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LATIN AMERICA AND CARIBBEAN HEALTH AND NUTRITION SUSTAINABILITY:

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**Access to Health Care in Jamaica:
Impact of the Health Sector Initiatives
Project**

February 28, 1995

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Beverley E. Russell, R.N., M.P.H.**

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Acronyms

CPI	Consumer Price Index
HSIP	Health Sector Initiatives Project
LAC HNS	Latin America and Caribbean Health and Nutrition Sustainability
PIOJ	Planning Institute of Jamaica
SLC	Standards of Living Conditions
USAID	United States Agency for International Development

Summary

The Survey of Living Conditions is an annual household survey. Since 1989, it has interviewed between 6,960 and 17,298 Jamaican residents per year. Utilization of and expenditures for health services in the 4 weeks prior to the interview is the subject of one of its 17 modules. Through those data, we have evaluated the impact of initiatives in health financing and management implemented by the USAID Health Sector Initiatives Project and related programs. The data show that the policies to implement higher user fees and more complete collections were, in fact, implemented. After adjusting for inflation, out-of-pocket payments for care in the public sector had fallen through 1992 but then increased fourfold from 1992 to 1993. Nevertheless, average expenditures per person treated in the public sector in the past 4 weeks (J\$80 in 1993 prices, or US\$2.86 at the 1993 exchange rate of J\$28 per US\$1) were only about a quarter of the average expenditures per person treated in the private sector in the same period (J\$298 or US\$10.64).

Despite the price increase, the survey shows that access to care was maintained during the interval with the greatest price increase. The proportion of respondents sick or injured who sought medical care actually arose from 1992 to 1993, both overall and specifically for households in lower socio-economic levels. The public share among those using medical services was also maintained. Based on available data, the moderate fee increases implemented by the Ministry of Health have not adversely affected utilization. In fact, if fee increases can sufficiently improve quality, they improve utilization. Thus, higher user fees have the potential to improve quality of public services without adverse effects on access.

Finally, the results show the importance of perceptions and communications. Despite the fall in real prices through 1992, discussions and impending price increases led to fears that the poor would be denied services and use by patients of lower economic levels would decline sharply. While the gap in user rates between upper and lower level consumers declined from 1992 to 1993, the 1993 level remained larger than in 1989 and shows the importance of public education and training of social workers to ensure that exemptions for indigents will be applied equitably and efficiently.

Introduction

The Health Sector Initiatives Project (HSIP) was designed to improve the financing, management, and quality of the public health facilities in Jamaica. Because of the financial constraints of the Government of Jamaica, one of the main strategies to improve the financing of public facilities was to require higher user fees for patients. In Jamaica, as in any country adopting this policy, officials fear that the services will become unaffordable to the people they are designed to serve. If this effect happened, then utilization of services would decline.

The HSIP made considerable efforts to forestall the possible adverse effects of fee increases. First, it conducted marketing studies to determine fee levels that would be acceptable (generally not more than twice the pre-existing levels). Second, it developed a far reaching publicity campaign about the need for higher user fees. The project developed a catchy slogan ("Share Care") to announce that patients and officials each shared a portion of the responsibility for care.

Quality improvements, on the other hand, can increase utilization, even in the face of higher fees as shown in a Cameroonian study (Litvack and Bodart, 1993). While a companion study for Jamaica did not find quality improvements due to the initial implementation of only one component of the HSIP, the installation of Chief Executive Officers, overall levels of quality were acceptable.

The data used here to address those questions are derived from household surveys. Household surveys are necessarily expensive. The Survey of Living Conditions, described further below, provides a rich data source available in only a few countries to monitor social progress.

Methods

The Survey of Living Conditions (SLC) is a series of annual household surveys begun in 1989. Supported by the World Bank, the SLC is based on its Living Standards Measurement Survey. In Jamaica, the SLC has been designed and analyzed by the Planning Institute of Jamaica (PIOJ), which writes the questionnaires. The sample design, field work, and data management are performed by the Statistical Institute of Jamaica.

The 1989 SLC illustrates the procedures which have been used on all subsequent surveys. Clusters were randomly drawn from the Labor Force Survey sample pool, and households chosen from those clusters. After a pretest and a smaller survey earlier in the year, the main 1989 survey entered the field in November, 1989. After excluding 89 households which refused to respond to some or all questions, 3,861 households with usable data were analyzed. Of these, 1,074 came from the Kingston Metropolitan Area, 738 from other towns, and 2043 from the rural areas.

The 1989 survey contained 17 parts, and subsequent surveys were similar. One part enumerates each member of the sampled household. Another part determines the household's overall level of consumption, an important indicator in rating the economic level of the household. And finally, it asks several questions about health, use of health services, and expenditures for health services.

The core questions have been retained in each subsequent year, ensuring valuable continuity in the data. In subsequent years, however, some supplemental questions were added (e.g. a survey of facilities in 1989, and questions about hospital use over the past *year* in 1993). Around July of each year the survey was field tested again and implemented in the field about November. PIOJ has generally published a full report about a year and a half after each study entered the field.

Core questions on health are:

- Was any member of the household ill or injured during the last four weeks?
- If so, was care obtained?
- If care was obtained, at which level (i.e. ambulatory or hospital)?
- In which sector was care obtained (public, private, or both)?
- How much was paid for care in each sector?

The full health section of the 1993 questionnaire is given in Appendix B. For questions on obtaining care and the source of care, only those respondents ill or injured in the last four weeks are eligible to answer the questions. Thus, the sample size for these items is considerably smaller than that for the overall survey. Nevertheless, the overall sample size is sufficiently large that even these items can be analyzed by important population characteristics, such as geography or economic status. Table 1 gives the sample sizes for each year's survey.

Table 1. Sample sizes for SLC by year

	1989	1990	1991	1992	1993
Number of households	3,861	1,828	1,776	4,413	1,866
Average household size	4.26	3.92	3.92	3.92	3.92
Number of people	16,448	7,166	6,960	17,298	7,313
Percent of people ill/injured in 4 weeks prior to survey	17.7%	18.3%	13.7%	10.6%	11.8%
Number of people ill or injured	2,911	1,311	954	1,825	861

In this analysis, monetary amounts were adjusted to constant 1993 prices based on the Consumer Price Index (CPI) for all Jamaica, published in March 1994.¹ This index differed slightly from one published in 1993² due to some revisions. The overall CPI was considered the most appropriate adjustment for inflation so that increases in health expenditures could be compared to overall rises in the cost of living. While Jamaica does

¹ Statistical review, March 1994. Kingston: Statistical Institute of Jamaica, 1994, p. 100.

² Consumer Price Indexes, annual review, 1993. Kingston: Statistical Institute of Jamaica, 1994.

have a more focused component of the CPI, "health and personal services," it includes hair-do's, personal care items and other personal expenditures not particularly relevant to health care costs.

To compare economic policies among households in different economic levels, the SLC tabulates most items against per capita consumption. For this purpose, consumption is divided into quintiles. To improve statistical stability, we aggregated these quintiles in this report into two consumption groups. The "lower" group comprises the poorest two quintiles. The "upper" group is the other three quintiles, thus including both median and higher level respondents.

Results

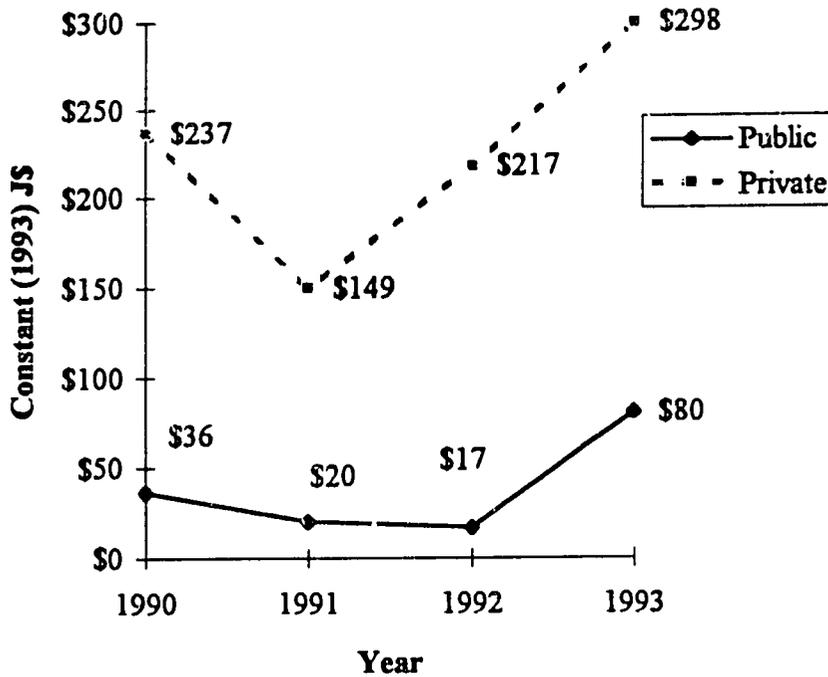
Higher out-of-pocket payments

Figure 1 shows the amounts that Jamaicans who obtained health care over the past four weeks have paid for this care in both the public and private sectors from 1990 through 1993. Out of pocket payments for health care changed in two offsetting ways over these three years. In the first one or two years of this period, both public and private sector payments declined. They reached their lowest in 1991 in the private sector and in 1992 in the public sector. The real (inflation adjusted) public sector amounts fell by half (from J\$36 in 1990 to J\$17) from 1990 to 1992.³ This decline occurred because nominal prices barely changed, while the purchasing power of the Jamaican dollar tumbled by 60 percent over those two years. Similarly, real private sector expenditures fell by 37%, as the small nominal increases were far below the 45% decline in the Jamaican dollar's purchasing power.

In the last one or two years, real expenditures rose sharply in both the public and private sectors. In the private sector (primarily private doctors offices), real expenditures doubled over the two years from 1991 to 1993. In the public sector, the real expenditure per user increased five fold, from J\$17 to J\$80 from 1992 to 1993. These escalations more than offset the earlier reductions. As a result, by the end of this three year period, real out-of-pocket expenditures for health had risen by 26% in the private sector and by a striking 122% in the public sector from 1990 to 1993.

³ In 1992, the exchange rate was approximately J\$20 per US\$1. In 1993, it was about J\$28 per US \$1.

Fig. 1. Mean cost for all visits in past 4 weeks



The public sector increase is due to a combination of higher public fees, more efficient collections, and a higher prevalence of practitioners receiving private fees. These private fees arise when a physician (often a surgeon) is paid a private fee for delivering private services to a patient in a public facility.⁴ Overall, expenditures on private care were about three times those on public care in 1993. With encouragement and support from international organizations (especially USAID, through the HSIP, the World Bank, and the Inter-American Development Bank), the Government of Jamaica implemented its first fee increase in several years in 1992. Fees were raised for most ambulatory visits and prescriptions to J\$50 each at most public hospitals. To improve collection of official fees, the HSIP provided training and the hospitals received incentives. Fees collections were monitored monthly, hospitals could keep the proceeds (at least in the short run), and cashier's hours were extended, so that patients could not avoid payment by leaving the hospital after hours.

Finally, in the 1993 survey, payments by public patients to private providers for care in public facilities first became apparent in the SLC. As the site of care was a public facility, these payments were classified as occurring in public settings, even though the patient's payment to the provider was private. A 1994 hospital-based survey of inpatients

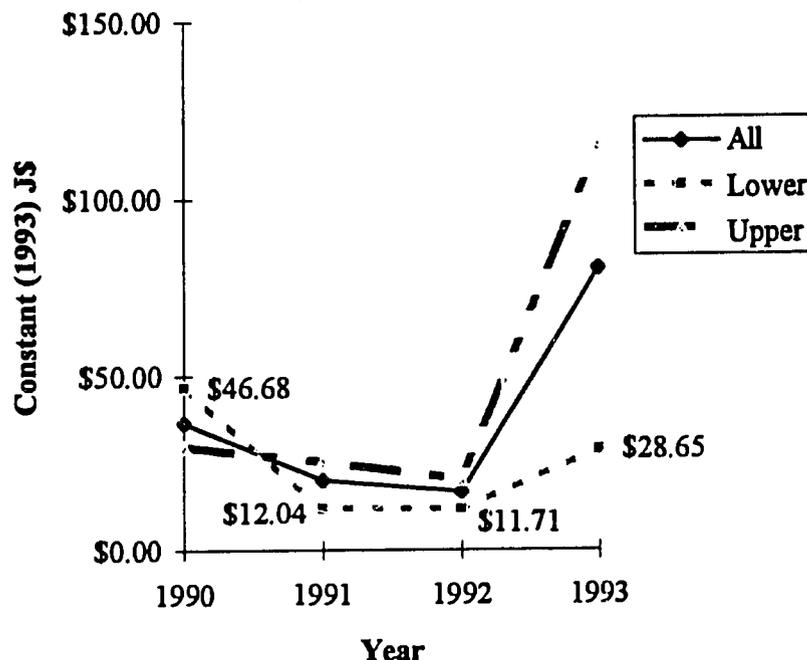
⁴ This practice is allowed provided the physician does not pressure the patient to pay for private services nor obtain special privileges from the hospital (such as preferential admission).

in *secondary* hospitals found that 4.3% reported private payments to doctors.⁵ The average of these payments (J\$4,590) was six times the average public payment to the hospital itself (J\$746). Private payments to providers were probably higher at *tertiary* hospitals, which were covered in the SLC but not the hospital-based survey.

To examine public expenditures in more detail, expenditures for medical services were tabulated by the two consumption groups (see Figure 2). These results show that the lower economic group showed a modest increase in expenditures from 1992 to 1993. Nevertheless, their real expenditures remained less than their level in 1990, the earliest year for which these data are available. And, in each year except 1990, the lower economic (consumption) group spent less than the upper group. Thus, the combination of higher official fees and more private fees in public facilities seems to have been progressive: it affected upper income users more than those of lower income.

Compared to lower income patients, upper income patients were probably more likely to seek the services of private doctors in public facilities. Also, private doctors working in these facilities may have adjusted their fees according to their perceptions of their patients' ability to pay. While reported data are too highly aggregated to confirm these speculations about the origin of the progressive rise in fees, the next variable, seeking care, examines its effect.

Fig. 2 Mean cost for all visits in public sector in past 4 weeks, by group

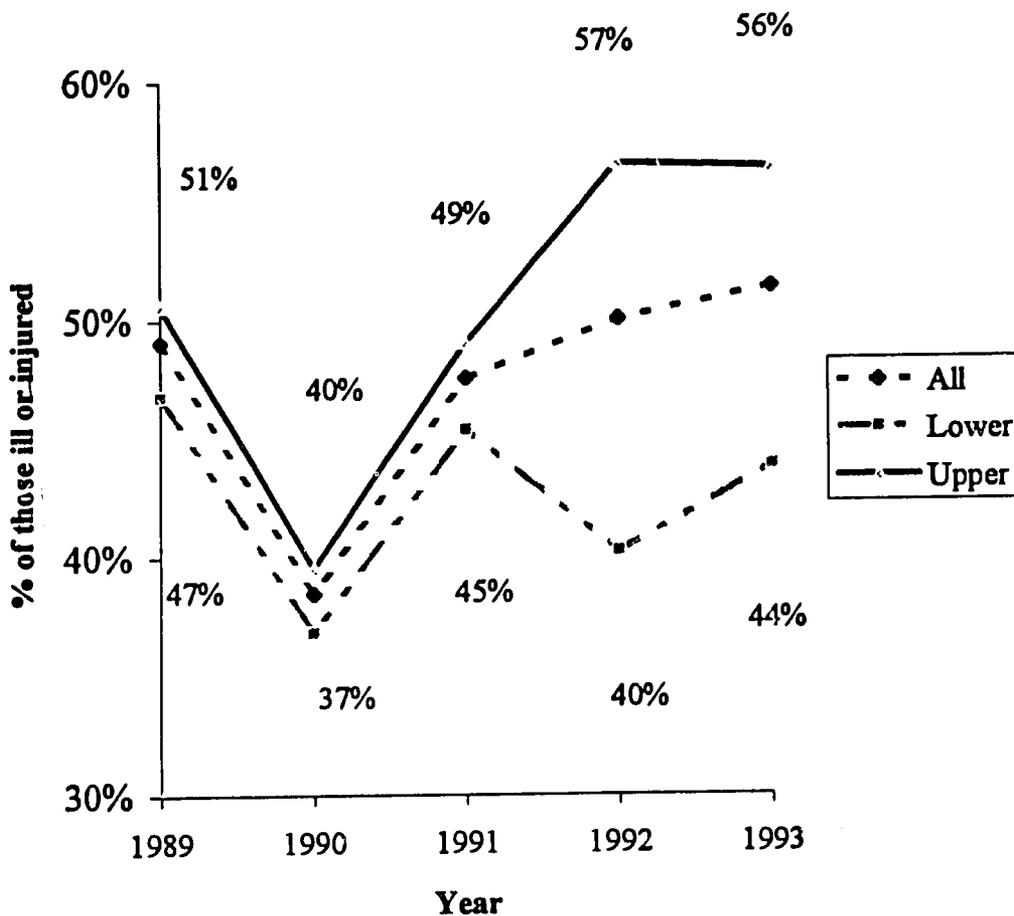


⁵ Shepard DS, Brown D, Ruddock-Kelly, T. Patient satisfaction in Jamaican hospitals. Prepared for the Latin America and the Caribbean Health Financing and Sustainability. Waltham, MA: Institute for Health Policy, Brandeis University, 1995.

Access maintained

Critical questions for policy makers are whether the public health system has been able to maintain access to services and quality of care. While a related study showed that perceived quality was acceptable in Jamaican hospitals,⁶ this present survey allows access to be examined. The first measure of access is the overall proportion of people who were ill or injured in the past 4 weeks and received medical care. Although responses include services in both the public and private sectors, the public sector is considered the provider of last resort or the metaphorical "safety net." As was shown in Figure 1, public sector expenditures among users were only 8% to 27% of those in the private sector. Thus a low rate of using medical services would indicate holes in the safety net. Figure 3 displays the time trend on this variable from 1989 through 1993 by three economic levels – lower, upper, and overall (denoted by "all").

Fig. 3. Seeking care, by consumption group



⁶ Shepard, Brown and Ruddock-Kelly, *op cit.*

Figure 3 shows that there has been little systematic change in access to care. Access in the lower economic group has remained below that in the upper group, as expected. The difference in the rate of access between the upper and lower consumption groups has fluctuated considerably, however. It reached a low of only 3% in 1990 (40% less 37%) compared to a high of 17% (calculated as 57% minus 40%) in 1992.

These gaps in rates of seeking care are not associated with the relative expenditures in the public sector. The difference in expenditures between the upper and lower economic groups was small in 1992, but the gap in access was largest. From 1992 to 1993, the gap in expenditures grew sharply, but the gap in access declined. This erratic pattern suggests that perceived prices may be more important than actual prices in determining access. Although increases in public sector prices were not implemented until the beginning of 1993 (as shown by the expenditure pattern in Figure 2), they were discussed in 1992. Despite policy to the contrary, patients of lower economic levels may have feared that they would be denied services in public facilities and refrained from using them.

As one study from Cameroon showed, increases in price could, in fact, increase utilization if the accompanying improvements in quality were sufficiently great.⁷ Jamaica, of course, has a substantially better public health system than Cameroon. The above mentioned satisfaction survey found relatively high rates of client satisfaction, even in "control" hospitals which lacked Chief Executive Officers. Thus, improvements in access would not have been expected. It is a credit to the overall confidence in the public health system, and perhaps to systems of exemptions for the poor, that access has been maintained.

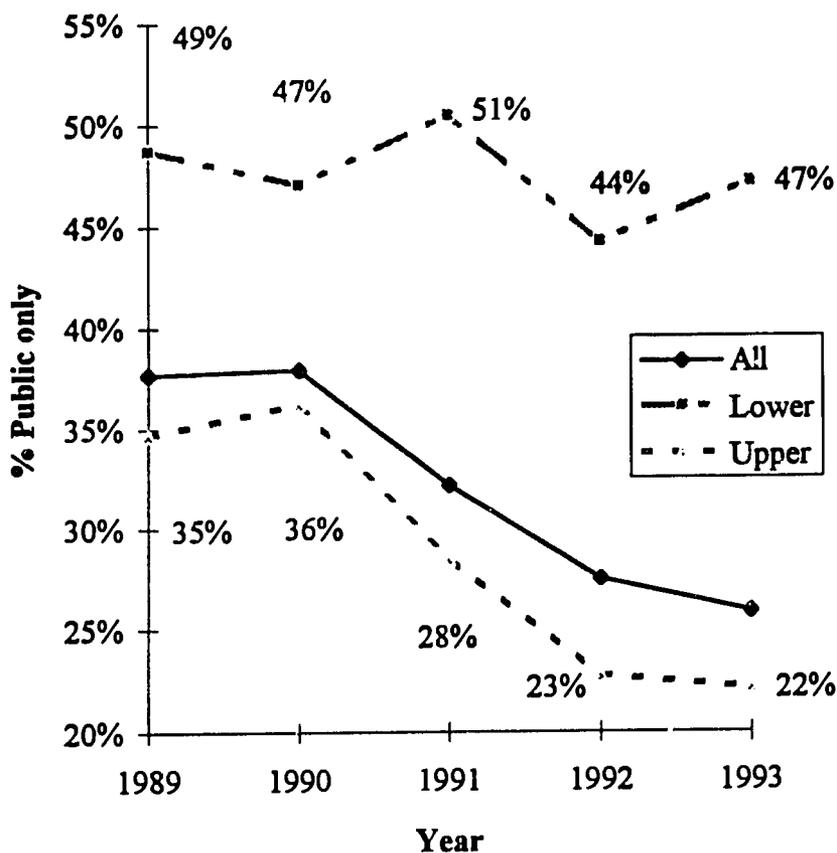
Market share

A final indicator of impact is market share: the proportion of patients seeking care who use the public sector. This indicator can be expressed as either the proportion of "public only" clients, or the proportion of "any public" clients. The former excludes those patients (who average about 5 percent of users) who use *both* the public and private sectors within the past 28 days. Clients using only the public sector would seem to be the more appropriate indicator of quality. Cost-conscious patients would probably seek treatment first in the public sector. Despite the price increases, the public fees are modest compared to those in private practice. If clients considered the public treatment adequate, they would not seek further care for the episode. If the public treatment were not considered adequate, then private care would be sought. Patients who lacked confidence in the public sector altogether would go directly to the private sector if they perceived if they could afford it.

⁷ Litvack JJ, Bodart C. User fees plus quality equals improved access to health care: results of a field experiment in Cameroon. *Soc. Sci. Med.* 1993; 37:369-383.

To examine these patterns, Figure 4 shows the proportion of patients seeking care who used only the public sector by year. Overall, this proportion declined from 1989 to 1993 in both upper and lower economic groups. The decline may well reflect patients' perceptions of quality, as budget constraints and managerial problems have led to drug shortages. From the data in Appendix A, one can calculate that the proportion of respondents using both public and private sector rose from an average of 1% in 1989 and 1990 to 7% in 1991 through 1993. Anecdotally, financially limited patients report that they first seek public care, but may seek private care if they do not obtain drugs. It is encouraging that this pattern seems to have been arrested in the last year. Despite the increase in prices in the public sector from 1992 to 1993, the public sector's share of the market rose for the *lower* economic group (from 44% to 47%), who are most dependent on the public sector, and was virtually maintained in *upper* economic group (changing from 23% to 22%).

Fig. 4. Source of medical care by consumption group



Discussion

Household surveys, such as the SLC, provide data not available by other means. Measuring access to care requires interviewing persons who were ill but did not necessarily receive care. Because of the substantial organizational costs of sampling and contacting households and obtaining consumption to be able to sort households into economic groups, there are enormous economies in being able to use an existing survey for additional analyses, as was done here.

These results show that access to care has generally been maintained despite asking users to support a greater share of the costs of their health care. This is a commendable accomplishment. It is particularly salient because higher user fees has been on the policy agenda in Jamaica, as in other countries, for a decade. One of the major impediments has been a fear that higher fees would destroy access.⁸

It appears that quality and *perceptions* of prices have been major determinants of access and market share. The public sector market share declined from 1990 to 1992 even while real prices were falling. Although the authors are not aware of objective, year-by-year measures of quality, anecdotal information shows increasing shortages of staff and drugs. A perception that prices were going to be increased may have deterred utilization in 1992. Recognizing the importance of both of these factors, the HSIP includes staff training as an important component of its efforts to raise quality.

HSIP's social marketing effort ("Share Care") is educating consumers about their need to share a greater part of the cost of their curative health services. At the same time, posters and flyers must remind consumers that assessment officers will ensure that fees can be waived for indigent patients. The success of the HSIP in training cashiers and accountants in collection procedures must be extended to assessment officers and social workers, who can determine which patients should be exempted efficiently and equitably.

The ultimate aim of health policy makers is not just to maintain access, but to strengthen it compared to the situation expected without innovations in health financing. Improved financing is a key ingredient to improved cash flows, staff morale, quality, drug supplies, and other improvements at public health institutions. A 1994 survey of patient satisfaction provides a baseline against which subsequent changes in perceived quality can be measured. At the same time, policy makers should continue to monitor access using the survey of living conditions to see whether it is improved. Policies to publicize improvements in quality as they occur, to train staff in treating patients with the respect due a paying client, and to ensure that fees can be waived in cases of hardship remain important. Surveys such as this remain the ultimate watchman to ensure they are refined until they succeed.

⁸ Cumper G. Should we *plan* for contraction in health services? The Jamaican experience. *Health Policy Planning*, 1993; 8:113-121.

Appendix A: Data by year

Appendix A. Results from the Jamaica Survey of Living Conditions, by Year

	1989	1990	1991	1992	1993
Of those ill or injured in past 4 weeks, percent seeking medical care					
	1989	1990	1991	1992	1993
Poor	44%	36%	39%	35%	29%
2	50%	38%	52%	46%	49%
3	48%	39%	49%	54%	45%
4	53%	40%	51%	56%	63%
Rich	52%	40%	48%	60%	60%
All	49%	38%	48%	50%	51%
Lower	47%	37%	45%	40%	44%
Upper	51%	40%	49%	57%	56%
Private only					
	1989	1990	1991	1992	1993
Poorest	47%	49%	34%	49%	52%
2	52%	57%	53%	48%	59%
3	54%	52%	65%	65%	62%
4	63%	66%	53%	65%	74%
Richest	75%	74%	74%	78%	83%
All	58%	60%	56%	61%	62%
Lower	50%	53%	44%	49%	46%
Upper	64%	64%	64%	70%	73%
Public only					
	1989	1990	1991	1992	1993
Poor	51%	51%	58%	47%	58%
2	47%	43%	43%	42%	37%
3	44%	48%	29%	29%	29%
4	36%	34%	36%	27%	21%
Rich	24%	26%	21%	12%	17%
All	38%	38%	32%	28%	26%
Lower	49%	47%	51%	44%	47%
Upper	35%	36%	28%	23%	22%

Any public

	1989	1990	1991	1992	1993
Poor	53%	51%	66%	51%	68%
2	48%	43%	47%	52%	41%
3	46%	48%	35%	34%	38%
4	38%	34%	47%	35%	26%
Rich	25%	26%	26%	22%	18%
All	39%	38%	39%	36%	31%
Lower	50%	47%	56%	51%	55%
Upper	36%	36%	36%	30%	27%

Mean expenditures in last 4 weeks (current \$)

	1990	1991	1992	1993
	Public			Public
Poor	\$14.50	\$7.10	\$10.80	\$33.70
2	\$13.90	\$6.10	\$7.20	\$23.60
3	\$5.70	\$21.90	\$7.40	\$231.00
4	\$11.00	\$13.30	\$13.70	\$87.90
Rich	\$10.30	\$6.60	\$25.50	\$ 25.90
Calc. All	\$ 10.23	\$ 11.98	\$ 13.45	\$ 92.10
Input All	\$10.90	\$10.90	\$13.90	\$114.80
New index/a	166.1	299.3	419.6	546.0
Old index/b	160.8	278.6	416..3	523.5

	Private	Private	Private	Private
Poor	\$50.00	\$62.90	\$95.80	\$116.00
2	\$62.20	\$67.10	\$151.70	\$149.10
3	\$53.90	\$80.80	\$129.70	\$278.30
4	\$77.30	\$86.40	\$175.30	\$394.80
Rich	\$86.60	\$104.60	\$235.30	\$331.80
Input All	\$72.10	\$81.90	\$167.00	\$298.20

Mean expenditures in last 4 weeks (1993 \$)

	1990	1991	1992	1993
	Public			Public
Poor	\$47.66	\$12.95	\$14.05	\$33.70
2	\$45.69	\$11.13	\$9.37	\$23.60
3	\$18.74	\$39.95	\$9.63	\$231.00
4	\$36.16	\$24.26	\$17.83	\$87.90

Rich	\$33.86	\$12.04	\$33.18	\$25.90	
All	\$35.83	\$19.88	\$18.09	\$114.80	Input
All	\$36.42	\$20.07	\$16.81	\$80.42	Calculated
Lower	\$46.68	\$12.04	\$11.71	\$28.65	
Upper	\$29.58	\$25.42	\$20.21	\$114.93	
New index/a	166.1	299.3	419.6	546	
Old index/b	160.8	278.6	416.3	523.5	

	Private	Private	Private	Private
Poor	\$164.36	\$114.75	\$124.66	\$116.00
2	\$204.46	\$122.41	\$197.40	\$149.10
3	\$177.18	\$147.40	\$168.77	\$278.30
4	\$254.10	\$157.62	\$228.11	\$394.80
Rich	\$284.67	\$190.82	\$306.18	\$331.80
Input All	\$237.01	\$149.41	\$217.31	\$298.20
Lower	\$215.64	\$152.51	\$198.44	\$336.55
Upper	\$260.84	\$170.11	\$261.74	\$315.00
New index/a	166.1	299.3	419.6	546

Public as % of Private

Poor	29%	11%	11%	29%
2	22%	9%	5%	16%
3	11%	27%	6%	83%
4	14%	15%	8%	22%
Rich	12%	6%	11%	8%
All	15%	13%	8%	27%

/a Statistical review. Kingston: Statistical Institute of Jamaica, March 1994, p100.

/a Consumer Price Indices: annual review Kingston: Statistical Institute of Jamaica, 1993, p6.

Mean expenditures in constant (1993) J\$

	1990	1991	1992	1993
Public	\$36	\$20	\$17	\$80
Private	\$237	\$149	\$217	\$298

Appendix B: Survey of Living Conditions 1993 questionnaire

JAMAICA SURVEY OF LIVING CONDITIONS 1993

DATE OF THE INTERVIEW			PARISH	CONSTITUENCY	ENUMERATION DISTRICT N°			DWELLING N°				H/H	AREA	SERIAL N°
DAY	MONTH	YEAR												0292

INTERVIEWER: _____

SUPERVISOR: _____

ADDRESS OF DWELLING: _____

TOTAL TIME OF INTERVIEW -- HOURS: MINUTES:

NUMBER OF TIMES HOUSEHOLD VISITED --

ANTHROPOMETRIST: _____

DATE OF ANTHROPOMETRIC

DAY MONTH YEAR

SECTIONS COMPLETED :

R	A	B	C	D	E	F	G	H	I	J	K	L	M
<input type="checkbox"/>													

-----TO BE COMPLETED BY SUPERVISOR-----

HAS THIS QUESTIONNAIRE BEEN RETURNED TO THE FIELD FOR RECTIFICATION OF ERRORS? YES.....1 NO.....2

IF YES, FOR WHICH ITEMS: _____

INDIVIDUAL N°	1	2	3	4	5	6	7								8	9
	Have you had any illness, injury during the past 4 weeks? For example, have you had a cold, diarrhea, injury due to an accident or any other illness? YES....1 NO.....2 (> 20)	Did this illness or injury begin within the past 4 weeks or before the past 4 weeks? WITHIN PAST 4 WEEKS 1 BEFORE PAST 4 WEEKS 2	For how many days during the past 4 weeks have you suffered from this illness or injury? DAYS	For how many days during the past 4 weeks were you unable to carry on your usual activities because of this illness or injury? DAYS	Has a doctor, nurse, pharmacist, midwife, healer or any other health practitioner been visited during the past 4 weeks? YES....1 NO.....2 (> 16)	How many visits did you make in the past 4 weeks to health practitioners? NUMBER OF VISITS	Where did the visit(s) take place? In a...								How much did you have to pay at public health facilities for all visits made during the past 4 weeks? Do not include the cost of drugs nor any costs paid by your insurance. IF NOTHING SPENT WRITE ZERO AMOUNT JS	How much did you have to pay at private health facilities for all visits made during the past 4 weeks? Do not include the cost of drugs nor any costs paid by your insurance. IF NOTHING SPENT WRITE ZERO AMOUNT JS
	Public Hospital?	Private Hospital?	Public Health/Maternity Centre?	Private Health/Maternity Centre?	Private Doctor's Office?	Private Pharmacy?	Patient's Home?	Other? (SPECIFY)								
01																
02																
03																
04																
05																
06																
07																
08																
09																
10																
11																
12																

INDIVIDUAL H#	10	11	12	13	14	15	16	17		18	19	20
	Did you spend a night in a public hospital or other public establishment during the past 4 weeks?	How many nights during the past 4 weeks did you spend in the public hospital?	How much have you paid or will have to pay altogether for this stay in a public hospital? Do not include the cost of medicines or any costs paid for by your insurance. IF NOTHING SPENT WRITE ZERO AMOUNT JS	Did you spend a night in a private hospital or other private establishment during the past 4 weeks?	How many nights during the past 4 weeks did you spend in the private hospital?	How much have you paid or will have to pay altogether for this stay in a private hospital? Do not include the cost of medicines or any costs paid for by your insurance. IF NOTHING SPENT WRITE ZERO AMOUNT JS	Did you buy medicines during the past 4 weeks for this illness or injury?	Did you purchase medicines in a		How much have you spent for medicines at public sources, e.g. public hospital, health centre, during the past 4 weeks? Do not include costs paid for by your insurance. IF NOTHING SPENT WRITE ZERO AMOUNT JS	How much have you spent for medicines at private sources, e.g. private doctor, pharmacy, etc., during the past 4 weeks? Do not include costs paid for by insurance IF NOTHING D	Are you covered by any health insurance?
	YES....1 NO.....2 (> 13)	NIGHTS		YES...1 NO...2 (> 16)	NIGHTS		YES...1 NO...2 (> 20)	Public Facility?	Private Facility or Pharmacy?			YES...1 NO....2
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PART A - TO BE ASKED OF EACH HOUSEHOLD MEMBER (CONCLUDED)

INDIVIDUAL N°	HOSPITALIZATION EXPENSES DURING PAST 12 MONTHS							28	29	30	31
	21 Have you been hospitalized during the past 12 months? YES...1 NO....2(» 28)	22 How many nights during the past 12 months did you spend in a public hospital or other public health facility? IF ZERO (» 25) NIGHTS	23 How much have you paid or will have to pay altogether for this stay in a public hospital or other public health facility? Do not include the cost of medicines or any cost paid for by your insurance. IF NOTHING SPENT WRITE ZERO AMOUNT J\$	24 How much has your insurance company paid or will have to pay for this stay in a public hospital or other public health facility? IF NOTHING SPENT WRITE ZERO AMOUNT J\$	25 How many nights during the past 12 months did you spend in a private hospital or other private health facility? IF ZERO (» 28) NIGHTS	26 How much have you paid or will have to pay altogether for this stay in a private hospital or other private health facility? Do not include the cost of medicines or any cost paid for by your insurance. IF NOTHING SPENT WRITE ZERO AMOUNT J\$	27 How much has your insurance company paid or will have to pay for this stay in a private hospital or other private health facility? IF NOTHING SPENT WRITE ZERO AMOUNT J\$	ASK TO ALL WOMEN 13-49 YEARS		ASK IF YES FOR Q28 OR Q29	ASK FOR ALL CHILDREN 6 MONTHS TO 71 MONTHS
							Do you have a child under six months? YES....1 NO.....2	Are you currently pregnant? YES...1 NO....2	Are you attending a public health clinic? YES....1 NO.....2	Has this child attended a public health facility? YES.....1 NO.....2 NEXT PERSON	
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