

OVERVIEW

The *Jamaica Survey of Living Conditions (JSLC)* is an annual report on the standard of living of the Jamaican people. It has been conducted since 1988 and this is its twentieth year of providing a perspective on the well-being of the population. The JSLC is a subset of the Labour Force Survey (LFS) and this, therefore, allows for integrated analysis and linkages between the JSLC and the LFS. As is standard practice for the regular JSLC surveys¹, the sample used was one-third of the households in the Labour Force Survey, that is 0.33 per cent of all households islandwide, and the questionnaire was administered using face-to-face interviews over the period May–August, 2007

The 2007 report presents the standard of living and status of Jamaican households and individuals for the year 2007 and examines trends for the period 1997–2007. The topics are: Demographic Characteristics; Household Consumption; Health; Education; Housing; and Social Welfare and Related Programmes. The findings are disaggregated by region (the Kingston Metropolitan Area (KMA), Other Towns and Rural Areas); by population consumption quintiles (Quintile 1 being the poorest and Quintile 5 being the wealthiest) based on annual per capita expenditure; by sex of head of household; and by age and sex of individuals where applicable.

This issue also looks at the prime working age. The prime working age is defined as the age range 20–59 years as distinct from the working age, 15–64 years. It must be noted that the definition of the prime working age differs from working definitions proffered by the International Labour Organization (ILO), for example, which utilizes 25–54 years.

Overall, the findings of the 2007 survey indicated positive trends and improvements in the standard of living or well-being of the Jamaican population. The demographic structure is in a relatively favourable position as the age dependency ratio and mean household size continue to decline. Real per capita consumption continued to increase, consistent with the trend of the past 10 years. There was a reduction in the level of consumption inequality as well as gender-based consumption inequality. The incidence of poverty continued to decline and reached its lowest level over the past 20 survey years. The Housing Quality Index has improved indicating a relative improvement in housing conditions over 2006 as most of the indicators improved.

Reported illness/injury increased, but also health-seeking behaviour improved as well as those possessing insurance coverage. The impact of the removal of user fees for children in 2007 was not captured by the survey, as the policy change occurred at the time of data collection. There was improvement in enrolment at all levels of the education system. The out-of-school population in the 12–16 years age group declined. There was

¹ The regular JSLC uses a sample of 0.33 per cent of households, but this is increased to 1.0 per cent periodically to enable the production of estimates at the level of the parishes. This increase was done in 1998 and 2002. Note should be taken of the fact that the 2006 report incorrectly stated that the sample size in 2006 was 1.0 per cent of households.

also improvement in the academic achievement of the 35–59 years cohort as well as a decline in the percentage of uncertified workers.

The Programme of Advancement Through Health and Education (PATH) targeted those it was designed to assist most—the poorest children and the elderly—with a relatively high level of compliance by all beneficiaries.

Taken in totality, the findings of the survey indicate that the well-being of the population continued to improve and that the year 2007 had a number of notable achievements compared with the previous 10-year period 1997–2006. It must, however, be noted that these findings are for mid-2007 and do not reflect the impact that the rising food prices has had on vulnerable groups since the latter part of 2007.

While the improvements augur well for the continued well-being of the population, there are important issues which, if addressed effectively, can further enhance the living conditions of the population especially given the goal of Jamaica achieving developed country status by 2030. Female-headed households in Rural Areas have not recorded a decline in mean household size over the period 1997–2007 and these households consistently had a greater mean number of children compared with those headed by males. Additionally, female-headed households were more prevalent in the poorest quintiles. Given the onset of rising food prices, these vulnerable groups are precariously placed and their well-being/ living conditions can easily worsen.

With regard to the education sector, persistent disparities exist in terms of geographical region, consumption quintiles and by sex at the secondary and tertiary levels. Levels of attendance were below national targets at the primary and secondary levels of the education system.

Health security for the poor is also important given the association between quintile and insurance coverage- the poorer the quintile level of the individual, the lower the likelihood of insurance coverage. While the public health-care system has greatly enhanced the affordability of drugs, it also needs to better facilitate the access and availability of these drugs.

Attention needs to be paid to general housing conditions in the Rural Areas given the decline relative to 2006. Nationally, the prevalence of soak-away pits instead of households being linked to waste water treatment facilities remains too high and has serious implications for the pollution of fresh water and access to potable water. This concern is especially important for Rural Areas which has the highest prevalence of these pits and are most dependent on untreated fresh water. The use of soil absorption systems should be employed as a preventative measure to mitigate potential health hazards. The low level of insurance coverage among homeowners, given the context of proneness to natural disasters, does not lend itself to recovery from the events and places a greater burden on the state.

With regard to social welfare/social assistance, the data show that PATH continues to be well targeted, and has a good representation of children and the elderly. However, there are obstacles to overcome in reaching persons with disabilities and pregnant and lactating women. Issues of leakage to the wealthier quintiles and under-coverage of the poorest are also highlighted.

DEMOGRAPHY

Jamaica is undergoing a demographic transition known as population ageing. This is a confluence of decreases in both fertility and mortality which have reduced the natural rate of increase. While the working-age population (15–64 years) and the elderly dependent (65+ years) are on the increase, as a share of the total population, those in the age group 0–14 years are declining. These simultaneous changes have resulted in a decline in the total age dependency ratio (ADR). While this decline is an opportunity for the country to consolidate its social and economic gains and leverage these to engender economic growth and prosperity, this relatively lower age dependency ratio will be reversed by 2030. The ADR declined from 73.0 per 100 in 1997 to 66.4 per 100 in 2007. Overall, the Rural Areas continued to have the highest age dependency ratio.

Of interest is the fact that while the elderly are considered as dependents, they have high levels of household headship (67.3 per cent) evident in all regions and quintiles. This has been the pattern since 1997. Household size, headship and composition have maintained certain associations over the life of the survey. The households with the largest size have been, predominantly, in the poorest quintiles, in Rural Areas or headed by females with a large number of children.

HOUSEHOLD CONSUMPTION

Mean per capita consumption in 2007 at current prices was \$165 761. As in previous surveys, the KMA had the highest mean per capita consumption followed by Other Towns and the Rural Areas. For All Jamaica, real mean per capita consumption increased by 10.3 per cent. All regions recorded increases with the KMA recording the largest increase (14.4 per cent), followed by Other Towns (11.9 per cent) and Rural Areas (3.6 per cent).

Nationally, Food & Beverage represented the largest proportion of household expenditure, followed by Housing & Household expenses, then Transportation. However, the proportion on food decreased with increasing consumption quintile even though in absolute amounts expenditure on this commodity was highest in the highest quintile. This is indicative of the disparities existing between the poorest and wealthiest quintiles. The commodity which received the smallest share of consumption expenditure in all regions was Recreation.

Consumption inequality in 2007, as measured by the Gini coefficient (0.3675), was at its lowest ever for the period 1997–2007. Gender-based consumption inequality also declined as more female-headed households consumed in the \$500 000 to \$999 999 per capita range.

Nationally, there was a decline in the per cent of households receiving remittances (3.5 percentage points). While the KMA and Rural Areas registered declines there was an increase in the proportion of households receiving remittances in Other Towns. Consistent with the pattern observed in previous years, the proportion of households receiving remittances was positively associated with increasing socio-economic status. A higher proportion of female-headed households, compared with male-headed households received remittances and this relationship was consistent with previous years.

During the period 1997–2007, the prevalence² of poverty declined from 19.9 per cent to 9.9 per cent. In 2007, poverty was 4.4 percentage points lower than in 2006. The prevalence of poverty in 2007 is the lowest it has been since the inception of the **JSLC**. Other Towns had the lowest prevalence (4.0 per cent) followed by KMA (6.2 per cent). Rural Areas continued to record the highest prevalence of poverty (15.3 per cent) and as a result, the majority of poor persons (71.3 per cent) lived in the Rural Areas. Other Towns showed the greatest decline between 2006 and 2007, followed by Rural Areas and the KMA.

HEALTH

Health conditions in the Jamaican population were assessed based on the prevalence of self-reported illness/injury, health service utilization, health insurance coverage and real mean expenditure on health care during the four-week reference period. Immunization coverage for children 6 to 59 months and the nutritional status of those under 5 years, is also examined.

The proportion of respondents reporting illness/injury increased by 3.3 percentage points to 15.5 per cent. The increase was highest in Rural Areas. There was little difference across quintiles as the proportions reporting illness ranged from 14.5 per cent for Quintile 2 to 16.1 per cent for Quintile 4. There was a greater percentage of self-reported illness among females and among the age cohorts 0–4 and 50 +.

Over the 10-year period, 1997 to 2007, there has been a general increase in the percentage reporting illness/injury. Increases have been recorded across all regions, quintiles, age and sex to varying degrees. The reasons for these increases are not known but may be due to heightened awareness of health and health issues among the population and/or increases in the prevalence of chronic diseases.

There has been an overall upward trend in those seeking care between 1997 and 2007, increasing to 66.0 per cent in 2007, from 58.1 per cent of those ill/injured in 1997. In 2007, however, there was a decline of 4 percentage points relative to 2006. The proportion seeking health care exclusively in the public sector increased but declined for the private sector and for those seeking care from both public and private facilities.

² In previous editions the term “incidence” was used. The term “prevalence” in this issue refers to the incremental change in poverty for a given period.

However, it was still higher in the private sector. Utilization of the public health sector is also inversely related to increased socio-economic status as more people in the lowest consumption quintile sought care through the public sector. The reverse is true for the private sector.

The private sector continued to be the preferred choice for purchasing medication, and actually increased its market share in 2007. This was probably due to the non-availability of drugs in the public sector as expenditure on medication in the private sector increased while it decreased in the public sector. The proportion that was hospitalized declined over the 10-year period in both the public and private sectors.

The KMA and Quintile 5 had higher percentages of persons seeking care. While the Rural Areas had the highest percentage reporting illness, it must be noted that this region had the smallest percentage seeking care. This is within the context of the Rural Areas having the lowest insurance coverage of all three regions.

There was a decline by 2.5 percentage points in those who indicated that they could not afford to seek care. However, a larger percentage of respondents (8.2 percentage points more) indicated that they did not seek care because they were not ill enough.

The level of chronic illnesses as a percentage of reported illness is a cause for concern; KMA had the greatest proportion of those ill with chronic illnesses of all the regions. There was no pattern by quintile, however, a greater percentage of females reported chronic illnesses.

Health insurance coverage is extremely important because it impacts on health-seeking behaviour both in terms of visits and purchase of drugs and is a critical determinant of access to health care. Over the past three survey years—2004, 2006 and 2007—health insurance coverage has increased steadily from 18.4 per cent to 21.2 per cent. Of the three regions, KMA has had the greatest improvement and maintained the highest coverage. As socio-economic status increased, the proportion of each quintile that had insurance coverage increased.

In relation to children, there was improvement in immunization coverage between 2006 and 2007 with the exception of measles which declined. The nutritional status of children, 0–59 months, also improved for all indicators with the exception of over-nutrition. The impact of the removal of user fees for children accessing health care from the public sector was not fully captured in this survey as the fees were removed in May 2007, while the survey was being conducted.

With regard to the elderly, since illnesses associated with age become more prevalent for this group, it would be expected that more of the elderly would report illness/injury; this stood at 42.0 per cent. Of those reporting illness/injury 72.0 per cent sought care and 75.1 per cent had a chronic illness. Some 27.8 per cent had health insurance coverage which is the only indicator of health status on which the elderly fared better than the general population.

Overall, there has been an increase in those reporting illness/injury in all regions, as well as improvement in health-seeking behaviour. All the quintiles favoured the private sector over the public sector for visits and medication. Health insurance coverage has increased though more so in the KMA. The immunization coverage and nutritional status of children has also improved.

EDUCATION

The educational status of the Jamaican population is examined through the use of access and equity indicators. The two access indicators are enrolment and attendance of the school-aged population, 3–24 years. Equity is measured by three indicators: Household Expenditure on School and School-related items; Participation in the School Feeding and Textbook Programmes; and Distance and Mode of Travel to School by School Type and Consumption Quintile.

Universal access for children aged 3–11 years has been achieved with gross enrolment rates of over 99.0 per cent, and no differences by consumption quintile, sex, or geographic region. In terms of age appropriate or net enrolment rates, the first cohort (3–5 years) and the second cohort (6–11 years) achieved 91.7 per cent and 90.9 per cent, respectively.

At the first cycle of secondary level education, there was a gross enrolment rate of 99.8 per cent; age appropriate or net enrolment, however, was 77.6 per cent as some of the cohort was still at the primary level of education. There were no differences by consumption quintile, sex, or geographic region but at this level, females represented the majority of those enrolled (51.3 per cent).

There was a 4.7 percentage point increase to 93.0 per cent gross enrolment rate at the first stage of the second cycle of secondary education which caters to those aged 15–16 years. It is at this stage of the education system that associations between enrolment and consumption quintile, geographical region and sex become evident. Children from the wealthiest quintile, from the KMA and females had the highest enrolment rates.

Improvement in enrolment was also reflected at the second stage of the second cycle of secondary education as enrolment within the 17–18 years age group saw a 7.4 percentage point increase over 2006 to 53.3 per cent (gross enrolment rate). Differentials were also obvious at this level by geographical region, consumption quintile and sex, with the KMA—the wealthiest quintile and females having higher enrolment.

Of special interest is the disparity between male and female enrolment in All-Age and Primary & Junior High Schools: Males outnumbered females 2:1 in these three-year type secondary schools as a result of their inferior performance on the Grade Six Achievement Test (GSAT).

For the 20-day reference period of the survey, there was slightly improved attendance at the primary level, but no change at the secondary level of the educational system. The geographic, socio-economic status and sex disparities in enrolment were also apparent in relation to attendance. The main reason for non-attendance was “Money Problems,” which is consistent with the trend since 1988, although in 2006, this reason was replaced by “Running Errands.” “Money Problems,” as a reason for non-attendance, was more prevalent in the poorest quintiles and Other Towns in 2007, while the wealthiest quintiles indicated “Illness” as the reason for non-attendance.

In 2007, students were travelling longer distances to school, particularly at the secondary level and in the Rural Areas.

An important determinant of quality of education is the ownership of the required textbooks. However, while the Government provides the key required texts at the primary level at no cost to the beneficiary, teachers generally specify additional texts as necessary. Some 70.1 per cent of children at the primary level and 73.1 per cent at the secondary stated that they had all the texts required by the school. An examination of students possessing the required texts by socio-economic status and by geographical region reveals that 53.0 per cent of the poorest have the required texts compared with 91.7 per cent of the wealthiest; and children in the Rural Areas are less likely to have all their textbooks (66.7 per cent) compared with their peers in the KMA (77.2 per cent).

The School Feeding Programme (SFP), while being a mechanism to improve access to education by increasing regular attendance and enhancing students’ nutritional intake, continued to be regressive as more of the wealthiest quintile (55.3 per cent) accessed the programme than their counterparts in the poorest quintile (40.1 per cent). This occurred in spite of the fact that students from Rural Areas were more likely to participate in the SFP (78.0 per cent) compared with their peers in Other Towns (60.1 per cent) and the KMA (58.9 per cent).

Since 2002, Education’s share of total consumption has declined consistently from 8.5 per cent to the current 4.5 per cent. The decline in 2007 belies the reality of increased expenditure on school and school-related expenses in both real and nominal terms, the former increased by 11.2 per cent and the latter by 17.6 per cent. The top four school and school-related expenditures continued to be (in nominal prices): Lunch & Snacks (\$23 912.13); Transportation (\$14 799.62); Extra Lessons (\$14 376.37); and Tuition (\$10 595.31).

The out-of-school population in the 12–16 years age group decreased as a share of the cohort by 2.7 percentage points. The profile of this group continued to reveal distinct dynamics; they were predominantly from Rural Areas (63.2 per cent), in the two poorest quintiles (73.7 per cent), and disproportionately male (64.3 per cent). It is significant that the majority of this group had reached the terminal grade in Primary/Junior High, or All-Age Schools, which are predominantly in the rural areas.

Overall, there has been improvement in the education sector. Universal enrolment remains an achievement to maintain. The out-of-school population in the 12–16 years age group is declining. However, disparities by geographical region and consumption quintiles and sex persist. More needs to be done to ensure that programmes that are implemented by the Government to enhance both access and equity in the education sector benefit the neediest.

HOUSING

Housing is evaluated within the context of both quantity of housing units or housing stock and quality of housing. This is undertaken through an analysis of selected components that determine the housing stock; selected indicators which comprise the Housing Quality Index (HQI); and access to social amenities. Household expenditure is also assessed. In 2007, approximately 80.0 per cent of Jamaican households lived in separate, detached housing which has been the dominant type of housing in Jamaica in all regions and quintiles over the past decade. This type of housing was more noticeable in Rural Areas (92.2 per cent) and Other Towns (83.4 per cent) compared with the KMA (63.4 per cent), and was more evident among the poorest quintiles.

The international standard is 1 to 1.01 persons per habitable room and in 2007, 51.2 per cent of Jamaican households met this standard. Rural areas and the poor quintiles had smaller percentages of households meeting the standard.

There has been an increasing trend toward home ownership between 1997 and 2007, as Quintiles 1, 2 and 5 recorded increases of between 8.0 and 8.7 percentage points over the 10-year period. However, home ownership was highest among the poorest households, and the oldest age group.

Over the decade, also, there has been an increase in household dwelling types that are Rent-free (to 19.0 per cent in 2007) and a corresponding decrease in those Rented/Leased (to 20.7 per cent in 2007).

A majority of Jamaican households (70.2 per cent) had access to Piped/Tap water to dwelling and/or yard in 2007 and this has moved from 66.1 per cent in 1997. Public standpipes have declined from 15.1 per cent in 1997 to 6.4 per cent in 2007 and this may be attributed to the efforts of the Government to expand the nation's pipelines to many communities in an effort to increase access to potable water and to improve water supply. Rural Areas continued to have lower access to potable water as their main source of drinking water (43.7 per cent) and this suggests that a greater proportion of rural households may be at risk of consuming potentially unsafe water. The same risk applies to households in the lowest quintiles.

Water closets have been the main type of toilet facility utilized by households (64.3 per cent) in 2007. However, access to water closets, as with other indicators, exhibited the tendency for Rural Areas and the poorest quintiles to be at a severe disadvantage. Of concern is the fact that soil absorption systems were the dominant means of sewage disposal for some 42.4 per cent of households. This is potentially

hazardous to ground and surface water sources and, in essence, potable water supply, particularly for Rural Areas which relies most heavily on untreated fresh water as its main source of potable water.

Electricity was the most widely used source of lighting in all regions and by all quintiles. The most significant change in electricity as the main source of lighting was in Rural Areas which experienced a 15.5 percentage point increase in electricity usage between 1997 and 2007. This increase can be related to the work of the Rural Electrification Programme which started in 1975.

The Housing Quality Index (HQI) measures the housing quality in Jamaica and is a composite index for multiple indicators. The HQI has increased consistently over the 10-year period, moving to 68.1 per cent in 2007 from 60.0 per cent in 1997. Generally speaking, all the components improved over the period. Between 2006 and 2007, there were increases in the HQI for KMA and Other Towns, but for Rural Areas it remained relatively unchanged.

In real terms, mean monthly mortgage payments increased in 2007 while utilities expenditure decreased and property tax saw no change. The KMA had the highest mortgage, utility payments and property taxes.

While JSLC 2007 data indicate that, generally, both housing stock and housing quality in terms of access to certain social amenities has improved, there are disparities by region and quintile which point to the disadvantages that those in Rural Areas and the poorest quintiles face in terms of housing. Overall, much progress has been made between 1997 and 2007 but there is much more to achieve, especially with regard to the use of soil absorption systems to mitigate the potential health hazards associated with polluted water sources.

SOCIAL WELFARE

The Programme of Advancement Through Health and Education (PATH) was introduced in 2002 and is the Government's major social safety net programme. The largest proportion of those who 'had ever applied' to the programme were from the Rural Areas (43.6 per cent) and from the poorest quintile (61.2 per cent). The largest proportion who had been accepted were from the KMA (49.0 per cent) and from the poorest quintile, Quintile (53.6 per cent).

Some 83.4 per cent of beneficiaries were from Rural Areas which had 71.1 per cent of the poor. The KMA and Other Towns had 7.6 per cent and 9.0 per cent, respectively of PATH beneficiaries. The two poorest quintiles represented 75.0 per cent of beneficiaries; as this is the second time that this proportion declined, falling by 4.4 percentage points since 2004, it suggests that leakage has increased.

Data reveal that 84.9 per cent of all beneficiaries had received the April payment with the Rural Areas having the largest proportion (89.1 per cent) receiving the payment.

Approximately 25.0 per cent of those surveyed had been on the programme since its inception. Beneficiaries reported that experience with the programme was satisfactory—there was a high level of awareness and contact with programme staff, and only 3.0 per cent reported any difficulty in collecting cheques.

Importantly, the main reason cited for not attending school was ‘Money Problems’ (59.5 per cent) followed by ‘Illness.’

PATH beneficiaries were well-represented on other safety net programmes such as Jamaica Drug for the Elderly Programme (JADEP), the School Fee Assistance Programme and Poor Relief with, respectively, 44.1 per cent, 26.6 per cent and 16.7 per cent of those eligible. Coverage of the poorest quintile by PATH was rather low however, with 38.5 per cent of children and 32.3 per cent of the elderly. Efforts to improve targeting are clearly warranted and plans are being put in place.

The current global food crisis highlights the importance of conditional cash transfer programmes such as PATH in effectively targeting those who are most needy. The Government has already initiated the expansion of PATH and our international development partners are being encouraged to provide support to the poorest through this medium.

PERSONS OF PRIME WORKING AGE (PWA), 20 TO 59 YEARS

The Prime Working Age (PWA) group bears the age-dependency burden and drives national development. It is important that the PWA, therefore, be looked at to ascertain how this group is performing relative to the rest of the population given its role in the society and economy.

The PWA is defined as the age range 20 to 59 years as distinct from the working age, 15 to 64 years. As a proportion of the population, the PWA amounted to 48.0 per cent compared with 45.3 per cent in 1997. The Rural Areas had the highest proportion of PWA. However, since 2004, there has been notable expansion of this group in Other Towns.

The highest percentage of the PWA was in the richest quintile, declining steadily to the poorest quintile. Additionally, nominal mean per capita consumption for households headed by PWA at \$215 800 was 30.2 per cent higher than the national average. However, gender disparity in favour of male-headed households was higher among PWA-headed households than the general population. The proportion of households headed by PWA also declined from the richest to the poorest quintile, possibly reflecting economic constraints on assuming household headship for those in the lower consumption quintiles. Some 51.0 per cent of PWA household heads owned their dwellings.

In relation to health, the main differences between the PWA and the general population are with respect to both chronic illnesses and health insurance coverage where the PWA fared better. With the exception of asthma, all the chronic illnesses increased

markedly for those over age 40 years within the PWA. A greater proportion of the PWA sought care and purchased drugs from the private sector, and they spent 2.9 times more for private sector visits than public sector visits and 2.7 times more for drugs in private facilities when compared with public facilities.

Overall, 74.1 per cent of PWA was not academically certified. On average, however, the lower the age group, the higher the level of academic achievement. Disparities are evident by sex, location of residence and quintile, with females, urban residents and wealthier quintiles having better levels of educational achievement.

In general, the data indicate that the prime working age is faring better in all the major indices of well-being. They are: consuming at a higher level than the general population; exhibiting better health-seeking behaviour and a preference for private sector as opposed to public health in both seeking care and purchasing medication; pursuing training and certification to better integrate in the job market and take advantage of the existing opportunities. The only area in which the prime working age group is at a disadvantage in comparison with the general population is with regard to sex inequality of income which is much higher in this segment of the population.