OUT-OF-POCKET PAYMENT ON HEALTHCARE: IMPLICATION ON THE HEALTH STATUS OF WOMEN IN ENUGU STATE, SOUTH-EAST NIGERIA

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KEYWORDS
Women, Out-of-pocket, healthcare, Enugu State, South-East Nigeria, medical bill

ABSTRACT
Health care expenses in Nigeria are done mainly through Out-of-pocket (OOP) expenses. Women irrespective of their age, status and location have need for medical care and this creates a burden on their expenses due to OOP medical expenses. This study therefore, examines the implications of healthcare payment through OOP medical expenses on the health status of women in Enugu State, South East Nigeria. A cross sectional study was conducted in Nsukka LGA and Enugu urban both in South – East Nigeria. Quantitative data was collected from 522 female respondents through structured questionnaire. The result shows that women irrespective of their place of residence are aware of health insurance scheme ($p<0.00$) and utilization of health insurance (0.00). There is also a significant relationship between employment status and encountering the challenge of paying for medical treatment due to cost of healthcare ($p< 0.01$). Furthermore, women in spite of their locality indulge in self-medication ($p<0.00$), patronize patent medicine dealers ($p< 0.00$) and roadside herbal medicine dealers ($p< 0.00$). The study

concludes thatthe reliance on out-of-pocket payments for healthcare services, particularly among uninsured women in Enugu State, Nigeria, has significant implications for their health status. This practice introduces financial barriers that may result in delayed or forgone care, leading to self-medication, utilization of informal healthcare providers, and ultimately, adverse health outcomes. Moreover, the regressive nature of these expenditures exacerbates disparities, disproportionately affecting women, female-headed households, and the poor. To address these challenges, policymakers are urged to consider universal health insurance coverage and reforms in the healthcare sector to alleviate financial burdens and promote healthcare equity.

Introduction

Out-of-pocket expenditures refer to the direct payments individuals make to healthcare providers when they use medical services. It is usually made at the time of illness. It reflects the actual expenses individuals bear for healthcare services rendered at the point of use, irrespective of economic fluctuations (World Health Organisation Observatory, 2022). They are expenses not covered by a person's insurance plan, and include charges such as co-payments, deductibles and coinsurance (Mangan & Coombs, 2017). It is obtained when government owned hospitals are unable to provide free healthcare services and when individuals use the services of private owned hospitals. These are expenditure on drugs, injections, consultation, laboratory tests, medical examinations, surgeries and other medical procedures and hospitalization fees.

The high cost of consultation, treatments and/or hospitalization however constitute a financial burden for sick persons (Adeniji, 2021) and their households (Naz & Sriram, 2024) and increases their poverty level (Aregbeshola & Khan, 2018).Out-of-pocket cost burden falls most heavily on patients who are least able to bear it, both in terms of their health and in terms of their income (Health Pocket, 2019).Also, when evaluating expenses in relation to income, out-of-pocket spending tends to burden the poor disproportionately, leading to regressive and often catastrophic financial outcomes. Conversely, when considering expenditures relative to consumption, the affluent bear a higher burden, resulting in progressive patterns. Particularly in low-income nations, where the extreme poverty line of $1.90 per day prevails, out-of-pocket expenses significantly contribute to impoverishment, emphasizing the stark impact on economically disadvantaged populations (Wagstaff, Eozonou & Smitz, 2020). OOP expenditures often constitute a major access barrier to needed health care and makes individuals to seek alternative and harmful alternatives or they could decide to forgo needed medical attention (Aregbeshola & Khan, 2018).

As reported by the 2018 National Demographic and Health Survey, only about three percent (3.0%) of women and men age 15-49 have health insurance in Nigeria (National Population Commission & ICF, 2019) which could be an alternative to OOP expenditure on health. The implication therefore is that more people engage in out–of-pocket health expenses to pay for their medical bills. Health insurance however, is a social security mechanism that guarantees the provision of needed health services to persons on the payment of some amount at regular intervals and protects them from financial hardships occasioned by large or unexpected medical bills (Adefoju, 2014). This scheme therefore ensures that individuals who have the insurance get the necessary treatment without forgoing or postponing medical treatments due to lack of money. In Nigeria, however, health insurance can be obtained from private organizations or from government agencies.

Studies have shown that women have higher rates of healthcare utilization, as shown by significantly higher rates of hospitalization and outpatient encounters (Bashiru & Xicang et al., 2015). As payment for health costs are mainly done through Out-of-pocket expenses, this have placed women in a disadvantageous position because they need more medical care services than the men folks especially within their reproductive ages. Women within the reproductive age that is, years between puberty and menopause, which is acknowledged as a time of health risks specifically, associated with sex and reproduction and may result in a significant burden of mortality and disability. This period is equally associated with high mortality and disability associated with HIV/AIDS and maternal conditions. Women are equally exposed to health problems related to pregnancy, childbearing, contraception, cancer, maternal conditions and sexually transmitted infection (World Health Organization, 2009). Therefore, the burden of these health costs is high and poses a challenge to women as they equally have higher out-of-pocket medical costs and affects their healthcare utilization.

Women in underdeveloped countries face the challenges of poverty whereby they are unable to afford basic necessities of life, health services, good drinking water, food and nutrition, good and affordable housing. Single mothers as well as older women living who women who live alone have higher risks of poverty than men in similar types of households. Lone mothers with children are more likely to be poor than lone fathers with children (United Nations, 2015). Poverty scourge in sub-Saharan Africa gives way to lack of knowledge, hunger and malnutrition, sicknesses and inability to access credit facilities, short life span and hopelessness (Abiola & Olaopa, 2008 in kaka, 2013). Studies have also shown that low income people, older people including women tend to pay a greater share of their incomes towards Out-of-pocket health costs (Mangan & Coombs, 2017).In addition, women are shortened by ownership of properties including land, economic independence, economic empowerment and social integration than men (Ajala, 2017). This is also worsened by a high likelihood of widowhood where women experience denial of rights and inheritance (Durojaiye, 2013). More so, lower proportions of women than men have savings due to gender pay gap, unpaid labour and gender job segregation. All these factors negatively influence the health status and healthcare utilization among older women including lower rates of hospitalization and outpatient encounters. The plight of women are worsened by economic recessions which are accompanied by loss of jobs and increased prices of goods and services which affect all sectors of the economy including the health sector (Raaber, 2010).

Nigeria Demographic and Health Survey of 2018 reported that 51.6% women aged 15-49 reported that they have serious problems in accessing health care for themselves when they were sick and it was attributed it to their inability to get money for medical payment (National Population Commission & ICF, 2019). Studies have also shown that women are often forced to difficult tradeoffs between healthcare and other family needs such as school fees, rents, feeding or other basic needs. This is because out-of-pocket health care cost is considered high relative to their income. And since women, unlike men, are subjected to triple burden of disease, namely, non-communicable and communicable diseases and reproductive health related diseases (Ladusingh, Kumar & Thangjam, 2018), this could impact negatively on them due to the burden of Out-of-pocket expenses. National Academics of Sciences, Engineering, and Medicine (2018) also identified that women all over have higher health-care utilization than men and these health-care utilizations occur during and after menopause. Studies have also shown that women are more likely to have chronic conditions that require ongoing medical treatment, are more likely on the average to use prescription drugs, suffer from mental health problems more than men (Borchelt, 2018).

Bottom of Form

It has been identified that the poverty rate of families with children headed by women is higher than those headed by men or those headed by married couples (Borchelt, 2018). OOP expenditure on health further impoverishes poor families and plunges them into more hardships and may push household's consumption expenditure below poverty line. As reported in Nigeria Demographic and Health Survey of 2018 the least and most common problems women face in accessing health care are getting money for treatment (46%) and getting permission to go for treatment (11%). This gets tougher with women who have five or more children, who more often reported that getting money for treatment is a challenge (51%) along with the difficulty in getting to the health

facility due to distance (29%) (NPC & ICF, 2019). Therefore, to stay financially secure, women may forgo needed care, postpone diagnosis of serious health problem or go without needed treatment which can leave them in poor health. Since women make up the majority of the poor people in Nigeria, the implications of OOP payments for health care access from a gender perspective have little attention (Onah & Govender, 2014).

Statement of the problem

Enugu State, along with Abia, Anambra, Ebonyi, and Imo, constitutes the South-East zone of Nigeria. According to the National Population Commission and ICF (2019), the total health insurance coverage for women in this zone, including those enrolled in employer-based, community-based, and privately purchased insurance, is extremely low, with percentages as low as 2.1%, 0.5%, and 0.6% respectively. Consequently, women in these states, including Enugu, predominantly rely on out-of-pocket (OOP) payments for healthcare expenses. This reliance imposes a significant financial burden on women from diverse backgrounds, spanning age, socioeconomic status, and geographic location. Moreover, research indicates that women in Enugu State face challenges in land ownership, with a limited percentage having their names on title deeds (0.7%) or owning land without formal documentation (0.08%) (NPC & ICF, 2019) This situation limits their access to ownership of land necessary for livelihood, such as homes, agricultural land, and income-generating opportunities (APXN Property, 2024; Udoekanem, David & Onwumere, 2014). As a result, the ability of women to generate income for medical expenses is further constrained, particularly considering the low coverage of health insurance.

Previous research, such as the study conducted by Wagstaff, Eozenou, and Smitz (2020), concentrated on broader healthcare access problems, neglecting the particular difficulties that women encounter in relation to out-of-pocket costs and how it affects their behaviour when seeking healthcare. Furthermore, there is a lack of thorough examination on the differential impact of out-of-pocket (OOP) spending on households, particularly in relation to women's socioeconomic status, caregiving responsibilities, and health requirements. In addition, there is a dearth of study on the coping techniques utilised by women in Enugu State to handle out-of-pocket healthcare expenses. Given these circumstances, it is imperative to examine the impact of OOP healthcare expenses on women in Enugu State.

Conceptual framework



Fig 1: Determinants of women's access to healthcare

The framework in fig 1 provides a comprehensive lens through which to examine the multifaceted factors contributing to disparities in healthcare access and outcomes of women.

Conceptual review

Health outcome: Health outcomes serve as critical indicators of the effectiveness, equity, and efficiency of healthcare systems and interventions.

Health Insurance Coverage: The extent of health insurance coverage among women in Enugu State, reflecting whether women have access to insurance schemes that can offset or reduce out-of-pocket healthcare expenses.

Health Status: The overall health status of women in Enugu State, including physical, mental, and reproductive health outcomes, influenced by their access to and utilization of healthcare services, as well as their ability to manage out-of-pocket healthcare payments.

Out-of-pocket Healthcare Payments: This refers to the direct payments made by women for healthcare services, including consultation, treatments, medications, hospitalization, and other medical expenses.

Socioeconomic Status: Women's socioeconomic status, including factors such as income, education level, employment status, and household wealth, which influence their ability to afford healthcare and manage out-of-pocket payments.

Theoretical orientation

The Health Belief Model (HBM) was initially developed by researchers at the United States' public health services in the 1950s, with updates made during the 1980s. The Health Belief Model posits that an individual's health-related behaviors are influenced by their perceptions of susceptibility to a health threat, the severity of the threat, the benefits of taking action to

reduce the threat, and the barriers to taking action. It was designed to predict health behavior and understand why individuals may fail to adopt disease prevention strategies or undergo screening tests for early detection. The model was later expanded to include patients' responses to side effects and adherence to medical treatment (LaMorte, 2019; Boskey, 2020). According to the HBM, individuals' perceptions of their health status inform their willingness to change health behaviors. The model posits that individuals are likely to take action to prevent illness if they believe they are susceptible to a condition, perceive it as having serious consequences, believe that a specific action could reduce severity or lead to positive outcomes, and do not perceive significant barriers to taking that action.

The HBM focuses on two main aspects: perceived susceptibility and severity of illness, and perceived benefits and barriers to health behavior. Some scholars have added two additional constructs: cues to action and self-efficacy (LaMorte, 2019; Boskey, 2020). The HBM can help understand why women in Enugu State may perceive themselves as vulnerable to health issues such as maternal mortality and infectious diseases, worsened by limited healthcare access due to financial constraints. Despite these barriers, they would recognize the benefits of healthcare services and may be encouraged by external cues like community programs to seek care despite out-of-pocket payments. Their self-efficacy in navigating the system and accessing resources also influences their health-seeking behaviors. However, the model has been criticized for not considering individual attitudes and beliefs that influence health behavior, ignoring environmental and economic factors that may hinder or facilitate recommended actions, and overlooking social norms and access to information. Critics suggest that the model is overly simplistic and propose the need for more complex causal models in HBM research (Champion & Skinner, 2008).

Materials and Methods

Study area: The study area is Enugu State, situated in southeastern Nigeria, boasting a population of approximately 3,267,837 individuals, with females accounting for 1,671,795 (National Population Commission, 2006). Established in 1991 through the partition of Anambra State, Enugu serves as both the capital and the largest city within the state. Notable towns within Enugu State include Enugu, Nsukka, Agbani, and Awgu, all strategically positioned. Enugu State shares boundaries with Imo, Anambra, Abia, Ebonyi, Benue, and Kogi States. Nsukka, a significant urban center in Enugu State, is nestled within the Udi Hills, boasting an elevation of 1,300 feet (396m).

Study population: The target population for this study consisted of all women aged15-50 in Enugu State. The focus on this segment of the population was justified with the fact that women have higher rates of healthcare utilization due to their higher rates of hospitalization and outpatient encounters (Saeed & Xicang et al., 2015). The target population was estimated at 1,372,989 (NPC, 2020). A multi-stage cluster sampling procedure, which entails successive selection of local government areas, community clusters and respondents were employed. The towns were grouped into two clusters based on their proximity to the capital of Enugu State. Cluster A (Enugu-East) are largely urban while cluster B (Nsukka) were largely rural. The essence of this clustering was to ensure that women from both urban and rural areas were adequately captured in the study.At first, two local government areas were picked using simple random sampling by balloting. They include: Nsukka and Enugu-Eastlocal Government Areas.

Secondly, from each of the LGA, three communities were selected also through simple random sampling by balloting. Thirdly, 87 women of child bearing age (15 – 50 years) were purposively selected for the study from each of the six selected communities, resulting in a total of 522 participants. Data collection utilized self-administered methods. Enugu State was specifically chosen for this study due to findings from the 2018 National Demographic Survey in Nigeria, which revealed that only 3.2% of women in the South-East region, comprising Enugu, Abia, Anambra, Ebonyi, and Imo States, had any form of health insurance, indicating that the vast majority, 96.8%, lacked health insurance coverage (NPC & ICF, 2019). This underscores the prevalence of out-of-pocket expenditure among residents of Enugu State.

Data collection: An interviewer-based questionnaire, designed to provide information on the socio-demographic characteristics of the

respondents as well as the implications OOP on healthcare access of the women was administered.

Data analysis: The data collected was processed and analyzed using SPSS version 25. Descriptive statistics such as percentages, frequency tables was employed in characterizing the respondents. Chi-square ($\chi 2$) analysis was also utilized to illustrate the relationship between socio-demographic variables and the implications of OOP on women with $p<0.05$.

Presentation of Results

Table 1: Socio-demographics of respondents

Variables		Frequency/Percentage
Age group	15-35years (young women) 36 and 50 (older women) **Total**	301(57.7%) 221(42.3%) **522(100%**)
Marital status	Single Married Widowed Separated **Total**	164(31.4%) 290(55.6%) 45(8.6%) 23(4.4%) **522(100%)**
Employment status	Employed Unemployed **Total**	332(63.6%) 190(36.4%) **522(100%**)
Monthly income	N0-N59,000(low income) N60,000 & above (high income) **Total**	364(69.7%) 158(30.3%) **522(100%)**
Place of residence	Rural Urban **Total**	261(50.0%) 261(50.0%) **522(100%)**

Table 1, shows the socio-demographic characteristics of respondents. The respondents in this study were women of child bearing age and had a mean age of ±23.5 years. A greater proportion of the respondents were between the ages of 15 -35 years and are referred to as young women (57.7%). Most of the respondents were married (55.6%) and a greater percentage (63.6%) wasemployed. More of the respondents fall into the low income bracket and earn between N0-N59,000 (69.7%). There is equal representation of rural and urban dwellers (50%) respectively.

Table 2 Awareness of Health Insurance Scheme (HIS)

Variables		Awareness of HIS		Total N=522	p-value
		Yes	**No**		
Age	Young Older	141(27.0%) 116(22.2%)	160(30.7%) 105(20.1%)	301(57.7%) 221(42.3%)	0.20
Employment status	Employed Unemployed	159(30.5%) 98(18.8%)	173(33.1%) 92(17.6%)	332(63.6%) 190(36.4%)	0.46
Monthly income	Low High	170(32.6%) 87(16.7%)	194(37.2%) 71(13.6%)	364(69.7%) 158(30.3%)	0.08
Place of residence	Rural Urban	98(18.8%) 159(30.5%)	163(31.2%) 102(19.5%)	261(50%) 261(50%)	0.00

Table 2 shows the awareness of Health Insurance Scheme. The results show that slightly above half of the respondents are aware of health insurance. The younger respondents (27.0%) the employed (30.5%) the low income earners (32.6%) as well as urban dwellers (30.6%) are mostly aware of health insurance scheme. The Chi-square analysis shows a

significant relationship between place of residence and awareness of health insurance scheme (p<0.00).

Table 3: Utilization of Health Insurance Scheme (HIS)

Variables		Utilization of HIS		Total N=522	p-value
		Yes	No		
Age	Young	107(20.4%)	194(37.2%)	301(57.7%)	0.62
	Older	74(14.2%)	147(28.2%)	221(42.3%)	
Employment status	Employed	115(22.0%)	217(41.6%)	332(63.6%)	0.62
	Unemployed	66(12.6%)	124(23.8%)	190(36.4%)	
Monthly income	Low	126(24.1%)	238(45.6%)	364(69.7%)	0.98
	High	44(8.4%)	103(19.7%)	158(30.3%)	
Place of residence	Rural	48(9.2%)	213(40.8%)	261(50%)	0.00
	Urban	83(15.9%)	178(34.1%)	261(50%)	

Table 3 shows that the utilization of health insurance among the women respondents were low (34.7%). The results show that that the utilization of health insurance is more among the younger women (20.4%), the employed respondents (22.0%), low income earners (22.1%) and the urban dwellers (15.9%). The Chi-square analysis shows a significant relationship between place of residence and utilization of health insurance (p<0.00).

Table 4: Ability to access needed medical care

Variables		Access to needed medical care		Total N=522	p-value
		Yes	No		
Age	Young	76(14.6%)	225(43.1%)	301(57.7%)	0.90
	Older	55(10.5%)	166(31.8%)	221(42.3%)	
Employment status	Employed	81(15.5%)	251(48.1%)	332(63.6%)	0.62
	Unemployed	50(9.6%)	140(26.8%)	190(36.4%)	
Monthly income	Low	55(10.5%)	238(45.6%)	364(69.7%)	0.96
	High	126(24.1%)	32(6.1%)	158(30.3%)	
Place of residence	Rural	100(19.2%)	161(30.8%)	261(50%)	0.11
	Urban	83(15.9%)	178(34.1%)	261(50%)	

Table 4 shows the distribution of respondents by their ability to access medical care when needed. The results show that access to needed medical care is low (25.1%). The study found out that more of the young women (14.6%), the employed (15.5%), high income earners (24.1%) and rural dwellers accessed needed healthcare treatment regularly. The Chi-square analysis shows no significant relationship between all the socio-demographic variables and ability to access the needed medical care (p>0.05).

Table 5: Accessing respondents who have had the challenge of paying for medical treatment

Variables		Ever had issues paying for medical treatment Yes	No	Total N=522	P-value
Age	Young	156(29.9%)	145(27.8%)	301(57.7%)	0.28
	Older	145(27.8%)	96(18.4%)	221(42.3%)	
Employment status	Employed	192(36.8%)	140(26.8%)	332(63.6%)	0.01
	Unemployed	89(17.0%)	101(19.3%)	190(36.4%)	
Monthly income	Low	191(36.6%)	173(33.1%)	364(69.7%)	0.34
	High	90(17.2%)	68(13.0%)	158(30.3%)	
Place of residence	Rural	149(28.5%)	112(21.5%)	261(50%)	0.13
	Urban	132(25.3%)	129(24.7%)	261(50%)	

Table 5 shows the distribution of the respondents by those who experience challenges in paying for medical expenses. The result shows that slightly half of the respondents have had challenges in paying medical bills. Also, more of younger respondents (29.9%), the employed (36.8%), low income earners (36.6%) and rural dweller (28.5%) have had issues with paying for medical treatment. The Chi-square analysis shows a significant relationship between the employment status of the respondents and encountering challenge of paying for medical treatment ($p<0.01$).

Table 6: Implications of out of the pocket expenses on women

Socio-demographics		Forgoes medical treatment Yes	No	Total N=522 (100%)	p-value
Age	Young	260(49.8%)	41(7.9%)	301(57.7%)	0.09
	Older	179(34.3%)	42(8.0%)	221(42.3%)	
Employment status	Employed	276(52.9%)	56(10.7%)	332(63.6%)	0.42
	Unemployed	163(31.2%)	27(5.2%)	190(36.4%)	
Monthly income	Low	308(59.0%)	56(10.7%)	364(69.7%)	0.62
	High	131(25.1%)	27(5.2%)	158(30.3%)	
Place of residence	Rural	220(42.1%)	41(7.9%)	261(50%)	0.90
	Urban	219(42.0%)	42(8.0%)	321(50%)	
Socio-demographics		**Self-medicate due to cost Yes**	**No**	**Total N=522**	**p-value**
Age	Young	190(36.4%)	111(21.3%)	301(57.7%)	0.71
	Older	136(26.1%)	85(16.3%)	221(42.3%)	
Employment status	Employed	200(38.3%)	132(25.3%)	332(63.6%)	0.16
	Unemployed	126(24.1%)	64(12.3%)	190(36.4%)	
Monthly income	Low	229(43.9%)	135(25.9%)	364(69.7%)	0.74
	High	97(18.6%)	61(11.7%)	158(30.3%)	
Place of residence	Rural	199(38.1%)	62(11.9%)	261(50%)	0.00
	Urban	127(24.3%)	134(25.7%)	261(50%)	

Socio-demographics		Patronize roadside herbal drug sellers Yes	No	Total N=522	p-value
Age	Young	103(19.7%)	198(37.9%)	301(57.7%)	0.37
	Older	84(16.1%)	137(26.2%)	221(42.3%)	
Employment status	Employed	118(22.6%)	214(41.0%)	332(63.6%)	0.85
	Unemployed	69(13.2%)	121(23.2%)	190(36.4%)	
Monthly income	Low	132(25.3%)	232(44.4%)	364(69.7%)	0.75
	High	55(10.5%)	103(19.7%)	158(30.3%)	
Place of residence	Rural	91(17.4%)	170(32.6%)	261(50%)	0.64
	Urban	96(18.4%)	165(31.6%)	261(50%)	
Socio-demographics		**Patronize patent medicine vendors Yes**	**No**	**Total 522(100%)**	**p-value**
Age	Young	257(49.2%)	44(8.4%)	301(57.7%)	0.14
	Older	178(34.1%)	43(8.2%)	221(42.3%)	
Employment status	Employed	272(52.1%)	60(11.5%)	332(63.6%)	0.25
	Unemployed	163(31.2%)	27(5.2%)	190(36.4%)	
Monthly income	Low	298(57.1%)	66(12.6%)	364(69.7%)	0.17
	High	137(26.2%)	21(4.0%)	158(30.3%)	
Place of residence	Rural	215(41.2%)	46(8.8%)	261(50%)	0.55
	Urban	220(42.1%)	41(7.9%)	261(50%)	

Table 6 shows the distribution of respondents by the implications of paying medical expenses through Out-of-pocket and the results show that some of the respondents forgo medical treatment (84.1%). A high proportion of the young respondents (49.8%), the unemployed (52.9%), low income earners (59.0%) and rural women (42.1%)had forgone medical treatment due to their inability to pay their medical expenses. Additionally, the study revealed that the majority of the respondents engage in self-medication (62.4%). Specifically, more of the younger respondents (36.4%), the employed (38.3%), the low salary earners (43.9%) and rural dwellers (38.1%) indulge in self-medication when sick due to personal expenses they will incur on medical services.

On patronizing roadside herbal drug sellers, young respondents patronize roadside herbal drug sellers (19.7%) more than their older counterparts (16.1%). A higher proportion of the employed respondents patronize roadside herbal drug sellers (22.6%) compared to those who were unemployed (13.2%). Low income earners who patronize road side herbal drug sellers were more (25.3%) than those who earned high income (10.5%). Those who reside in urban area were slightly higher (18.4%) than those who reside in rural area (17.4%).

On the practice of patronizing patent medicine vendors, almost half of the respondents, made up of the young women patronize patent medicine vendors due to their inability to pay medical expenses (49.2%). Also, the percentage of employed who patronized patent medicine vendors when sick was more than half of the respondent (52.1%). More of the low income earners patronize patent medicine sellers (57.1%). However, those who buy medicine from patent medicine vendors in the urban area were slightly higher (42.1%) than those who reside in the rural area (41.2%).

Discussion of findings

Out-of-pocket expenditure refers to any direct payment made by individuals or households for healthcare services, including tips and non-monetary contributions, aimed at improving health. This includes payments to healthcare providers, purchasing medications,

medical devices, and other goods and services geared towards improving health. These expenses are considered part of private health expenditure, representing the financial burden individuals bear for their healthcare needs beyond what is covered by insurance or public healthcare systems. This study examined the implications of healthcare payment through OOP health expenses on the health status of women in Enugu State, South East Nigeria. It was revealed that awareness of national health insurance is average while its utilization was poor. This implies that a significant proportion of healthcare spending among the women were carried out through Out-of-pocket medical expenses and burden borne by the individual at the time of illness. The study also found out that both awareness and utilization of national health insurance were more among the young women, the employed and low salary earners.

On the respondents' ability to access regular needed medical care, the result showed that only a few respondents (25.1%) were able to. However, the ability to access needed medical care were higher for the young women, the employed and high salary earners. Studies have shown that poorer populations tend to incur higher catastrophic health spending and seek no, or lower quality of health care than less-poor populations (Seeberg et al., 2013; Brown et al., 2014). This implies that poverty could make families to choose not to seek health care because they cannot afford to pay for their health care. Thus a study by Bintabara, Nakamura and Seino (2018) in Tanzania identified that women's health problem can be alleviated by improving uptake of health insurance scheme.

The implication of women not being able to access needed health care leads to forgoing medical treatment. The result shows that a high proportion of young women (84.1%) forgo medical treatment due to medical cost. However, the unemployed, low salary earners and rural women forgo medical treatment due to the cost of medical treatment. This result is similar to a study by Rezayatmand, Pavloma & Groot (2012) which found out that Out-of-pocket payment can decrease the use of preventive services and the taking up of preventive medication especially among the poor. Uninsured people find it difficult to afford needed medical care, prescription drugs, delay or forgo them because of cost (Kaiser Family Foundation, 2016). Also, women with minimal income may decide to forgo medical treatment, delay diagnosis of serious health problem or go without needed treatment which can leave them in poor health. A study by Gunja, Tikkanen, Seervai and Collins (2018) found out through a study carried out in United States that women have the greatest burden of chronic illness, highest rates of skipping needed health care because of cost, difficulty affording their health care, and are least satisfied with their care. Furthermore, a study by Dominic, Ogundipe and Ogundipe (2019) found out that the average income leads to a negative effect on women's health outcomes in Africa. This is as a result of the weak average income in Sub-Saharan African economies due to widening income inequality. A study by Fawole and Adeoye (2015) also found out that women who have influence over money earned, further improved use of skilled antenatal and delivery care.

Another consequence of user fee identified was self-medication which was found to be high (62.4%). This study revealed that a greater percentage of the younger respondents, the employed, the low income learners and those in rural areas indulge in self-medication. The study by Carrasco-Garrido, Hernández-Barrera, López de Andrés, Jiménez-Trujillo and Jiménez-García (2010) found out that the prevalence of self-medication is higher in women than men in Spain and this could be attributed to low income among others. Another study by Ebrahimi, Atashsokhan, Amanpour and Hamidzadeh (2017) found out that the prevalence of self-medication, in women who had become ill at least once was high at 63.9% before pregnancy and 43.5% during pregnancy. Variables such as lack of insurance and high school education also contributed to the use of self-medication before pregnancy amongst women. In addition, another study carried out in Iran byKarimy and Rezaee-Momtaz et al. (2019) found out that 76% of women studied had a history of self-medication and factors that predisposes them to self-medication were health insurance status and education level amongst others. Self-medication practice which involves the use of medication without the prescription of health care professionals results to a lot of side effects including drug resistance, drug side effects, health hazards and death.

This study equally revealed that women's inability to pay on the spot for their medical expenditure could lead them to patronize roadside herbal drug sellers (35.8%). The study

found out that the proportions of young respondents, the employed, low income earners and urban dwellers who patronize road side herbal drug sellers were higher. In a similar study carried out by Nyeko, Tumwesigye, and Halage (2016) it was revealed that it was common for pregnant women in Gulu District to use herbal medicines and this was attributed to poor access to conventional western healthcare.

Patronage of patent medicine vendorswas also identified as an alternative in situations where women are not able to afford health care expenses. The result shows that 83.4% of the women surveyed patronize patent medicine dealers when sick. Those which the study identified that patronize patent medicine vendors mostly were the young women, the employed, low income earners and those who reside in urban areas. The implication is that they buy medicine off the shelves without proper diagnosis and treatment by qualified medical personnel.

Conclusion

The practice of out-of-pocket payments for healthcare services poses significant implications for the health status of women who are not insured in any health insurance scheme. The major aim of health insurance is to reduce the risk of high healthcare expenditure. Despite efforts to improve healthcare access, the reliance on direct payments at the point of service utilization introduces several challenges. These challenges include financial barriers that disproportionately affect individuals, potentially leading to delayed or foregone care, self-medication, patronizing roadside herbal vendors and patent medicine sellers, inadequate treatment, and adverse health outcomes. Furthermore, the regressive nature of out-of-pocket expenditures on women, female headed families and poor families may exacerbate existing disparities, widening the gap in healthcare access and outcomes between different socioeconomic groups. Understanding the specific implications of out-of-pocket payments on the health status of women in Enugu State, Nigeria is crucial for designing targeted interventions and policies to alleviate financial burdens and improve healthcare equity in the state.This study recommends that policy makers should have a rethink about making National Health insurance available to all Nigerians irrespective of their gender, area of residence, employment status, income level and age. This study also advocates for a reform of the health sector to protect women from the burden of medical expenditure.

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