post-secondary school education. However, regarding the occupation of the respondents, 21% were in agric sector, 25% were traders, 14% were artisans while 20% of the respondents were unemployed.In addition, 43% and 57% of the respondents interviewed were residing in the urban and rural areas as at the time of conducting the survey.

Table 2: Relationship between households' socio-economic background and Healthcare Seeking Behavioursin Nigeria

Socioeconomic Variables		**Yes**		**No**		÷2	**P-Values**
		N	**%**	**N**	**%**		
Gender	Male	533	52	1125	52	15.34	.000***
	Female	490	48	1052	48		
Age-Group	18-25 years			274	27	668	31
	26-35 years	286	28	704	32		
	36-45 years	200	20	454	21		.000**
	46-55 years	136	13	192	9	34.56	
	56-65 years	90	9	114	5		
	66 years & above	36	4	44	2		
		84	8	420	19		
Education	No formal education						
	Primary	180	18	386	18		
	Secondary	444	44	940	43	25.44	.000**
	Post-secondary						
Lived Poverty Index	No Lived Poverty						
	Low						

314	31	428	20	18	402	19		.000**
		1						
		8						
14	1	70	3					
		4						
	Moderat e Lived Poverty		410	40 40	854		32.87	
	High Lived Poverty		410	40 39	834			
Residence	Urban		456	45	914	42		.000**
	Rural		566	55	1264	58	54.67	

*Note:** denotes that variables are significant at 5% level of significance.*

Table 2 illustrates the correlation between respondents' rate of contact with health facility during any illness episode and respondents' socioeconomic backgrounds in the last twelve months. Table 2 indicates that the healthcare seeking behaviour of the respondents is significantly correlated with the respondents' socioeconomic characteristics as indicated by the p-values. However, 8% of the respondents with no formal education had contact with health facility while 19% does not visit health facility during any illness episode but rather patronize roadside and traditional herbs sellers, 18% of respondents with primary education had contact with health facility whenever any member of the family is ill while 18% said they never had contact with any health facility during illness but they purchase drugs from street hawkers and roadside medicine sellers.

However, 44% of the respondents with secondary school education said they visit health facility whenever any family member is ill whereas 43% said they don't visit any health facility during any illness episode. Also, 31% of the respondents with post-secondary school education said they usually visit healthcare centres whenever any member of the household is ill while 20% said they don't visit health facility during illness. In addition, 45% of the respondents interviewed during this survey residing in urban settlement said they visit health facility to seek medical attention when they are ill while 42% said they don't visit health centre during any illness episode but rather patronize traditional herbs sellers and road side medicine hawkers when they are ill. On the other hand, 55% of the survey participants residing in the rural settlement said they visit health facility whenever they are ill while 58% said they don't patronize health facility during any illness episode but they seek medication through inappropriate healthcare channels such as traditional herbs sellers and roadside drug hawkers to buy medicine for any household members that may need medical attention.

Table 3: Logistic regression result which depicts the determinants of healthcare seeking behaviour of households in Nigeria

	Coefficients	S.E.	df	[P-Values]	Odds-Ratio
Households'Healthcare Seeking Behaviour (HHSB)					
PAMS	10.530	3533.259	1	.000**	42.080
UFEPSHS	8.933	629.228	1	.000**	64.393
UFAHSPP	7.191	1063.240	1	.000**	49.304
LMC	5.158	2723.619	1	.000**	25.854
SMS	6.483	2530.176	1	.000**	36.617
LWT	3.353	4611.384	1	.000**	9.035
PCHF	4.952	1823.659	1	.000**	16.386
HLPI	11.175	1047.531	1	.000**	56.840
Constant	46.539	5949.710	1	.0000**	16.27

*Note: ** denotes that variables are significant at 5% level of significance; where PAMS = poor access to medical services,* UFEPSHS = *undue financial extortions from patients by care givers,* UFAHSPP= u*nfriendly attitudes of healthcare service providers to patients during care, LMC = Lack of medicines at the clinic, SMS = Shortage of Medical Staff, LWT = Long Waiting Time, PCHF = Poor Condition of Health Facilities and HLPI =Households' Lived Poverty Index. The observation is 3,200.*

Table 3 shows that the estimated logistic regression parameters are all significant at 5% level of significance as indicated by the p- values.By implication the odds-ratios indicate that undue financial extortions from patients seeking healthcare services, unfriendly attitudes of healthcare service providers to patients seeking medical attention, poor access to medical services, long waiting time, lack of medicines at the clinic, shortage of medical staff, poor condition of health facilities and households' lived poverty index are more likely to influence households' decision and propensity to visit public or private healthcare facility during any illness episode. This result is in conformity with the studies conducted by Abuduxike, Aşut, Vaizoðlu&Cali (2019) as well as Ahmed, Adams, Chowdhury &Bhuiya(2018) who reported evident disparities in socio-demographic characteristics of people who utilized public and private health facilities in Cyprus. However, they also reported that health- seeking behaviour of household was significantly related to factors such as insurance status, chronic illness, self-perceived health status, and family size.This result also corroborates the study conducted by Mohammed, Njiforti &Rafindadi (2022) who reported that most public health facilities in Nigeria especially in the rural areas have inadequate medical staff to effectively carry out various reproductive healthcare activities and the doctor-patients-ratios of these public health facilities were still far below expectation.

Further, from the result in table 4.3, poor access to medical servicescoefficient is positive with the value of 10.530. This means that poor access to medical services is 42.080 times more likely to interrupt households' decision in seeking healthcare serviceduring any illness episode. Also, undue financial extortions from patients seeking healthcare serviceappears to be significant with a positive value of 8.933. This connotes that undue financial extortions from patients seeking healthcare serviceis 64.393 times more likely to reduce the propensity of healthcare seeking behaviour in a household when any member of the household is ill.

However, the coefficient of unfriendly attitudes

Of healthcare service providers to patients seeking medical attention is equally positive with the value of 7.191, meaning thatunfriendly attitudes of healthcare service providers to patients seeking medical attentionis 49.304 times more likely to discourage households' decision to seek medical care during any illness episode. Meanwhile, the coefficient of lack of medicines at the clinic is also positive with the value of 5.158 which denotes that lack of medicines at the clinic is 25.854 times more likely to influence households demand for healthcare service when they are ill. In addition, shortage of medical staff has positive coefficient with the value of 6.483, this means that shortage of medical staff at the hospital is 36.617 times more likely to affect the healthcare seeking decision of households during illness. Long waiting time at the hospital equally has a positive coefficient of 3.353 indicating that long waiting time for medical care is 9.035 times more likely to discourage the healthcare seeking habit of households' members especially during emergency when an ill person needs to be urgently attended to.

Poor condition of health facilities also has a positive coefficient with the value of 4.952 which connotes that poor condition of health facilities is 16.386 times more likely to influence the healthcare seeking decision of households during any illness episode. Households' lived poverty index is equally significant with a positive coefficient of 11.175, meaning that households' lived poverty rate is 56.840 times more likely to influence households' healthcare seeking habit during any illness episode.

V. Conclusion And Policy Recommendations

Based on the result of the findings in this survey, the research concludes that the healthcare-seeking behaviour of the participants in this survey were significantly related to the enabling,

predisposing and need factors influencing the respondents' decision to visit public or private health facility during any particular illness episode.The study found significant correlation between households' healthcare seeking behaviour and the respondents' socio-demographic characteristics. The study also reveals that undue financial extortions from patients seeking healthcare services by healthcare service providers, unfriendly attitudes of healthcare service providers to patients seeking medical attention, poor access to medical services, long waiting time, lack of medicines at the clinic, shortage of medical staff, poor condition of health facilities, households' lived poverty index had significant influence on healthcare seeking behaviour of households in Nigeria.However, these factors have accounted for the low healthcare seeking behaviour among householdsin the urban and rural communities in Nigeria.

This study then recommends that government should put in place strategies that include the use of independent agencies to investigate and punish any health workers who extort patients at the point of paying medical bills and ensuring that information about healthcare prices is clear and accessible to the public together with increasing healthcare worker remuneration.

The study also recommends that the federal government should set up monitoring and compliance mechanism agencies across all states in Nigeria to ensure that the National Health Insurance Authority Act (NHIA) defines a structure for the implementation of recovering contributions from the informal sectorof the Nigerian economy across the thirty-six states in the country including the Federal Capital Territory.This development is key to ensuring a universal and sustainable healthcare coverage across the urban and rural communities in Nigeria.

The study also suggests the strengthening of health systems, and workforce development, including communication and counselling skills among healthcare service providers by the government and stakeholders in the private sector in order to curb the unfriendly attitudes of healthcare providers to patients seeking healthcare services.

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