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Health Inequality in Jamaica, 1988-2007

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Abstract: Objective: The mortality for men is not only greater than that of women as indicated by the life expectancy but of the five leading cause of death in the nation (malignant neoplasms; cerebrovascular disease; heart disease; diabetes mellitus and homicides), the rates for men were greater in four (malignant neoplasms; cerebrovascular; heart disease and homicides). Despite these realities, men seek less medical care than the women and stay longer in hospitals for curative care. This study examines medical seeking behaviour, self-reported ill-health, and gender differential in medical seeking health care and self-reported ill-health. Method: The current research used secondary data. The data were extracted from the Jamaica Survey of Living Conditions (JSLC) on medical care seeking behaviour, self-reported illness (or ill-health) and the gender composition of those who reported ill-health. The JSLC was born out of the World Bank's Living Standard Survey. Data were also taken from the Ministry of Health's Annual Report, which provided statistics on actual percentage of Jamaicans who visited public hospitals. The current study used 19 years of published data extracted from the JSLC (1988-2007). Scatter diagrams and best fitted lines were used to examine correlations and trends. Results: Over a 2-decade period, 1988 to 2007, only a small percentage of Jamaicans reported ill-health (between 9 to 19 %) and 15.5% in 2007, which is an increase of 3.3% over the previous year. Despite this low figure, increasingly more men sought medical care over the study period (41.1%) compared to women (29%). Nevertheless, health care seeking behaviour is still gender bias – 68.1% of women and 62.8% of men who reported health conditions. For men, more of medical care seeking behaviour is explained by ill-health (r-squared=35.4%) than women (r-squared 8.8%). Conclusion: This study is one of the first to examine and provide some explanation on gender differentials in health care behaviour and self-reported illness/injury in Jamaica. We found that while more men who report ill-health have been seeking medical care, the gap between the sexes in regard health seeking behaviour has been narrowing.

Key words: Gender, Health Inequality, Self-reported Illness, Medical Seeking Behaviour, Jamaica.

INTRODUCTION

Globally, in 1950-1955, life expectancy for women was 47.9 years compared to 45.2 years for men. One-half of a century later, the disparity has increased to 4.2 years (68.1 years for women and 63.9 years for men). In the Caribbean, in the same aforementioned period, life expectancy for women was 53.5 years and 50.8 years for men and 50 years later the disparity has increased to 5.5 years (70.9 years for women and 65.4 years for men). Life expectancy which is an indicator of mortality and to some extent morbidity is also proxy for health status of people. Although there is some morbidity that is not life threatening, it is established that healthy life is not equivalent to longer life. Hence, the World Health Organization developed DALE (disability adjusted life expectancy) to discount life expectancy by lost time due to illness. This showed that developing countries lost 9 years of life expectancy owing to unhealthy years.

There has always been a health differential between the sexes in Jamaica (STATIN, 1990-2008) Dating back as far as 1880, which was the first time that life expectancy data was recorded for men and women in the island, women were outliving men. The Demographic Statistics for Jamaica showed that for 1880 and 1882 women lived approximately 3 years more than men and 122 years later (2002-2004), they outlived them by 6 years, which is an additional 3 years. Globally, women live longer than men by 8 years which is 2 years more than that of the life expectancy gender differential in Jamaica. They are not only living longer, but

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enjoying greater quality of life(WHO, 1998) A study of 3,009 older people done in 2007 in Jamaica (Bourne, 2008) revealed that elderly women had a higher quality of life (3.3 ± 2.2) than men (2.8 ± 1.8; p value = 0.001), which concurred with the earlier work done by the WHO in 1998. But, studies that have examined well-being have shown that men experienced a greater economic wellbeing than women (Rudkin, 1993), despite not having a higher subjective wellbeing. What is explaining this health differential between the sexes?

Life expectancy which is calculated using mortality data indicate that men are experiencing particular pathogen causing diseases which are accounting for the greater increase in mortality and lower life expectancy than women. An epidemiological profile of selected health conditions and services in Jamaica for 1990-2002 was conducted by the Health Promotion and Protection Division, Ministry of Health in 2005 which revealed that malignant neoplasm was the leading cause of death in Jamaica. It was 39% greater for men than women. The second leading cause of death, cerebrovascular disease, was 14% higher for men than women; heart diseases rate was 71.2 per 100,000 for men and 66.1 per 100,000 for women, and diabetes mellitus was greater for women than men. The statistics revealed that mortality caused by diabetes mellitus was 64% higher for women than men.

Jamaica is not unique in regard to i) women outliving men, ii) particular morality is greater for men than women, and ii) some of the leading causes and death are gender specific (WHO, 1998) The issue of higher mortality differential between the sexes at older ages begins with boys suffering more illnesses and injuries than girls (MOH, 2005) The World Health Organization (WHO) offered a potent finding that age-and sex differential in mortality dates back to 1955 (WHO, 1998) This indicates that higher mortality in the world's population tend to favour men, and justifies the longer life that they live compared to men.

In demography, life expectancy is used to measure health. But this approach fails to capture health as one can be alive but enjoy optimum health – living with varying levels of morbidity. There is an argument that morbidity is accounted for in mortality, and this so. However, some dysfunctions are not death causing, and so quality of life (health) will be lower with these health conditions. It is owing to this reality that the World Health Organization (WHO) introduced what is known as healthy life expectancy which discounts life expectancy by morbidity.

Healthy Life Expectancy:

One of the drawbacks to the use of life expectancy is its absence to capture 'hale' years of life. Traditionally when *life expectancy* is measured, it uses mortality data to predetermine the number of years of life yet to be lived by an individual, assuming that he/she subscribes to the same mortality patterns of the group. The emphasis of this approach is on length of life and not on the quality of those years lived. Hence changes in life expectancy are primary due to mortality movements, and imply changes in external conditions of the socio-biological environment. These changes include the components of public health, the physical milieu, and technological/medical advancement. With all the aforementioned conditions that have improved over the last century, increased life expectancy in the world is not surprising to scholars. One way of evaluating population ageing in the world or in any geopolitical space is 'life expectancy'. Today, it should come as no surprise to people that many developing nations have been experiencing increased gains in additional years of life for members with its population in comparison to 20th century.

Associated with ageing are high probability of increased dysfunctions and the unavoidable degeneration of the body. This explains why it is germane to analyze healthy life expectancy and not merely life expectancy. Healthy life expectancy is defined as the number of years that an individual is expected to live in 'good' health. Technological advancement is able to prolong life, but it is not able to remove morbidity and its deterioration in quality of lived years of the individual. Thus, while life expectancy in the Caribbean is increasing and that this is in keeping with the rest of the world, there is a simultaneous increase in chronic diseases and resurgence of infectious disease. This reality highlights the disparity between quantity of years lived and the quality of those lived years because of sociopsychological conditions- such as loneliness, bereavement, social support (or the lack of), low self-esteem, and low self-actualization and so on.

In evaluating health or wellbeing, we must seek to examine more than just the number of years that an individual is likely to survive as we should be concerned about the quality of those years. Even though, life expectancy is an indicator of health, the new focus is on *healthy life expectancy*. Based on the Healthy People 2010, the new thrust is on increasing quality of years of life**.** In attempting to capture 'quality of years lived', in 1999, the WHO introduced an approach that allows us to evaluate this, by the 'disability adjusted life expectancy' (DALE) (WHO, 2000) DALE does not only use length of years to indicate health and wellbeing status of an individual or a nation, but incorporate the number of years lived without disabilities.

DALE is a modification of the traditional 'life expectancy' approach in assessing health. It uses the number of years lived as its principal component. This is referred to as 'full health'. In addition, the number of years of ill-health is weighted based on severity as another component in the equation. This is then subtracted from the expected overall life expectancy to give what is referred to as years of hale life. Embedded in this approach is the adjustment of years lived in 'ill-health'.

Having arrived at 'healthy life expectancy', the WHO has found that poorer countries lost more from their 'traditional life expectancy' than developed nations. The reasons forwarded by the WHO are the plethora of dysfunctions and the devastating effects of some tropical diseases like malaria that tend to strike children and young adults. The institution found that these accounted for a 14 percent reduction in life expectancy for poorer countries and 9 percent for more developed nations (WHO, 2000) This is in keeping with a more holistic approach to the measure of health and wellbeing with which this study seeks to capture. By using the biopsychosocial model in the evaluation of wellbeing of aged Jamaicans, we will begin to understand factors that are likely to influence the quality of lived years of the elderly, and not be satisfied with the increased length of life of the populace. Looking at the life expectancy data for Jamaica, the figure is 74.1 years for both sexes[6] but by using healthy life expectancy it is 65.1 years (WHO, 2000) Here life expectancy has been increasing at a faster rate than 'healthy life expectancy'. Therefore, Jamaicans are expected to spend some 9 years of their life in 'poor health'.

In summary, the use of life expectancy to measure health is inadequate and so morbidity must be taken into consideration. When life expectancy is discounted by morbidity, it provides an account of the healthy life expectancy of an individual. Hence, the use of life expectancy to indicate health for men and women is equally insufficient in health analysis. It is evident from statistics on life expectancy and particular diseases causing mortality that men are experiencing a lower health status, and what accounts for this reality? Within the context of the aforementioned issues, and the fact that medical health care seeking has increased from 54.6% in 1989 to 66.0% in 2007 and that there is a decline of 5.7% over 2006 (Table 1), is this offering some explanation the gender differential in health status? Although less Jamaicans are seeking medical care of those who reported illnesses, 27.1% more Jamaicans reported dysfunctions (Table 1), suggesting that there is greater health differential between the sexes. Hence, for this study, medical seeking behaviour, self-reported ill-health, and gender differential in medical seeking health care and self-reported ill-health will be examine to provide a better understanding of the healthy life expectancy of the sexes in Jamaica.

MATERIALS AND METHOD

The current research used secondary data. The data constitute statistics from the Planning Institute of Jamaica and the Statistical Institute of Jamaica (in Jamaica Survey of Living Conditions, JSLC) and Ministry of Health Jamaica (MOH). The data were extracted from the JSLC on medical care seeking behaviour, self-reported illness (or ill-health) and the gender composition of those who reported ill-health. The Ministry of Health's Annual Report provided data on actual percentage of Jamaicans who visited public hospitals, which was contrasted by the JSLC's self-reported visits to public hospitals in order to further examine the gender differentials on subjective ill-health.

This study used 19 years of published data extracted from the JSLC (1988-2007). The JSLC was born out of the World Bank's Living Standard Survey. The JSLC began in 1988 when the Planning Institute of Jamaica (PIOJ) in collaboration with the Statistical Institute of Jamaica (STATIN) adopted with some modifications of the World Bank's Living Standards Measurement Study (LSMS) household surveys. The JSLC has its focus on policy implications of government programmes, and so each year a different module is included, evaluating a particular programme. The JSLC is a self-administered questionnaire where respondents are asked to recall detailed information on particular activities. The questionnaire covers demographic variables, health, immunization of children 0 to 59 months, education, daily expenses, non-food consumption expenditure, housing conditions, inventory of durable goods, and social assistance. Interviewers are trained to collect the data, which is in preparation of the household members. The survey is usually conducted between April and July annually. Furthermore, the instrument is posted on the World Bank's site to provide information on the typologies of question and the (http://www.worldbank.org/html/prdph/lsms/country/jm/docs/JAM04.pdf).

Ministry of Health is the body which is constituted by statutes to regulate all health institutions in the country. The Ministry of Health (MOH) collects statistics on health, health services, health utilization, health related matters, and carry out health mandate of the government. MOH has decentralized its operations. The island is sub-divided in four regions (South-East; North-East; Western, and Southern), which emerged owing to the passage of the National Health Service Act of 1997. Each region operates as a semi-autonomous regional

body under the general directs of the central Ministry of Health, which is subject to the directions of the Minister of Health. The central Ministry of Health collates all the data sent it by the four health authorities in country. Therefore, data revealed in the Annual Reported of the Ministry of Health, Jamaica, reflect actual accounts of the health matters in the country.

Scatter diagrams and best fitted lines were used to examine correlations between different variables, and percentages were also utilized to evaluate events over two decade (1988-2007).

Measure:

Gender is being male or female:

Gender differential is the disparity between self-reported ill-health of male or female.

Medical Care Seeking Behaviour denotes the proportion of self-reported cases of visits for seeking medical care of those who indicated ill-health.

Self-reported Illness is the percentage of people who have reported cases of dysfunctions (ill-health or health conditions) as indicated by a respondent in a 4-week reference period.

Poverty is measured using the poverty line. The poverty line estimate is particular attainable consumption expenditure in excess of a minimum necessary level of expenditure on a representative bundle of necessary goods and services valued at germane prices. (JSLC 2008)

RESULTS AND DISCUSSION

Some scholars may want to believe that the use of subjective data on health (self-reported ill-health) cannot be used to proxy health as it is not a good estimate of actual health status. In order to remove this myth, the researcher will examine the actual figures provided by the Ministry of Health on visits to public health care facilities and those garnered by the Jamaica Survey of Living Conditions (JSLC). The JSLC is an annual probability sampled survey which collects data from Jamaicans based on their recollection of events (self-reported). Based on Table 4, self-reported health as indicated by the JSLC is a good proxy of visits. The data revealed that in 1997, the difference between Jamaicans recall of events and those actually happened as recorded by the Ministry of Health was marginally different (1%). Some 7 years later (2004), the difference between same phenomena was 6.1% suggesting that subjective assessment of health is a good proxy for actual health. It is within this context, that the researcher will examine self-reported health data from JSLC to understanding health differential between the sexes in Jamaica.

During the periods of the greatest double digits inflation in history of Jamaica (early 1990s) (Table 2) in particular inflationary rates that were in excess of 25% (1990-1995), Jamaicans reported the lowest percentages in ill-health (health conditions). Moreover, in 1991 when inflation was at it peaks, the prevalence of poverty stood at its highest (44.6%), and the data showed that self-reported illnesses were 13.7%. This figure was the fifth highest self-reported ill-health in an 18 year period (1989-2007). In the unprecedented inflation of 1991 (80.2%), less men sought medical care (12.0%) over 1990 (16.35) compared to 15.0% in 1991 and 20.3% in 1990. In 1990, it was the first time in the history the of nation that inflation rose to in excess of 20% and self-reported illness reached its maximum of 18.3%, and medical care seeking behaviour was at its lowest (38.6%). In addition, in 1990, both sexes sought the most medical care (Table 3). Two years later (1992), inflation rate fell by 49.9% (to 40.2%) over 1991 which explains the rationale for the 24.0% decrease in prevalence of poverty; self-reported ill-health declined by 22.6%, ownership of health insurance increased so to were people seeking medical care and the private health care utilization. The irony here is that 17.5% less men reported accessing medical care for their ill-health and 24.7% less women. This indicates that more of those people who did not report ill-health visited private health care facilities for medical care. In 1993, inflation declined further by 25.1%; poverty saw a reduction of 28.0%; self-reported health conditions increased by 13.2%; health insurance coverage increased by 12.2%; number of people seeking medical care increased by 1.8%. In that same period, the number of women who sought care was 3.8 times more (19.5%) than men (5.1%). Hence, high inflation was reducing visits for medical care and another matter which emerged from the data during that period, that those who attending public hospitals began reducing their visits while private hospital users, increased utilization (Table 2). There is a paradox post-2005 as inflation increased by an unprecedented 194.7% in 2007 over 2006 and this explains a corresponding decline in the number of persons who sought medical care (by 5.7%). Nevertheless, the number of men who visited health care facilities increased in the period by 21.2% and the number of women was 1.24 times more than men.

The data show that in the last 17 years, women place more emphasis on their health than men. Between 1988 and 2007, it was only on one occasion that men have indicated having sought more medical care than

women (in 1997) (Table 3). The difference between men seeking medical care and that of women was 0.7%. If health seeking behaviour is a proxy for preventative care, then it would appear that they were more health conscious. This is the not the case as in the same period, then spent more days receiving care (mean of 11 days) compared to 10 for women. Hence, this increased in health seeking behaviour was owing to curative and preventative care. Nevertheless, over the studied period, severity of care for both sexes has been reality the same. Using mean number of days men received care for illness/injury, the difference is minute, suggesting that severity of illness between the sexes in Jamaica is the same.

Another interesting finding that emerged from the data is the narrowing of the gap between public health care utilization and private health care utilization in the nations, suggesting that costing of living is accounting for more visits to public care facilities. Embedded in those findings is the affordability in people's decision to seek medical care. This indicates that there are some other conditions that are interfacing with men's and women's decision to visit health care facilities for care outside of prices (inflation).

Results: Bivariate Analyses:

Percentage of People Seeking Medical Care by Percentage of People reporting Illness:

On examination of Figure 1, it was revealed that a negative correlation exists between number of people who sought medical care and percentage of people who reported ill-health. This indicates that as more people report health conditions, less of them are likely to seek medical care. Furthermore, 16.3% of the variability in people seeking medical care can be explained by illness, suggesting that ill-health is not a good reason for Jamaicans visiting health care practitioners. On further investigation of people seeking medical care and self-reported illness/injury, data (Tables 2,3) revealed that on the occasion when the highest percentage of illnesses were reported, the least number of person sought care for those conditions. This irony was equally the case for men (16.3%) as well as women (20.3%) (Table 3).

Percentage of People Seeking Medical Care by Prevalence of Poverty:

On examination of a scatter diagram; it was observed that there is a negative correlation between the percentage of people seeking medical care and prevalence of poverty. The best fit line revealed that 57.6% of why people seek health care in Jamaica is determined by poverty (Figure 2). Hence, people are highly likely to visit health care facilities in periods of low poverty and vice versa. This indicates that medical care is not simply about ill-health, it is equally determined by affordability, suggesting that people will switch to home care in periods of increased poverty. Irrespective of this knowledge, is there is sex disparity in regard to seeking medical care and reporting illness?

Percentage of Men Seeking Medical Care by Percentage of Men reporting Illness:

Generally 16.3% of why Jamaicans visit health care facilities in search of care is owing to their health conditions. However, for men, 35.4% of why they sought medical care was due to ill-health as 35.4% of the variability in men seeking medical care can be explained by medical care. On decomposing the data, when the least percentage of men sought medical care assistance (37.9%), the most percentage of them reported illness (16.3%) (Table 3). Furthermore, when the lowest percentage of men reported ill-health (health conditions/injuries) (7.4%), this was in 60% of those seeking more medical care. However, in 1999 and 2004, low self-reported illness was correlated with relatively high health seeking behaviour.

Percentage of Women Seeking Medical Care by Percentage of Women reporting Illness:

Health (medical) care seeking behaviour of women is lowly correlated with self-reported illness (injury) (Figure 3). The scatter plot revealed that generally, the more women reported health conditions the less likely they are to seeking medical care. Some 8.8% of the variability in medial care seeking behaviour of this cohort can be explained by a change in self-reported health conditions. Self-reported illness of women accounted for 54% less of the explanatory reason for seeking medical care compared to that of the both sexes (16.3%), suggesting that women's health care behaviour is driven by other factors than ill-health. There are some similarities between health care seeking behaviour and self-reported illness of both sexes as when women reported the least percentage of health care seeking behaviour, this was corresponding to the most reported health conditions (Table 3). Furthermore, when the least percentage of ill-health was reported, this earmarked 59th percentage of the highest seeking medical care behaviour of women. These were also the case for men. Deconstruction the Self-Reported Health Status of Jamaicans by Gender, 1989-2006

Over the last 2 decades (1988-to-2007), asmall proportion of Jamaicans have reported illness (or dysfunction) (Table 5). This has been has high as 168 per 1,000 (in 1989) to a low of 88 per 1,000 (in 1997),

and the figure was 155 per 1,000 in 2006 (Table 5). On deconstruction the population self-reported health status, it was revealed that women continue to report more health conditions than men. In 1989, there 123 women (or women) who reported health conditions to 100 men (or men), and in 2004, the ratio was as high as 153 women per 100 men. This indicates that 53% more women reported health conditions than men in the latter year and there was an increase of 30% more women reporting dysfunctions over the 2 decades. Over the studied period, in 1992, the disparity in self-reported health conditions between men and women was very close of which there were 114 women to 100 men as it relates to self-reported health conditions. On the other hand, over the last decade (1997-to-2006), the disparity was 136 or 153 women per 100 men, and in the last 2 years the value has been relatively stable (136 or 137 women per 100 men).

Percentage of People Seeking Medical Care by Percentage with Health Insurance:

Health Insurance is one indicator of people's intent to access care. On examination of the data (Table 2), only a small percentage of Jamaicans in 2007 had health insurance (21.1%). This meant that more people who will become ill would need to meet their medical expenses out of savings, current income and assistance from social support agent(s). Table 2 revealed in 8.6% of Jamaica had health insurance coverage during the period when the inflation rate was at its peak (80%) and when it fell to 40.2%, health insurance coverage increased by only 0.4%. Further investigation of health seeking behaviour and health insurance coverage showed that the ownership of health insurance was positively related to health seeking behaviour. A bivariate correlation between the two aforementioned factors revealed that 56.1% of the variability in people seeking medical care was as a result of ownership of health insurance (Figure 5).

Ownership of Health Insurance and Prevalence of Poverty:

Poverty does not only mean ones inability to purchase consumption items, but also non-consumption items such as health insurance. On examining a scatter diagram with a best fit line to establish any correlation between the two aforementioned variables, it was observed that a moderately strong correlation existed (R-squared = 0.597) – Figure 5. This means that 60% of the variability in ownership of health insurance can be accounted for by prevalence of poverty, suggesting that poor is less likely to have health insurance coverage.

Discussion:

In the conclusion of the health chapter in one of the JSLC's reports (WHO, 2003) it reads "Gender differentials with respect to self-reported illness and health seeking behaviours need to be investigated." This is the rationale for this study, to provide an assessment of differences in subjective health and medical seeking behaviour of men and women in Jamaica.

Globally, regionally and in particular Jamaica, women seek more health care than men (STSTIN, 1990-2008; WHO, 1998; Rudkln, 1993; MOH, 2005; WHO, 2000; statin, 2007). This is not alarming as it commences from at childhood. In 1998, one health organization wrote that girls are less likely to be injured and have broken bones compared to boys (WOH, 1998), which continue during the life span. So when the mortality rates show a higher rate for men than women (WHO, 1998; WHO, 2000) this is just a continuation of early socialization. Health, therefore, is gender bias. One of the rationales for the emphasis on health care by women is reason for male's abstinence, the culture. Within many cultures, men are not to display any form of weakness which includes ill-health. This culturalization has embedded in boys and avoidance of speak of illness/injury and the image of ill-health is negative and is primarily feministic in nature. This is not limited to Jamaica or African descendent societies as it is equally the case in European geopolitical zones such as Norway (STATIN, 2000).

Many cultures view (image) of health is the absence of diseases and this is sometimes linked to cure of the gods or moral rationale, suggesting that ill-health is a weakened biological state. Men who are culturalized to be strong and macho must now balance ill-health within a plural culture. The 21 st century has seen the exponential increase in life expectancy of men compared to women in nineteenth and earlier centuries, but what about high mortality for this group. There has always been feminization of life expectancy in Jamaica since 1880 (Table 1) and the disparity in life expectancy has double from 1880-1882 to 2002-2004 from 3 years to 6 years respectively. Life expectancy which is an indicator of health does not only speak of longer life, there are also some cultural changes that account for this increased life span, the social milieu.

Despite the advancement in medical technology, men continue to outnumber women in particular mortality rates. These include heart disease and neoplasm to name a few non-communicable diseases. Heart disease and neoplasms are caused through either lifestyle behaviour or heredity, and the former explains more of heart disease than the latter. Globally, the fact that women outlived men by 8 years and in Jamaica by 6 years, lifestyle behaviour undoubtedly is explaining the higher morbidity in heart diseases of men.

Table 1: Life Expectancy at Birth of Jamaicans by Sex: 1880-2004

	Average Expected Years of Life at Birth	
Period:	Man	Woman
1880-1882	37.02	39.80
1890-1892	36.74	38.30
1910-1912	39.04	41.41
1920-1922	35.89	38.20
1945-1947	51.25	54.58
1950-1952	55.73	58.89
1959-1961	62.65	66.63
1969-1970	66.70	70.20
1979-1981	69.03	72.37
1989-1991	69.97	72.64
1999-2001	70.94	75.58
2002-2004	71.26	77.07

Sources: Demographic Statistics (1972-2006) in Bourne, P. Determinants of well-being of the Jamaican Elderly. Unpublished thesis, The University of the West Indies, Mona Campus; 2007.

Table 2: Inflation, Public-Private Health Care Service Utilization, Incidence of Poverty, Illness and Prevalence of Population with Health Insurance (in per cent), 1988-2007

Year	Inflation	Public Utilization	Private Utilizationo	Prevalence fpoverty	Illness	Health Insurance Coverage	Seeking Medical Care	Mean Days of Illness
1988	8.8	NI	NI	NI	NI	NI	NI	NI
1989	17.2	42.0	54.0	30.5	16.8	8.2	54.6	11.4
1990	29.8	39.4	60.6	28.4	18.3	9.0	38.6	10.1
1991	80.2	35.6	57.7	44.6	13.7	8.6	47.7	10.2
1992	40.2	28.5	63.4	33.9	10.6	9.0	50.9	10.8
1993	30.1	30.9	63.8	24.4	12.0	10.1	51.8	10.4
1994	26.8	28.8	66.7	22.8	12.9	8.85	1.4	10.4
1995	25.6	27.2	66.4	27.5	9.8	9.7	58.9	10.7
1996	15.8	31.8	63.6	26.1	10.7	9.8	54.9	10.0
1997	9.2	32.1	58.8	19.9	9.7	12.6	59.6	9.9
1998	7.9	37.9	57.3	15.9	8.8	12.1	60.8	11.0
1999	6.8	37.9	57.1	16.9	10.1	12.1	68.4	11.0
2000	6.1	40.8	53.6	18.9	14.2	14.0	60.7	9.0
2001	8.8	38.7	54.8	16.9	13.4	13.9	63.5	10.0
2002	7.2	57.8	42.7	19.7	12.6	13.5	64.1	10.0
2003	13.8	NI	NI	NI	NI	NI	NI	NI
2004	13.7	46.3	46.4	16.9	11.4	19.2	65.1	10.0
2005	12.6	NI	NI	NI	NI	NI	NI	NI
2006	5.7	41.3	52.8	14.3	12.2	18.4	70.0	9.8
2007	16.8	40.5	51.9	9.9	15.5	21.2	66.0	9.9

Ssource: Bank of Jamaica, Statistical Digest, Jamaica Survey of Living Conditions, Economic and Social Survey of Jamaica, various issues
Note: Inflation is measured point-to-point at the end of each year (December to December), based on Consumer Price Index (CPI)
NI – No Information Available

Table 3: Seeking Medical Care, Self-reported illness, and Gender composition of those who report illness and Seek Medical Care in Jamaica (in percentage), 1988-2007

Year	Seeking Medical Care	Health Insurance Coverage	Seeking Medical Care - Men	Seeking Medical Care - Women	Reporting Illness-Men	Reporting Illness-Women	Mean Days Of Illness Men	Mean Days Of Illness Women
1988	NI	NI	NI	NI	NI	NI	NI	NI
1989	54.6	8.2	44.7	52.8	15.0	18.5	10.6	11.1
1990	38.6	9.0	37.9	39.2	16.3	20.3	10.2	10.2
1991	47.7	8.6	48.5	47.4	12.1	15.0	10.0	10.3
1992	50.9	9.0	49.0	52.5	9.9	11.3	10.7	10.9
1993	51.8	10.1	48.0	54.7	10.4	13.5	10.7	10.1
1994	51.4	8.8	49.0	53.4	11.6	14.3	10.3	10.4
1995	58.9	9.7	59.0	58.9	8.3	11.3	10.6	10.7
1996	54.9	9.8	50.5	58.5	9.7	11.8	10.0	11.0
1997	59.6	12.6	60.0	59.3	8.5	10.9	11.0	10.0
1998	60.8	12.1	57.8	62.8	7.4	10.1	11.0	11.0
1999	68.4	12.1	64.2	1.1	8.1	12.2	11.0	11.0
2000	60.7	14.0	57.4	63.2	12.4	16.8	9.0	9.0
2001	63.5	13.9	56.3	68.2	10.8	15.9	9	10

Table 3: Continuos

2002	64.1	13.5	62.1	65.3	10.4	14.6	10.0	10.0
2003	NI	NI	NI	NI	NI	NI	NI	NI
2004	65.1	19.2	64.2	65.7	8.9	13.6	11.0	10.0
2005	NI	NI	NI	NI	NI	NI	NI	NI
2006	70.0	18.4	71.7	68.8	10.3	14.1	9.7	10.0
2007	66.0	21.2	62.8	68.1	13.1	17.8	10.6	9.3

Source: Jamaica Survey of Living Conditions, various issues
NI - No Information was available

Table 4: Public Health Care Visits (using the JSLC, data) and Actual Health Care Visits (using Ministry of Health Jamaica, data), 1997 and 2004

	Public Health Care Visits in Jamaica	
Year	Actual Visits, MOH[1]	Self-reported Visits, JSLC
	%	%
1997	33.1	32.1
2004	52.9*	46.8

Source: Ministry of Health Jamaica and the Jamaica Survey of Living Conditions (JSLC)
[1] The Percentages of Actual visits were computed by author
*Preliminary data were used to calculate this percentage

Table 5: Self-reported Health Status per 1,000 by Population, Men and Women; Sex-Ratio of Self-reported Health Status, and Female to Male Ratio of Self-reported Health Status, 1989-2006

Year	Self-reported Health Status per 1,000			Male-to-Female ratio of Self-reported Health Status	Female-to-Male ratio of Self-reported Health Status
	Population	Men	Women		
1989	168	150	185	81	123
1990	183	163	203	80	125
1991	137	121	150	81	124
1992	106	99	113	88	114
1993	120	104	135	77	130
1994	129	116	143	81	123
1995	98	83	113	73	136
1996	107	97	118	82	122
1997	97	85	109	78	128
1998	88	74	101	73	136
1999	101	81	122	66	151
2000	142	124	168	74	135
2001	134	108	159	68	147
2002	126	104	146	71	140
2003	-	-	-	-	-
2004	114	89	136	65	153
2005	-	-	-	-	-
2006	122	103	141	73	137
2007	155	131	178	74	136

Computed by Paul Andrew Bourne from Jamaica Survey of Living Conditions from various years

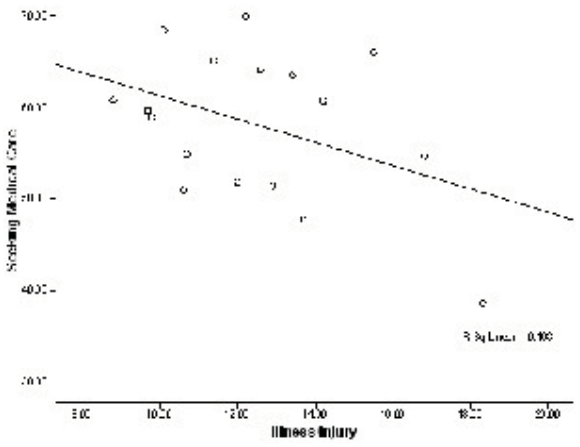

Fig. 1: Percentage of Men Seeking Medical Care by Percentage of Men reporting Illness

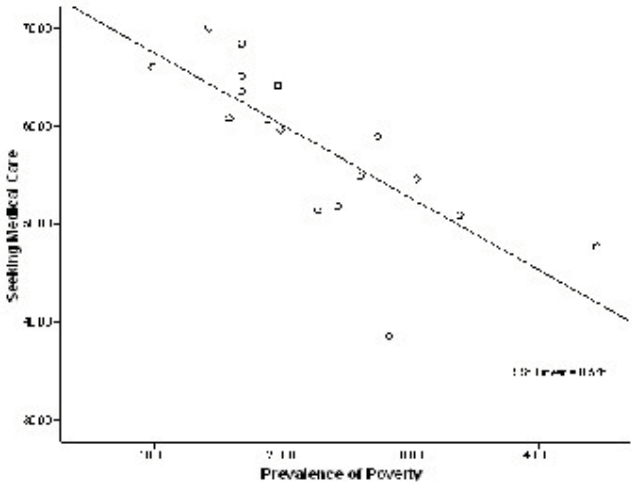

Fig. 2: Percentage of People Seeking Medical Care by Prevalence of Poverty

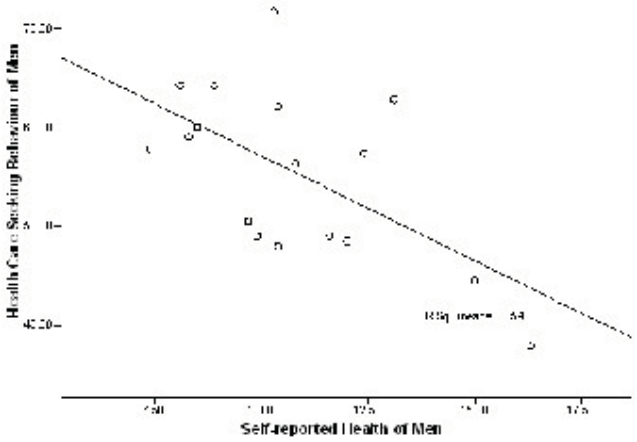

Fig. 3: Percentage of Men Seeking Medical Care by Percentage of Men reporting Illness

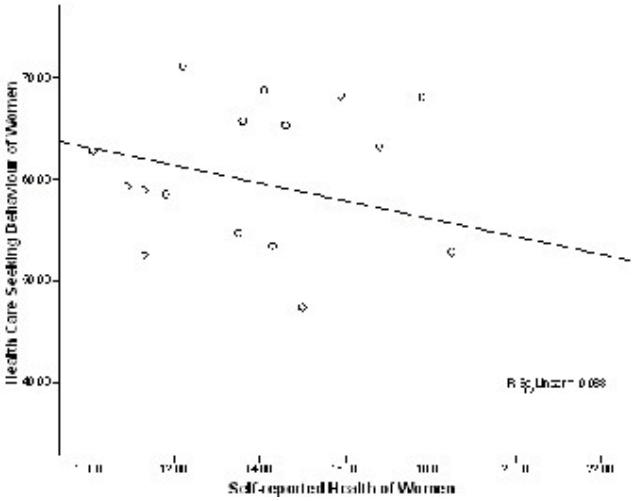

Fig. 4: Percentage of Women Seeking Medical Care by Percentage of Women reporting Illness

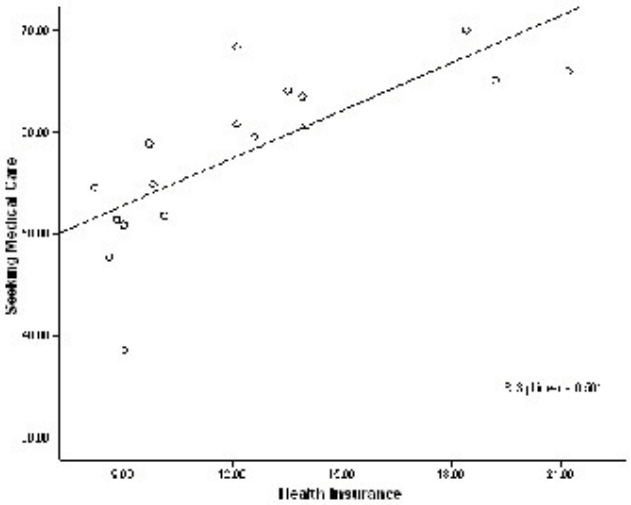

Fig. 5: Percentage of people Seeking Medical Care by Percentage with Health Insurance

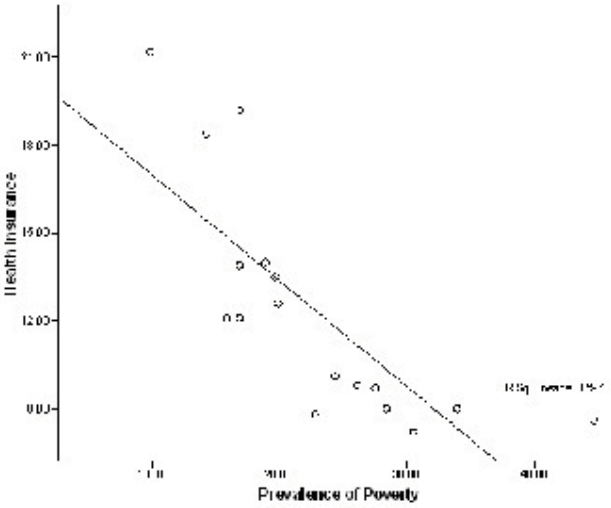

Fig. 6: Ownership of Health Insurance and Prevalence of Poverty

Life style behaviour is expressed in health seeking behaviour, the purchase of health insurance, preventative care and not curative care. Jamaica women continue to seek more care than men, and this concurs with the finding so other studies (WHO, 1998; Bourne, 2008; Kaasa, 1998; Hutchinson *et al.,* 2004) Women do not take their health for granted as society labels them with the nurturing role of children as well as ascribe them softer tasks. This means that health and ill-health are interpreted and viewed from within the perspective of personal experiences, and expectations. It is through the socialization process which is carried out by mothers (women) that ill-health and health will be defined which accounts for ones expectation and some percentage of how the world is viewed and interpreted by people. In a qualitative study that was done in Nairobi slums, the authors found a strong correlation between severity of illness and health seeking behaviour of children (Hambleton *et al.,* 2005) These children do not seek care of themselves, but are taken for medical care by their mothers. Another study on street children (ages 5 to 13 years), who take themselves, like the Nairobi study attended health care institutions for care dependent on i) severity of illness and ii) if it stops their economic livelihood (Taff and Chepngeno, 2005) Eight percentage of the sampled population of the latter study (in Pakistan) were boys (men). This speaks to the image of health as viewed by men, and when care is sought by them.

Ill-health, therefore, based on the image of health seen through the lens of men is weak, breaches machoism and borders on the fringes of feminism. Within the homophobis world, despite the gradual reduction of the degree in some societies, men (or boys) do not want to be labeled weak, homosexual or effeminate. Hence, there is dialectic here as men want to live which means that they must address ill-health and at the

same time they must appear to be macho. Men are less likely to both report ill-healths as well as seek medical care because of its image and social labels that they may ascribe to them by society. Women also play a part in this process as they grown their boys to be strong, 'tough', and that they should not show weakness. Ill-health is a weakness (or negative health), and so women on seeing men visiting health practitioners especially if this is frequent construe this as weak, but his is not ascribe to a female for doing the same thing.

Medical care seeking behaviour is, therefore, construed as indicating ill-health (curative care) and not preventative care for men. Chevannes (Ali and Muynck, 2002) wanting to explain how men are as they are, opined that early socialization played a critical role in shaping men's masculinity, image of self and interpretation of the world around them. The image of health as viewed as far back as prehistoric society is that of sickness, a curse, a plague, a weakness and a state of biological incapacitation. Men who are culturalized to be strong cannot afford to be seen as weak or incapacitate by their peers or the opposite sex as the society removes the acclaim of greater, power and prestige from any such male. This means that men must now report and display less signs of ill-health (weakness), and the only time that illness must be shown is in times of severity which is close to death.

Jamaican men displaying low medical care seeking behaviour as cultural underpinnings, and so does their unhealthy lifestyle practices. Unhealthy lifestyle is undoubtedly explaining high mortality of men than women. This dates back to prehistoric society, when men must hunters, heroes, warriors and fierce to defend themselves, their tribes and women. Such events meant that they would take more risk than women, and this has continued during the centuries. Although vast amount of information are available on health and health treatment, men continue to indulge in risky behaviour which accounts for their high morbidity and mortality in some conditions. The literature speaks to 80% of injuries and between 30-40% of cases with cardiovascular conditions and diabetes mellitus could have been prevented by lifestyle practices[5] This explains much of the health conditions and increased in reported ill-health and medical care seeking behaviour. What is the role of education in health differential in the sexes?

Education which is well established has directly correlated with better health (Chevannes, 2001; Bourne, 2007; Bourne, 2008; Brannon and Feist, 2007; Grossman, 1972; Smith and Kington, 1997; Ross and Mirowsky, 1999; Freedman and Martin, 1999; Meryn, 2004; Speetor, 2004) does not remove early culturalization by family, peer groups and religious affiliations. The general education level of the Jamaican populace has been improving since the last 3-decade, but this does mean the remove of the gender bias health image or stigma of weakness associated with illness. In 1989, 54.6% of Jamaicans sought care for ill-health and in 2007 that figure has increased by 9.9% (to 60%). In the same period that rate of increase for women was 29.0% compared to 41.1% for men. Nevertheless, in 2007, for every 100 men that sought care for ill-health, 108 women sought medical care. Although, we cannot divorce health from the social milieu, more men are seeking medical care for illness and this accounts for the faded difference between the mean numbers of days spent for care in both sexes. The 21 st century has aided men in their recognition for the need to seek medical care for ill-health, in spite of traditional cosmologies (Freedman and Martin, 1999; Meryn, 2004).

In contemporary societies, illness for men is not tied to health conditions such as neoplasm, heart disease, hypertension, mellitus diabetes and stroke, but is synonymous to sexuality which is a legacy of their socialization (Ali and Muynck, 2002; Freedman and Martin, 1999; Bailey, 1998) A medical doctor ascribes to the 21 st century, gender roles that are tied to sex (biological category). This means that being male is linked to being the stronger sex, fertile, and sexual prowess. Society has not removed from its men that gender stereotype, and so the image of health for them is substantially tied to sexuality. Men, therefore, do not see themselves as ill, unless they are impotent. Culturally, because impotency and infertility are a curse, men will not openly speak about those matters or/and other heath conditions. Again, male means strength, sexual potency, and these are all at the other end of the pendulum of ill-health. This explains the reason for the lower purchase of individual health insurance as this symbolizes weakness or preparation of some negative conditions. In spite of this reality, over the last one-half of a decade, there has been an increase in health insurance coverage and health seeking behaviour of both sexes. As of 2007, 2.1% more women had health insurance coverage than men (20.1%), which was more than the national average of 21.1%. Again this speaks to the differences in image of health held sexes and how their decision is based on this view. Health insurance is a component of lifestyle practices justify the advantages that women enjoy compared in men concerning health status. This is also reinforced in the fact (in 2007) that for every 133 women who indicated that they were unable to afford to seek medical care 100 men (STATIN, 1990-2008), showing that men are naturally, owing to their culturalization, unwilling to seek medical care and this is evident in their lifestyle practices, purchase of health insurance, reporting ill-health and visits to health care institution for preventative and curative care (STATIN, 1990-2008, MOH, 2005).

According to one scholars income buys health (Marmot, 2003), which has some merit. The merit to this argument is linked to the fact that income affords one the ability and option to purchase better foods, medical

care, a particularly good physical environment that are all positively correlated with good health (Bourne, 2008; Chevannes, 2001; Longest, 2002) There is a negative side to affluence and income, as it afford particular lifestyle that retard good health. Income affords one the lifestyle to purchase cigar, tobacco, speedy cars, and in the process remove the disadvantage of low income or poverty. In a study done by a group Caribbean scholars of 1,338 Jamaicans (ages 15 to 99 years), they found that greatest subjective psychosocial wellbeing was had by the middle class followed by the wealth and lastly by the poor (Powell *et al.,* 2007).

Embedded in the income and health debate, is the difficulty of the poor in seeking medical care (curative and preventative care). This study has shown that there is a moderately strong correlation between seeking medical care and prevalence of poverty, suggesting that poor men are even less likely to seek care than those in the middle to upper class. When poverty is coalescing with the cultural biases and image of health, men are likely to suffer more as they must balance ill-health which is a weakness with in affordability. The issue of affordability is seen in the percentage of those in the poorest quintile with health insurance in 2007 (6.6%) compared to 12% in quintile 2, 18% in quintile 3, 22.7% in quintile 4 and 43.4% of those in the wealthiest quintile. Embedded in this disparity is the poor's inability to plan for the eventuality of ill-health coupled with deplorable reality of the physical environment. This physical environment is such to account for ill-health (Pacione, 2006) and when poor nutrition is added to this situation the poor will become even more ill.

Concluding Comments:

In summary, illness is still seen and interpreted by Jamaicans as punishment and negative health, and this explains their low self-reported health conditions and health care seeking behaviour. Men who are product of the society must abide within the image of its dictates, which justifies their unwillingness to seek medical care, report illness, purchase health insurance coverage and create an image of weakness. In spite of this reality, men have become more involved that women in seeking medical care over the last 17 years. This means that the society is becoming increasingly more cognizant that ill-health is more than negative health or is simply equivalent to weakness, female or less macho men. Although men are substantially driven by health conditions to seek medical care than women, they are becoming more involved in health care treatment.

Recommendation:

Further efforts are needed to eliminate more of the barriers of the negative image of health and the use of medical services for ill-health in Jamaica. Medical practitioners, health care workers, social workers and researchers must integrate the image of men in their treatment, and create an atmosphere which is conducive to health care for men. A single prevalence study is needed to ascertain the influence of each of the identified variables in this study and others in order to understand the role of poverty, health insurance, ill-health, on the health seeking behaviour of Jamaicans, the media, education as well as confounding variables such as gender, age, religiosity, area of residence and subjective social class. In addition, a study is necessary to ascertain whether the increased in self-reported health is owing to unemployment, and how much of ill-health is accounted for by psychological conditions.

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