OVERVIEW

The *Jamaica Survey of Living Conditions* (*JSLC*), which has been conducted annually since 1988, is a joint effort of the Planning Institute of Jamaica (PIOJ) and the Statistical Institute of Jamaica (STATIN). It offers a unique opportunity to assess the socio-economic and demographic situation of the Jamaican population and to examine trends. Ever since its establishment, it has become the leading tool for the monitoring and evaluating of national social policies, for measuring the standard of living of the Jamaican people and for informing policy, especially those policies that will effectively target the "at risk" and needy in the population.

The data for this report were collected using the standard survey design of a 1.0 per cent sample of households, administered using face-to-face interviews during the period May to August 2006. The sample is selected by multi-stage stratified sampling with the first stage being the selection of areas, enumeration districts (EDs), then the selection of households. This sampling method is administered for the Labour Force Surveys of which the JSLC sample is a subset. The advantage of this method is that the two datasets can be linked to facilitate an integrated analysis. This methodology is robust and consistent with international practice.

The 2006 report provides an assessment of Demographic Characteristics, Household Consumption, Health, Education, Housing and Utilities, and Social Welfare and Related Programmes, and examines trends during the period 1996 to 2006. A special module on remittances is included in the report. The findings are presented, by region: Kingston Metropolitan Area (KMA), Other Towns and Rural Areas; by population consumption quintile which divides the population into five groups based on their annual per capita expenditure; by sex of household head; and by age and sex of the individuals where appropriate. The body of the report discusses the major findings in each area and detailed information is found in the Standard Tables.

The findings show some positive trends in the standard of living. The demographic structure continued to shift towards an optimal position in which the age dependency and the household size are relatively low. Real mean per capita consumption continued its upward trend. The incidence of poverty was at its lowest since the inception of the survey and the gap in per capita expenditure of female-headed and male-headed households narrowed. Universal enrolment of children up to 11 years of age continued in 2006. The prevalence of illness has remained stable but more ill persons sought health care. The Programme of Advancement Through Health and Education (PATH) recorded progressive targeting of those most in need with a relatively high level of compliance among the recipients. There has been general improvement in housing conditions, as measured by the Housing Quality Index (HQI). Remittances continued to contribute to household expenditures among all socio-economic groups. Altogether, the above findings are indicative of enhanced well-being of the population.

In spite of the observed improvements, there are still issues of concern. For example, the disadvantaged, as measured by per capita expenditure, continued to record higher age dependency ratios and larger household sizes; lower levels of enrolment at the upper levels of education and lower levels of school attendance at both primary and secondary level; and lower levels of seeking health care. Ongoing initiatives instituted to address these problems e.g. PATH, and NI Gold, along with other new, carefully targeted interventions should impact positively on the target population. Additionally, continued low inflation and sustained economic growth should contribute to improved socio-economic status of the Jamaican population.

Demographic Characteristics

The demographic structure of Jamaica's population continued to record decreases in fertility and mortality. In 2006, the proportions of its working age (15–64 years) and dependent elderly (65+ years) increased and the proportion of those in the under 14 age group declined. The net effect of these changes is a decline in the total age dependency ratio. This decline places the country in a favourable economic position. However, this situation is transitional and its reversal is expected to commence in about 20 years. In spite of the demographic ageing of the population, it is still relatively young, with approximately one-third being less than 15 years old.

In 2006, the Age Dependency Ratio (ADR) was 69.5, declining from 72.7 in 2005 and from 76 in 1996. While declines were observed in all three regions, Rural Areas continued to record the highest age dependency ratio as a result of a higher proportion of children 0–14 years. On the other hand, the proportion of persons in the working age group in the Rural Areas is lower than in either KMA or in Other Towns. These trends reflect higher fertility rates in the Rural Areas accompanied by migration of persons in the working age group to urban areas.

At the national level, the mean household size was 3.3 persons in 2006, declining from 3.8 in 1996. However, no decline was observed for female-headed households in Rural Areas, where mean household size was 4.1 and has not declined since 1996. This compares with a mean household size of 2.7 for male-headed households in KMA, which declined from 3.3 in 1996. Female-headed households, which accounted for 46.7 per cent of all households, continued to record a greater mean number of children and adult females compared with those headed by males. Male-headed households, on the other hand, continued to record a greater mean number of adult males.

Household size, headship and composition are commonly associated with consumption status. These associations were observed in JSLC 2006. Households in the poorest consumption quintile were larger than those in the wealthiest quintile. Only 21.5 per cent of households in the poorest consumption quintile had 2 persons or fewer compared with 68.4 per cent in the wealthiest quintile. At the other end of the spectrum, 51.8 per cent of households in the poorest quintile had a household size of five persons or more compared with 6.6 per cent of households in the wealthiest quintile. By sex of household head,

mean household size was largest in female-headed households across all quintiles compared with the mean household size for male-headed households. Female-headed households were also more concentrated in the poorest quintiles. The proportions of single-member households were highest in the wealthiest quintile and this was more evident for single male households.

Household Consumption

JSLC determines the per capita consumption as a proxy for income and as a measure of the welfare of the Jamaican population. Data collected on household expenditure, home production, remittances and gifts during specific reference periods are annualised to provide an estimate of total annual consumption and per capita consumption (see technical notes in Appendix).

In 2006, the mean per capita consumption at current prices was $139 595, with the KMA being the highest at $178 350 followed by Other Towns $147 068, and Rural Areas reporting the lowest at $109 978. Nationally, there was an increase of 2.2 per cent in the real mean per capita consumption level. This increase was only reflected in Other Towns and Rural Areas, as the KMA registered a decline of 2.0 per cent. Households continued to allocate the greatest proportion of their consumption to Food & Beverages regardless of quintile level, but the proportion allocated decreased as consumption quintile increased and, over time, the share has been declining. Real mean household expenditure on Education declined in 2006, a trend that has been observed since 2003, which may indicate the support provided by both the public and private sectors. While there were reductions in Health Care expenditure in the KMA and Rural Areas, Other Towns showed an increase. This may reflect the fact that there was an increase in the proportion of persons 65 years and over in Other Towns and older persons spend more on health care. The KMA experienced a decline of 16.4 per cent in Transportation expenditure, while there was a relatively small increase of just over 3.0 per cent in both Other Towns and Rural Areas. Related to this contrasting change may be the fact that transportation fares in KMA are under greater regulation than in other parts of the country and no increase was granted in 2006.

There was an increase in the level of consumption inequality in 2006 as measured by the GINI Coefficient which was 0.3826 compared with 0.3810 in 2005, thereby reversing the gain made in 2005. Based on consumption expenditure, the welfare of female-headed households was lower than that of male-headed households. However, there was a reduction in the level of gender-based consumption inequality, as a larger percentage of female-headed households moved into the middle and upper consumption levels.

In 2006 the incidence of poverty nationally was 14.3 per cent, showing little change when compared with 14.8 per cent in 2005. However, over the past 10 years, poverty levels have declined substantially. The Rural Areas continued to record the highest levels of poverty, being approximately double those of KMA and Other Towns. The majority of poor persons (65.7 per cent) lived in Rural Areas.

Health

The health situation of the Jamaican population is assessed based on the prevalence of self-reported illness, along with health service utilisation and expenditure. The immunisation and nutritional status of children less than five years is also examined.

The health status of the population has remained stable over the past five years, with the percentage of persons reporting illness during the reference period for these years fluctuating between 11.0 and 13.0 per cent. In 2006, the percentage of persons reporting illness was 12.2 per cent. Regionally, KMA reported the lowest prevalence of illness/injury (9.6 per cent) followed by Other Towns (11.4 per cent) and Rural Areas the highest (14.4 per cent). In every year of the JSLC, the elderly and the young, females and people living in rural areas have reported the highest percentages of illness/injury. The mean duration of illness was 9.8 days with no major change being noted in the duration of illness compared with previous years. Persons living in Other Towns and Rural Areas were, on average, ill for 2.0 days more than those in the KMA. Likewise, for persons in the poorest two quintiles the mean duration of illness was over 11.0 days compared with 8.4 days for persons in the two wealthiest quintiles. The mean days of impairment fell to 4.8 days in 2006 from 6.0 days in 2004.

In 2006, 46.5 per cent of persons reporting illness stated that it was due to a chronic disease, with hypertension accounting for the majority of these complaints. As expected, the elderly were disproportionately represented with the highest percentage of ill reporting a chronic disease in the 65 years and older age group (77.0 per cent). More women than men reported having diabetes, hypertension and arthritis, while more men reported having asthma. Fewer persons in the Rural Areas reported that their illness was due to asthma but more reported that it was due to diabetes.

Generally speaking, the percentage of ill who seek health care has increased annually since the inception of the JSLC, and 2006 was no different. Among those reporting illness, 70.0 per cent sought health care representing an increase of 5.0 percentage points compared with 2004, and over 10.0 percentage points since 1996. However, there are still significant disparities in health-care seeking behaviour by region and consumption quintile, with persons in KMA and those in the wealthiest quintiles having higher rates of health-care utilisation.

The proportion of persons who were ill, but did not seek care because they could not afford it, remains high at 22.2 per cent. Implementation of the Ministry of Health's Policy regarding no denial of health care on the basis of an inability to pay, needs to be evaluated as the poorest quintile reported the highest percentage of those who were ill but could not afford to pay for health care. Home remedies emerged as an important reason for not seeking treatment.

Between 2004 and 2006 there was an increase to 52.8 per cent by those seeking health care in private facilities, while use of public facilities declined to 41.3 per cent, and the

remainder using both also declined. Private sector usage was highest among persons living in Other Towns and the KMA, and among persons in the wealthiest quintile. The changes noted in the use of public vs. private facilities can be explained by the differentials in public and private health-care expenditures. While real expenditure on public health-care visits increased to $62 in 2006 from $41 in 2004, by contrast there was a reduction in the expenditure on private visits to $101 from $191 over the same period, leading to a narrowing of the gap between private and public health-care expenditures.

The majority of persons procured medication from private pharmacies as opposed to public pharmacies, with 15.9 per cent purchasing from the latter. This highlights the issue of inadequate access to pharmaceuticals in public health facilities, which may result from a complex problem of insufficient and irregular drug supply and scarce resources (staff and infrastructure). A workable mechanism needs to be found to address this issue.

Health insurance coverage was 18.0 per cent in 2006. While this was not different from 2004, it is approximately 6.0 percentage points higher than in 2002. New health initiatives such as the NI Gold insurance for NIS retirees are likely to have contributed, at least in part, to this increase. In spite of this, differentials in health insurance coverage are startling. Only 8.5 per cent of those in the poorest quintile have insurance coverage compared with 35.0 per cent of persons in the wealthiest quintile and coverage in KMA (24.0 per cent) was 10.0 percentage points higher than that of Rural Areas. Moreover, patterns of coverage were similar to usage patterns. In other words, individuals are more likely to seek health care if they have insurance coverage. Therefore health insurance may be an important factor in health-care utilisation.

Immunisation coverage remained high, at over 90.0 per cent except in the cases of the recently introduced HepB and Hib vaccines, where coverage was 48.6 per cent and 59.7 per cent respectively. The trend of decline in immunisation observed in 2004 continued in 2006. More effort is needed to achieve the immunisation target of 100.0 per cent. Increased coverage of the HepB and Hib vaccines is needed to reduce susceptibility of the Jamaican public to these diseases.

Education

Education of the Jamaican population is examined using indicators of access, equity and quality. Universal access to schooling of children aged 3–11 years as well at the first cycle of secondary level education, has been achieved, as is evident from the absence of significant differences in enrolment by geographical region, quintile or sex of child. At the second cycle of secondary education, catering for adolescents aged 15–16 years, enrolment was lower with 11.7 per cent of this age group being out of school. This is in part due to the fact that All Age and Primary /Junior High Schools end at Grade 9, resulting in the termination of formal schooling for some students aged 15 years. At the second cycle of secondary level education, differentials were observed with more children in the Rural Area, from the poorest quintiles and boys being out of school. Similar differentials in enrolment were also observed at higher levels of education but the gaps were even wider at these levels. For example, male:female enrolment was 1:3

among teenagers 17–18 years, while the association with Consumption Quintile was especially evident among tertiary level students, with 2.2 per cent of the poorest compared with 20.0 per cent of the wealthiest being enrolled.

The high levels of enrolment were not matched by the attendance rates observed for the 20-day period. Full attendance was 71.9 per cent at the primary level and 73.8 per cent at the secondary level, representing declines compared with 2004. Analysis by geographic region revealed that students in Other Towns had higher rates of attendance (82.4 per cent) than that in the KMA and Rural Areas, i.e., 72.4 per cent and 69.3 per cent respectively. There was also a direct relationship between consumption status and attendance, with 58.0 per cent of the poorest attending for the entire reference period compared with 84.7 per cent for the wealthiest. Females were more likely to attend school for all reference days, averaging 75.7 per cent compared with 69.7 per cent for males. It is noteworthy that for the first time in the history of the JSLC, "Money Problems" were not cited as the main reason for non-attendance; this being replaced by "Running Errands".

The Cost Sharing Scheme at the secondary level was enhanced with government paying one half of tuition fees across the board. There was an increase in the proportion of parents recording full compliance in school fee payments, indicating the affordability of the lower fees to more parents. Overall, there was a reduction by 6.5 per cent in real expenditure on education, which was $3 391.82 in 2006 compared with $3 629.36 in 2004. This reduction on education is attributable not only to the improved Cost Sharing Scheme but also to subsidies on Exam Fees provided by both government and the private sector. The effect of government's support was also reflected in the difference in expenditure for households with children attending private secondary schools ($70 789.17) compared with those with children in public secondary schools ($9 319.95).

The two compensatory programmes—Text Book and School Feeding—achieved some level of success with 66.9 per cent of students owning all their texts and 68.0 per cent being beneficiaries of school feeding programmes. However, benefits of the school feeding programme were regressive as more children from the wealthiest households accessed the provision compared with those from the poorest households.

The education sector has had substantial achievements in ensuring access to education for children at the preschool, primary and secondary levels of education. However, equitable distribution of educational resources remains a serious challenge to the sector as marked differences by geographical region, consumption quintile and sex, exist.

Housing

Adequacy of housing is examined based on housing stock and amenities, and housing expenses. Overall, there was general improvement in housing indicators in 2006.

The vast majority, 78.6 per cent, of Jamaican households lived in detached units but this is not necessarily an indicator of acceptable housing conditions. Based on the international standard that the accepted number of persons per habitable room is 1 to

1.01, a considerable proportion of Jamaica households (50.0 per cent) live in overcrowded conditions.

The percentage of households living in their own home has remained relatively unchanged since 1996. Nationally, 60.5 per cent of households owned the units in which they lived. Owner Occupied housing was highest in the Rural Areas, at 67.8 per cent and lowest in the KMA (47.8 per cent). It should be noted that ownership of house does not always mean ownership of the land on which the unit is constructed. Therefore, some homeowners may actually be squatters. However, land ownership has not been probed by the JSLC.

In terms of water provision, 67.8 per cent of households had piped water in 2006, but Indoor Taps remained at very low levels with more than one half of the households in Jamaica having no access to this facility. Considerable proportions of households shared their water facilities, relied on public standpipes, and travelled long distances to obtain water. Although more than half of Jamaican households (57.2 per cent) had Exclusive Use of Water Closets, 33.3 per cent used pit latrines. Rural Areas had the lowest levels of access to adequate water supply, toilet facilities, and electricity despite showing increases in the proportion of households with these amenities.

The HQI, which has been used to measure the status of the quality of housing in Jamaica, has made steady gains, moving from 58.5 in 1996 to 67.3 in 2006. However, some important indicators have remained relatively unchanged over the period. Regionally, progress was made only in the Rural Areas between 2004 and 2006 while the HQI for the KMA and Other Towns remains relatively unchanged. A decline in use of Indoor Taps in the KMA and a decline in the proportion of households having one person or less per habitable room in Other Towns were the main components which contributed to the negligible gains made in the HQI in those regions.

Expenditure data indicate that, with the exception of mortgages, there was an increase in real terms in all shelter-related household expenses between 2004 and 2006. The JSLC 2006 concludes that, at a broad macro level, gains have been made in the housing sector over the past ten years. However, there are some persistent and emerging gaps at the regional level which require sustained action if liveability in Jamaica's human settlements are to be improved.

Social Welfare

As an important part of the study of Jamaican living conditions, the JSLC examines the experiences of households which have sought assistance from governmental programmes that provide social welfare. In 2004, for the first time, the JSLC assessed Jamaican household experiences in relation to the Programme of Advancement through Health and Education, PATH, which was introduced islandwide in 2002.

The PATH continued to be very progressive, with 78.0 per cent of beneficiaries belonging to Quintiles 1 and 2. Fewer persons from Quintiles 3 to 5 applied for PATH benefits and higher proportions of applicants from Quintiles 1 and 2 reported receiving the PATH benefit.

Over one-quarter of all child beneficiaries (28.9 per cent) had, at some time, experienced loss of benefits or missed payments of their PATH benefit. Non-attendance of children at school was given as the main reason for loss of benefit.

The administration of the programme appeared satisfactory with few difficulties reported in the receipt of benefits; indeed, 97.3 per cent of all beneficiaries stated no difficulties in receiving benefits. The main difficulty mentioned by the remaining 2.7 per cent was that the PATH cheque did not arrive at the Post Office at the expected time.

Remittances

The importance of international remittances to Jamaica prompted a more expansive module on international remittances in the JSLC 2006. Information was obtained on the characteristics and behaviour of those who are remitters and recipients and how the remitter–recipient relationship impacts on the frequency and amount of remittance sent. In 2006, 45.3 per cent of Jamaican households received remittances. In per capita terms, the value of remittances was J$45 069 or US$700.4 per annum. Barring pension and contributions from organisations abroad, the largest source of remittances was spouses who live abroad and this was consistent for both Money and Goods received. However, the majority of remittances of all types were sent by Other Relatives who live abroad (26.8 per cent).

More households in KMA received remittances followed by Other Towns and Rural Areas, but the KMA had the lowest per capita remittances ($31 786), while Other Towns had the highest ($85 690). By Quintile, the percentage of households receiving remittances rose gradually from 30.4 per cent in the lowest quintile to 54.9 per cent in the highest. Mean per capita remittances also increased progressively from the poorest quintile ($19 338) to the wealthiest quintile ($63 896).

In general, female-headed households received more remittances than male-headed households. Remitters were also primarily female. These, together with the fact that household heads were the main recipients of remittances, imply that extended family relationships were a central feature of the remittance flows.

Remittances of money were received mostly on a monthly basis, while goods were received yearly and occasionally. The monthly frequency of money remittances is in keeping with the use to which these funds were put, as the majority of households (68.7 per cent) stated that the remittance was largely for day-to-day expenses. Next in frequency were education and health, for approximately 10.0 per cent of households each; investment, savings or any other improvement of assets was stated by approximately 5.0 per cent of households.