THE ABOLITION OF USER FEES IN THE JAMAICAN PUBLIC HEALTH SYSTEM: IMPACT ON ACCESS, CARE PROVIDED AND THE WORK OF THE PROFESSIONAL NURSE

BY

ADELLA CAMPBELL

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Abstract

The negative impact of user fees on the utilisation of the health services by the poor in developing countries such as Uganda and Jamaica is well documented. Therefore, various governments have been engaged in reforming public health systems to increase access by underserved populations. One such reform is the introduction of free health services. In Jamaica, user fees were abolished in the public health sector in 2007 for children under 18 years and in 2008 free health care was introduced for all users of the public health system. This study evaluated the impact of the 2008 reform on the Jamaican public health system at 1) the national level, 2) the provider level, and 3) the user level. Perspectives were sought on access to care, the care provided, and the work of the professional nurse. Participants were selected from the Ministry of Health (MOH), the four Regional Health Authorities (RHAs), and urban and rural health facilities.

Data collection was done during March – August 2010, using a multi-layered mixed methods evaluation approach, incorporating both qualitative and quantitative methods. Methods included individual interviews with key policymakers (eight) at the MOH and the four RHAs, as well as a senior medical officer of health (one) and pharmacists (three); focus groups with representatives of the main practitioners in the health system including nurses (six groups), pharmacists (one group) and doctors (two groups); document reviews of the MOH and RHAs' annual reports, and a survey of patients (200). Views on the impact of the abolition of user charges differed across the three levels and among the health authorities, facilities, and perspectives (policymakers, practitioners and users). Patient utilisation of the public health system increased exponentially immediately following the abolition of user fees, then declined, but remained above the pre-policy level. The work of health care providers, especially the professional nurse, was affected in that they had to provide the expected and required services to the patients despite an increase in workload and constraints such as inadequate resources.

The research found that, while policymakers were optimistic about the policy, providers had concerns but patients were satisfied with the increased access and the quality care they were now receiving. Users also encountered challenges that constituted barriers to access. In addition to providing further evidence about the abolition of user fees in the public health system, this research provides important new insights into the impact of the nationwide abolition of user fees, as well as the impact of the policy change on the work of the professional nurse. Equally, the findings highlighted the potential benefits, gaps, and failures of the abolition of user fees' policy, and will serve as a catalyst to improve the policy process regarding access to health services and the work of the professional nurse. The findings of this research will be valuable in the planning of health-related programmes for the consumers of health care in developing countries. Despite the need for further research in this area, this research has contributed to the body of knowledge regarding user fees and access to health care in developing countries.

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List of Abbreviations

A&E	Accident and Emergency Department
AIDS	Acquired Immune Deficiency Syndrome
ANOVA	Analysis of Variance
ART	Antiretroviral Therapy
CAT/CT	Computerised Axial Tomography
CARICOM	Caribbean Community
CHA	Community Health Aide
CHASE	Culture, Health, Arts, Sports and Education
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CEO	Chief Executive Officer
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
DR	Doctor
ECOSOC	Economic and Social Council
ESIF	Elective Services Initiatives
NP	Nurse Practitioner
GEASO	Government Employees Administrative Services Only
GDP	Gross Domestic Product
GOJ	Government of Jamaica
GNI	Gross National Income
HIV	Human Immuno-deficiency Virus
IDB	Inter-American Development Bank
ICN	International Council of Nurses
JADEP	Jamaica Drug for the Elderly Programme
JAMPRO	Jamaica Promotions Corporation
JIS	Jamaica Information Service
JSIF	Jamaica Social Investment Fund
JSLC	Jamaica Survey of Living Conditions
KES	Kenya Shilling
KFC	Kentucky Fried Chicken
KPH	Kingston Public Hospital
MDG	Millennium Development Goals

MOF	Ministry of Finance
MOH	Ministry of Health
MoU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
NERHA	Northern Regional Health Authority
NGO	Non-Governmental Organisation
NHF	National Health Fund
NHS	National Health Services
NIS	National Insurance Scheme
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
PAHO	Pan American Health Organisation
PATH	Programme of Advancement through Health and Education
PHC	Primary Health Care
PHI	Public Health Inspectors
PHN	Public Health Nurse
PIOJ	Planning Institute of Jamaica
RHA	Regional Health Authority
RN	Registered Nurse
SERHA	South East Regional Health Authority
SRHA	Southern Regional Health Authority
STATIN	Statistical Institute of Jamaica
STI	Sexually Transmitted Infections
SPSS	Statistical Package for the Social Sciences
TB	Tuberculosis
UK	United Kingdom
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America
USAID	United States Agency for International Development
UTI	Urinary Tract Infection
VEN	Vital Essential and Necessary
VJH	Victoria Jubilee Hospital
WHO	World Health Organisation
WRHA	Western Regional Health Authority

Chapter 1: Introduction

People have ‘good access’ to health services when they receive “the right service, at the right time, in the right place” (Chapman, Zechel, Carter, & Abbott, 2004, p. 374). For many people, however, poor access to health services is a reality. Furthermore, such poor access appears to be a global issue, regardless of the type of health care system that exists in any one particular country. Diverse factors such as one’s socioeconomic status, ethnicity and gender contribute to the inability to access health care. In addition, charges for health care (user fees) are major barriers to people’s ability to access health services when required (Flores, Abreu, Olivar, & Kastner, 1998; Hussey et al., 2007; Kiwanuka et al., 2008; Yamada, Chen, Yamada, Chiu, & Smith, 2009).

One solution adopted by some policymakers for the problem of poor access, as well as to ensure universal coverage, is the abolition of user fees (Bitran & Giedeon, 2002; Ridde & Diarra, 2009). Removal of user fees has been shown in many countries to be effective in achieving improved access to health services (Abdu, Mohammed, Bashier, & Eriksson, 2004; James, Morris, Keith, & Taylor, 2005; Ridde & Diarra, 2009; McPake, Schmidt, Araujo, & Tashobya, 2008). Based on the findings of the *Jamaica Survey of Living Conditions 2007* (Planning Institute of Jamaica [PIOJ] & the Statistical Institute of Jamaica [STATIN], 2008), it was apparent that patients encountered barriers in accessing health care in Jamaica. Inability to pay was identified as one such barrier to individuals of low socioeconomic status. Therefore, in 2007 and 2008 the government embarked on far-reaching policy changes regarding user fees in the public health sector as a means to improve access to health services by the underserved population. User fees had previously been charged to raise revenue in order to foster improvement and efficiency in the health sector. However, user fees were found to be regressive and resulted in unnecessary morbidity and mortality among the poor who could not afford the services (PIOJ & STATIN). This thesis reports on a study that examined the impact of the abolition of user fees on access to health care in Jamaica.

To better understand the Jamaican context, this chapter provides an overview of the profile of Jamaica and issues regarding access to health care within the country generally. It further sets out the aim; the research questions; the significance and relevance of the study; and presents the thesis outline.

1.1. Profile of Jamaica

Geographic characteristics. Jamaica, a member of the Commonwealth of Nations, is the largest English speaking Caribbean Island and the third largest country in the Caribbean Community (CARICOM). Jamaica has a land mass of approximately 10,991 square kilometres (km^2) and lies 885 km south of Miami, Florida, in the United States of America (USA) and 145 km south of Cuba (Jamaica Promotion Corporation [JAMPRO], 2010). Administratively, Jamaica is divided into three counties: Cornwall, Middlesex, and Surrey, which are further subdivided into 14 parishes. The parishes within the counties include Cornwall – St. James, Trelawny, Westmoreland, St. Elizabeth and Hanover; Middlesex – Clarendon, Manchester, St. Catherine, St. Mary and St. Ann, and Surrey – Kingston, St. Andrew, Portland and St. Thomas. Each parish has a capital and several districts. There are two major cities, Kingston, the capital, and Montego Bay, one of the main tourist resort areas (Figure 1) (Pan American Health Organisation/World Health Organisation [PAHO/WHO], 2007).

Figure 1. Map of Jamaica (Source: Pie a la Mode ©Action 4 Reel Filmworks, 2011). Reproduced with permission

Demographic characteristics. Jamaica had a population of 2,698,810 at the end of 2009 (Statistical Institute of Jamaica [STATIN], 2010) with a population growth rate of 0.2% over 2008 (Planning Institute of Jamaica [PIOJ], 2011). Jamaicans are predominantly of African descent – 97.0%, East Indian – 1.3%, European – 0.2%, Chinese – 0.2%, mixed - 0.7% and other – 0.6% (Jamaica Ethnic Group, 2009). In 2009, the age distribution comprised 0-14 years (27.4%, male 378,762/female 360,906), 15-64 years

(64.1%, male 849,073/female 880,471) and 65 years and older (8.5%, male 101,506/female 128,091) (STATIN). Of note is that the 15-64 age group is increasing and 65 years and older is the fastest growing group in proportion. Conversely, the 0-14 age group is declining. The ageing population may be a result of a reduction in fertility and mortality rates in addition to increased migration rates. The age profile has implications for the health sector both in terms of the development of programmes for the prevention and management of chronic non-communicable diseases, as well as adequate health financing for this group (MOH, 2009c).

In 2010, Jamaicans had a life expectancy of 74.13 years (STATIN, 2010), which compares well with global trends (UNDP, 2011; World Bank, 2011). The infant mortality rate was 16.7 deaths per 1,000 live births. The maternal mortality rate was 94.8 per 100,000 live births. The crude birth rate was 15.4, and the crude death rate was 6.0 per 1,000 population; total fertility rate stood at 2.4 children per woman (STATIN). The infant and maternal mortality rates may have implications for Jamaica's achievement of global targets such as health-related Millennium Development Goals (MDG) (PIOJ & Ministry of Foreign Affairs and Foreign Trade [MFAFT], 2009).

Jamaica enjoys good health status generally (Watson Williams, 2008), has a good primary health care (PHC) track record and compares well internationally; for example, immunisation coverage in 2010 was 95.0% whereas global coverage was 85.3% (PIOJ, 2011; World Bank, 2011).

Political characteristics. Jamaica is a former British Colony. Having obtained its Independence in 1962, the nation opted to remain within the British Commonwealth. The Queen is represented by a native Governor General, who is recommended by the Prime Minister. The Westminster Whitehall model of Parliamentary democracy is used with 'first past the post' general elections, which can only be called by the Prime Minister every five years. It has bicameral legislature; Cabinet governance; and Ministerial assignments (Jamaica Constitution 1962; PAHO/WHO, 2007; WHO, 2010a).

There is an inextricable link between the diversity of the population and the country's history of Plantocracy, also called Slavocracy (a political system in which white landowners dominated the government) (Black, 2011). The Jamaican motto "Out of Many One People" aptly reflects its ethnic composition, as well as accentuating the unity embraced by the Jamaican people as they contribute to nation building (Jamaica Information Service [JIS], 2007). Consistent with international trends there is increased urbanisation in Jamaica. Half of the population reside in urban areas, especially in the Kingston Metropolitan Area. This essentially is a result of industrialisation (PAHO/WHO, 2007), which has encouraged people to move to urban areas in search of jobs and better quality of life.

Social and health characteristics. Social indicators for Jamaica for 2006–2010 are shown in Table 1. Despite the fluctuating trends for some indicators it is important to note the achievements made over the years in the Human Development Index, literacy rates, and access to safe water. Enrolment in primary school has seen a minimal decline, which may be attributed to the decline in fertility rates. Another area of concern is the high unemployment rate, which has implications for the economy generally, and the health sector and the health of the nation by extension.

Table 1

Social Indicators for Jamaica 2006 – 2010

Indicators	Years				
	2006	2007	2008	2009	2010
Population	2,669,542	2,682,120	2,692,358	2,698810	2,705,800
Population growth (annual %)	0.5	0.5	0.4	0.2	0.3
Human Development Index	0.710	0.717	0.724	0.724	0.726
Enrolment in primary school (‘000)	318.7	310.0	315.1	307.8	294.7
Literacy rate (%)	85.5	86.0	86.4	86.8	91.7
Labour Force (Total)	1,229,633	1,243,867	1,256,272	1,228,415	1,223,195
Unemployment rate (%)	10.3	9.8	10.6	11.4	12.4
Access to safe water	77.3	78.7	81.1	81.3	88.0

Note. Source: PIOJ. (2011). *Economic and Social Survey Jamaica 2010. K*ingston, Jamaica: Author.

- STATIN. (2010). *Demographic statistics 2009*. Kingston, Jamaica: Author.
- UNDP. (2011). (2011). *International Human Development Indicators*. Retrieved from http://hdrstats.undp.org/en/countries/profiles/JAM.html
- World Bank. (2011). *World Development Indicators*. International Bank for Reconstruction and Development/ The World Bank, Washington D.C, USA: Author.

The nation is on track with targeted health-related MDG with successes in reducing absolute poverty, malnutrition and hunger. In addition, universal primary school enrolment has been achieved. In 2009, it was 99.5% for children aged 3-11 years (PIOJ & STATIN, 2010); and progress is being made in providing safe drinking water and reducing the prevalence of HIV/AIDS *inter alia* (PIOJ, 2009*)*. The estimated adult (15-49 age group) HIV prevalence rate was 1.7% in 2009, with approximately 21,000 Jamaicans of all ages living with the disease (United Nations International Children's Emergency Fund [UNICEF], 2010).

Economic characteristics. Despite perennial fiscal problems, Jamaica is currently classified as an upper middle-income country (World Bank, 2011). The economy has been negatively affected by servicing an external debt burden (4th highest debt-to-Gross Domestic Product (GDP) ratio in the world) (Economic and Social Council [ECOSOC], 2009) and, more recently, by contraction, as a spin off from the global recession, especially in revenue generated from remittances. To achieve some stability in the economy, the government renewed its relationship with the International Monetary Fund (IMF) in 2010 (Johnston & Montecino, 2011). The country had a GDP per capita of US$5,133 in 2010 (Table 2).

Table 2

Economic indicators for Jamaica 2006-2010

Indicators	Years				
	2006	2007	2008	2009	2010
GDP per capita (current $US)	4,616	4,949	4,994	4,615	5,133
GDP growth rate (%)	3.2	0.6	-1.7	-2.6	-0.6
Inflation, consumer prices (annual %)	8.6	9.3	22.0	9.6	12.6
External debt stocks (% GNI)	70.84	86.58	76.18	91.42	104.21
Net ODA received (% of GNI)	0.3	0.2	0.7	1.3	1.1

Note. Source: PIOJ. (2011). *Economic and Social Survey Jamaica 2010. K*ingston, Jamaica: Author.

- World Bank. (2011). *World Development Indicators*. International Bank for Reconstruction and Development/ The World Bank, Washington D.C, USA: Author.

Despite marginal increases in recurrent budgetary allocation, there has been a decline in capital budgetary allocation generally. For the financial year 2010/2011, an estimated $32.7 billion was allocated to the health sector, a 6.9% increase over the 2009/2010 financial year. Additional funding of $62.7 million was generated from new initiatives by the government, for example, the Jamaica/Cuban Eye Care Programme (PIOJ, 2011), introduced in 2005.

Environmental characteristics. Jamaica is susceptible to frequent natural disasters such as hurricanes and storms, which, undoubtedly, affect its progress economically. Disruption in the agricultural sector from these phenomena over the years has resulted in a decline in exports of produce such as sugar, banana and coffee. However, through governmental assistance to improve the robustness in the sector, there was some growth in 2010. The growth was realised despite damage caused by Tropical Storm Nicole to crops and livestock amounting to $576.5 million (PIOJ, 2011). The environment portfolio falls within the ambit of the MOH and, as such, has implications for funding of the health sector.

1.2. Overview of health care in Jamaica

Recent efforts by the Jamaican government to enhance access to health care were fast-tracked by data from the *Jamaica Survey of Living Conditions 2007*. The data revealed that approximately 50.3% of Jamaicans in the lower socioeconomic group were not accessing health care despite their illnesses (PIOJ & STATIN, 2008). The evidence indicated that the cost of services and socioeconomic status were determinants in individuals' ability to access health services.

Jamaica has a two-tiered health sector, which comprises both a public and private sector. This research focuses primarily on the public sector; however, a brief description of the private health sector will also be given in this chapter. Both systems will be discussed further in Chapter 2. Despite the dearth of literature on the private health sector, the available information suggests that it is utilised by individuals as an alternative to the public sector. The private sector is largely unregulated, and therefore has minimal obligatory responsibilities to the MOH (Health Sector Task Force, 2009).

Delivery of public health care is provided by four Regional Health Authorities (RHAs) through a network of primary, secondary and tertiary health care facilities. The public health services are funded by an annual national budgetary allocation from the government, revenues collected from user fees, funds donated by international bilateral and multilateral development agencies (MOH, 2008a), and gifts. Table 3 shows the expenditure on health for the period 2006-2010. While the figures portray some volatility in funding over time, they also highlight the significant role played by out-of-pocket expenditures. For some users of the public health sector, health insurance is not a reality and, as such, many experience difficulty obtaining care when required, especially from private providers.

Table 3

Health financing indicators in the Jamaican public health sector 2006 – 2010

Indicators	Year				
	2006	2007	2008	2009	2010
Total health expenditure (% GDP)	4.2	4.9	5.2	4.9	4.8
Per capita total health expenditure (current $US)	187	230	272	228	247
Public expenditure on health as a % of total expenditure on health	54.7	52.0	53.5	55.4	53.5
Out-of-pocket expenditure (% private expenditure on health)	63.7	71.0	71.0	71.0	71.0

Note. Source: World Bank. (2011). *World Development Indicators*. International Bank for Reconstruction and Development/The World Bank, Washington D.C, USA: Author

In contrast, private health care is available to consumers who can afford it. Private health care is provided by general practitioners and a network of institutions offering health services, mainly in the area of pharmaceuticals and diagnostic services. These private health facilities may be located within the 14 parishes and are not managed or regulated by the RHAs. Such services are funded by individuals through fees charged for services. Fees in the private sector usually exceed the charges for care in the public sector. Users of the private health sector often hold health insurance (PIOJ & STATIN, 2008). Of note is that some public health institutions also provide privately-funded health services for those who require it.

Health insurance will be discussed further in Chapter 2. It is provided mainly by private companies and has been used to offset the cost of health care in Jamaica. *The Jamaica Survey of Living Conditions 2007* revealed that more persons in the upper quintiles (where the statistical sample is divided into fifths, in which quintile 1 is the lowest and quintile 5 is the highest on the social status scale) have access to this arrangement in comparison to those who are of low socioeconomic status. This was more pronounced in the rural areas where health insurance coverage was lowest, albeit the group with a high percentage of individuals reporting illness but who did not seek health care (PIOJ & STATIN, 2008). The survey also found that increased health insurance coverage paralleled an increase in the number of individuals from the various quintiles (PIOJ & STATIN). These findings corroborated data from other studies (Flores et al., 1998; Hussey et al., 2007).

Choice of health facility is sometimes based on individuals' perception of quality and efficient service delivery (Kiwanuka et al., 2008; Nabyonga et al., 2005). Choice can also be influenced by distance from facility, transportation, diversity of the service, how technologically advanced the service is, operating hours, cost of the service, access to health insurance, preference, and severity of illness (MOH, 2008a).

Although consumers of health care in Jamaica have access to both public and private health care, data from *The Jamaica Survey of Living Conditions 2007* highlighted that, over time, there was an increase in the number of persons reporting illness and injury in all quintiles. Significantly, the findings showed that those in quintile 1 had a lower utilisation rate of the health system than those in the higher quintiles (PIOJ & STATIN, 2008). Despite the ability to choose, some consumers were challenged by issues relating to affordability and accessibility of care.

For this reason, policymakers are constantly monitoring the progress of health care and the quality of life of the nation's people through health indicators such as mortality rates and life expectancy (MOH, 2008a). In recent years, initiatives such as the Jamaica Drug for the Elderly Programme (JADEP), Programme of Advancement through Health and Education (PATH), the Culture, Health, Arts, Sports and Education (CHASE) Fund and the National Health Fund (NHF) have been implemented to improve access to health services, especially pharmaceuticals. These initiatives will be discussed in more detail in Chapter 2.

Accessing health care, whether public or private, from both hospitals and health centres involves a journey and patients can be either hindered or facilitated at varying stages. Persons facilitating the process include nurses, pharmacists, doctors and other health care providers. Noteworthy is that several categories of nurse facilitate the process at different stages of a patient's journey. Professional nurses in the secondary care settings include registered nurses (RNs) or staff nurses, ward managers and directors of nursing services, and in the PHC settings there are nurse/midwives, public health nurses (PHNs) and nurse practitioners (NPs). NPs attend to patients who are similar to the patients seen by doctors in both the secondary and PHC settings, while the PHNs focus on maternal and child health services. Nurses' roles are discussed further in Chapter 2.

Nurses as members of the health workforce in modern Jamaica are fundamental to achieving access to health care especially among the vulnerable. They have adopted new roles, expanded the scope of their practice, relocated where services are delivered and have consistently targeted at risk groups to improve access. Despite their innovative efforts however, very little is documented about nursing contribution to improving access as well as the impact of health policies on the work of the professional nurse. Therefore, this study also examined the impact of user fees policies on the work of the professional nurse.

Nominal fees used to be charged for health services, especially in the PHC setting. These, however, were found to be one of the barriers to accessing services in the public health sector. Geographic location was also identified as a barrier, especially for people living in the rural areas (PIOJ & STATIN, 2008). To meet the demand of this segment of the population, policymakers resorted to establishing new categories of health workers such as the NPs from as early as 1977 and expanding the role of others such as midwives in the 1970s (McCaw-Binns, Moody, & Standard, 1998).

The debate on user fees in the Jamaica public health system has been on-going. As a result, on May 28, 2007 user fees were abolished for children under 18 years and an election promise was made by the incumbent government to abolish user fees in 2008 for all users of the public health system. The Minister of Health, in a statement validating the government’s position on the abolition of user fees, mentioned the relationship between well-being and development (JIS, 2008), further reiterating the inextricable link between the growth of a nation and the health of its people. Subsequently, fees were removed for all users of public health facilities (hospitals, health centres, laboratories, diagnostic facilities, pharmacies) on April 1, 2008 (MOH, 2008b, 2008c).

This move was intended to indirectly improve access to health services for the poor. The MOH in outlining the policy context noted that:

> The imperatives that informed the abolition of user fees policy are not unique to Jamaica and are as follows: (a) user fees policy has been shown to be regressive and a major impediment to access to health. The *Jamaica Survey of Living Conditions 2007* show that 50.8% of the poorest quintile who reported an illness did not seek health care because they could not afford so to do; (b) user fees have increased poverty because they reduce the disposable incomes of the poor and deplete their asset base; (c) user fees policy impacts negatively on utilisation resulting in deteriorating health outcomes, increasing morbidity and reduced life expectancy. (MOH, 2008b, p. 1)

The aims of the policy included eliminating impediments to access, creating an equitable health sector, reorienting PHC, relieving health staff of administrative tasks such as assessment of patients and collection of fees, and identifying suitable alternative financing and modes of service delivery (MOH, 2008b). Reports have indicated that utilisation of the health facilities increased rapidly in the days following the removal of user fees. There was a 125.0% increase in utilisation for some institutions within days of the policy change (MOH, 2008d, 2009a).

1.3. Problem statement, aim and research questions

While initial government publications indicated increased utilisation of the Jamaican public health system one year after the policy change and poor Jamaicans having saved billions of dollars since the removal of user fees policy (MOH, 2009a; 2009b), it was unclear which segments of society were receiving the benefits. Additionally, there were limited discussions regarding other barriers to accessing health services, as well as the impact of the policy change on the work of the health workforce, especially the professional nurse. Due to limited work in this area and the paucity of information, this study examines the impact of the policy change on access, the care provided, and the work of the professional nurse.

Aim. The aim of this research was to examine access to health services, the care provided, and the work of the professional nurse after the abolition of user fees. The analyses focused on three perspectives: 1) the national level, which included national and regional policymakers sharing their roles in and experiences of the policy change, 2) the provider level, which included the perceptions of main health practitioners such as doctors, nurses and pharmacists in rural and urban settings, and 3) the user level, where patients using the public health system in rural and urban settings shared their perceptions.

Research questions. Four research questions were identified for this study:

1. What is the impact of the abolition of user fees on users’ access to health services?
2. What is the impact of the abolition of user fees on the utilisation of health services and nursing services in particular in the public health sector?
3. What is the impact of the policy change on the work of the professional nurse?
4. What are the lessons learned from the policy change for Jamaica and other developing countries?

1.4. Significance and relevance of the research

It is apparent from the MOH Jamaica reports that the current policy focus is on determining the effects of the user fees policy change on utilisation patterns, savings for the patient, use of pharmaceuticals, waiting time and patient satisfaction (JIS, 2009; MOH, 2009a). This is amidst disparaging remarks by critics, aimed at discrediting the free health care policy change. Critics frequently felt that the policy change was unrealistic and unable to be sustained in the present local and global economic situation (Luton, 2009).

While the policy change has its merits as an agenda to improve access by the poor to health services, little has been published about its success: in reaching target populations, health outcomes, or benefits to the nation from policymakers', providers', and users' perspectives. Most of the available literature has noted the impact of the removal of fees policy on health workers in African countries generally (Burnham, Pariyo, Galiwango, & Wabwire-Mangen, 2004; Wilkinson, Gouws, Sach, & Abdool Karim, 2001). However, very little has been documented about the impact on the work of the professional nurse. One study revealed nurses were indecisive about the impact on their work (Walker & Gilson, 2004). It has also been reported that nurses received bonuses, which contributed to quality of care and effectiveness of the policy change (Ridde & Diarra, 2009). Nurses also associated the removal of user fees with a "sense of being exploited, overworked and de-motivated to the point of considering resignation" (Ridde & Morestin, 2011, p. 8).

Therefore, this project evaluated the effects of the policy change at three levels. Triangulation was used to gather dissimilar but corresponding data that could be used to determine the impact of the no user fees policy. The findings from this multi-layered mixed methods evaluation generated three tiers of data on the impact of the removal of user fees and added to our knowledge of the effects of such policies. Findings also provide insights into how the removal of user fees affected the work of the professional nurse. These findings should be useful in influencing the policy process regarding access to and the delivery of health services.

1.5. Thesis chapter outline

Chapter 1 has provided an introduction to the study, highlighting health care access issues in the Jamaican context. To position the research, it presented the study's statement of problem, the aim, the research questions, and the significance of the study.

Chapter 2 introduces Jamaica historically, as well as providing a detailed description of the Jamaican health service from a policy and organisational perspectives. The purpose of the chapter is to highlight the development and reform of the public health system from the 17^{th}–21^{st} centuries. Additionally, it provides information on the private health system, funding of the health system including health insurance, Jamaican folk medicine, work of the professional nurse, patient's journey to accessing health services, and measures to improve access to care in the Jamaican context.

Chapter 3 provides information on the search strategy for this research, as well as literature about user fees in various health systems including Jamaica, and the impact of the abolition of user fees on health service delivery. It also provides information on the settings of available studies. Most of the studies were conducted in developing countries in Africa; however, some studies have been done in Jamaica. This chapter also highlights the research designs adopted by the researchers, which included qualitative, quantitative and mixed methods designs. The findings regarding the positive and negative effects of user fees and the abolition of user fees are presented. Additionally, it underscores the gaps in the literature, such as the limited work on the impact of the removal of user fees on the work of the professional nurse. The chapter concludes with a restatement of the objectives of the study.

Chapter 4 provides the theoretical framework for the study. It provides detailed discussion on access to health care, clarifying concepts such as access, need, and availability. In addition, it presents information on consumers and access, gender and access, health care affordability and availability, policymakers and access, providers and access, and access to health care within the Jamaican context. The chapter also describes nursing's contribution to improving access.

Chapter 5 describes the methodology for the study. It commences with an overview of the mixed method evaluation multi-layered approach. It highlights the strengths and weaknesses of the design, as well as providing information regarding ethical considerations; population and sampling; materials and methods, instrumentation and timeframe; analysis strategies, measures to ensure validity and reliability; and some of the limitations of the processes involved.

Chapter 6 presents the results for the national, provider and user levels of the study. It commences with the presentation of the policymakers' findings. In addition, it highlights the official statistics regarding utilisation patterns and key health indicators one year before and one year after the abolition of user fees, and the users' findings.

Chapter 7 presents findings on the impact of the abolition of user fees policy on the work of main health practitioners with a focus on the professional nurse. The chapter commences with the practitioners' and nurses' perspectives on their involvement in the policy process, impact of the policy change on their work, funding, their contribution to improving access, satisfaction with their work environment, and their general impression of the policy change.

Chapter 8 discusses the significance of the key findings of the study from the national, provider, and user perspectives. It discusses the impact of the policy change on service delivery in terms of access and utilisation of the services, and on the health of the workforce including nurses. The chapter commences with an overview of the key findings. It further provides justification for the interpretation using relevant research findings and explanations to support findings where appropriate. The discussion integrates all three levels of results.

Chapter 9 provides a conclusion to the study and presents the lessons learnt from the Jamaican experience of the removal of user fees for health services. In addition, it highlights the strengths and limitations of the study; implications for policy, practice and research; and concludes with recommendations for future policy implementation.

The terms users and patients and providers and practitioners will be used interchangeably throughout this study. In addition the 'abolition of user fees policy' will hereafter be referred to as the 'the user fee policy'.

Chapter 2: The Jamaican health system

2.1. Introduction

This chapter provides an introduction to Jamaica and its health system from a policy and structural perspective. It is intended to assist the readers to understand the historical and cultural climate within which the system operates, as well as highlighting significant developments and the current structure. The chapter includes a brief description of Jamaica as a country; the development and reform of the public health system from the 17th-21st centuries; health system funding from the 17th-21st centuries; and the delivery and utilisation of health services.

2.2. Jamaica

Indigenous people and the Spaniards. Historically, the first inhabitants of Jamaica were the Arawak Indians (also called Tainos) from South America. Very little is documented about these natives because they were exterminated seemingly by the 18th century due to the exploitation of the Spaniards and Europeans. Subsequent to the incursion of Christopher Columbus and Spanish convoys in 1494, mortality rates among natives increased exponentially. As a consequence of the high mortality rate among the natives there were fewer labourers to work on the plantations that were established by the Spaniards. Therefore, they resorted to African slave workers in 1517 (Black, 2011; Warner-Lewis, 2002). Mortality rates among the Arawaks were so concerning that “In 1598 the Governor of Jamaica Fernando Melgarejo was alarmed at the speed [with] which the Indian population was dwindling” (Black, p. 27). While many Indians died of the harsh treatment meted out to them by the Spaniards, others committed suicide or infanticide in order to escape the realities of slavery. Additionally, other Indians died as a result of infectious diseases brought into the country by the Europeans. Indians’ farms were also destroyed by the Europeans’ animals such as cattle and goats, leaving very little cultivated land for their survival. The decimation of the natives continued throughout the reign of the British, who conquered the Spaniards and occupied the country in 1655 (Robertson, 2002).

British and Slavocracy. Between the period 1655 and 1838 Jamaica was known for its Plantation System, mainly sugar plantations, which were first introduced by the Spaniards. Sugar production was an economically viable commodity at the time and Jamaica, a leading producer, had a reputation for producing quality sugar (Higman, 2005).

To maintain this status, British estate owners expanded the slave trade and brought slaves in large numbers from Africa to sustain their plantations, which were villages equipped with all the facilities for the production and manufacturing of sugar. This essentially was the precursor to the widely-known slave trade to Jamaica (Black, 2011). After much resistance by estate owners, Jamaica achieved full emancipation in 1838 (Campbell, 2002), a process that commenced with the Abolition Act of 1833. This process was further strengthened by pockets of sustained activism against the inhumane treatment of slaves on the plantations. Notable activists included Granville Sharp, William Wilberforce and William Knibb. Of note however, is that estate owners were averse to ending slavery because "sugar was the crop that produced the greatest wealth and the best opportunities for long term financial success" (Higman, p. 18). This resulted in the introduction of the Apprenticeship system. Under this arrangement, ex-slaves were employed to work 40½ hours per week for the estate owners without compensation (Black). The Apprenticeship system was transitory because reports of the brutal treatment of apprentices resulted in the passing of a resolution in England that signalled its end in 1838. Absentee estate owners had to seek labourers elsewhere (Black). For this reason, persons from India and China were brought to Jamaica as indentured or contract labourers to work on the plantations (Campbell, 2002).

2.3. Development and reform of the Jamaican health system (17th – 21st Centuries)

In the absence of easily accessible archival material, a document prepared by the MOH Health Sector Task Force in 2007 was used to provide background on the history of the public health sector in this chapter. The Jamaican health system evolved over time and has its history embedded in the Plantation System. While there is limited documented evidence on the health services for the native people prior to the arrival of the Africans, reports implied that 'medicine men' treated sick Arawaks and that folk medicine was often adopted for ailments (Hay Ho Sang, 1985). The following discussion highlights the health service delivery system in existence during the colonial period. The historical underpinning of the health system is one of oppression, inequity and mistrust. This has influenced political and social reforms, as well as the policy directives of the nation and the manner in which people respond to the processes over the years.

Plantation System (1658 – 1838). During this period, Jamaican society was pluralistic and greatly influenced by Plantocracy (Black, 2011). The health system, which dates back approximately two and a half centuries, was hierarchical (Health Sector Task Force, 2007), providing quality services for the whites and substandard services for the blacks. A glance at the Plantation System reveals a health system in which health care for slaves was not a priority and inhumane treatment of slaves a daily occurrence. Epidemics among the slaves were widespread, mainly because the attention estate owners gave to the health of slaves was negligible. Diseases affecting the slaves included yaws, dysentery, yellow fever, small pox, tuberculosis, and worm infestations. In addition to the epidemics, there were reports of high incidences of infant mortality rates, maltreatment, overwork and starvation among the slaves (Health Sector Task Force; McCaw-Binns & Moody, 2001). A possible explanation for the neglect of the slaves' health was their position in society; they were treated as property. Furthermore, the death of a slave was not a challenge for estate owners, because a replacement could be obtained through the lucrative slave trade without much difficulty.

Despite lacking an organised structure, by 1774 the health system had military hospitals and a naval hospital in the main cities at which medical officers administered health services on a capitation basis (Golding as cited in McCaw-Binns & Moody, 2001). In 1776, the first public hospital, the Kingston Public Hospital (KPH), was established and served as a hospital, alms-house and asylum (Swaby, 2005). It provided health care exclusively for whites. Categories of health workers included medical officers, who had responsibility for demographics such as births and deaths, management of infectious diseases, and hygiene on the properties generally. They also delivered health care to the plantation owners, their families, and the house slaves. Although limited attention was given to the health needs of slaves, records indicated they were treated by doctors in hospitals known as "plantation hospitals" or "hot houses" (Black, 2011, p. 137). In contrast to the military hospitals, these facilities were sometimes managed by veterinarians (Health Sector Task Force, 2007). There were also nursing homes for those who could pay for the services (Hay Ho Sang, 1985). In addition to medical officers, records make reference to other categories of health workers, namely "grandees", "wet nurses" and 'doctresses', who assisted with the care of the sick, and the pregnant and dying slaves (Swaby, p. 16). Nanas (untrained midwives) and nurses also delivered care to the sick (Hay Ho Sang). Golding, in identifying the category of staff in hospitals during this era, asserted that the staff included "one part-time physician, two apothecaries, a matron and five slaves" (as cited in McCaw-Binns & Moody, p. 7). They provided care to individuals who could not afford to pay for services.

Given the high mortality among slaves, poor health services and intolerable treatment meted out to them, anti-slavery movements raised consciousness regarding the evils of the system and, in 1792, the Consolidated Slave Act was enacted in Britain, giving slaves the right to improved health services (Health Sector Task Force, 2007). One of the articles of this Act dealt with the mandatory submission of reports by medical officers, regarding the number of deaths among slaves, as well as causes of death. These data had not been previously reported (Health Sector Task Force). Despite these arrangements, the inhumane treatment of slaves persisted. Poor living conditions, unacceptable health care and maltreatment of slaves were often a reality on the plantations for many more years.

Early Emancipation (1839 – 1846). After the abolition of slavery in 1838, extensive changes took place in the social system, which served as catalysts for change in the health system. Notable changes in the social system included movement of slaves away from the plantations, with only a few loyal slaves remaining, which led to the collapse of operations on the plantations (Health Sector Task Force, 2007). In 1846, the Sugar Equalisation Act was passed, further dismantling the plantation system. As a result, medical officers' incomes declined; therefore, they migrated to other countries such as England in search of employment (Health Sector Task Force; McCaw-Binns & Moody, 2001). These changes contributed to the deteriorating social and health conditions of the nation. The deteriorating conditions occurred because earnings from the plantations were non-existent and inadequate provision for ex-slaves inevitably resulted in anarchy. Furthermore, the absence of medical officers in a poorly organised and ailing health system created an environment that was conducive to epidemics.

Colonial Post Emancipation (Crown Colony Period) (1847 – 1900). The demise of the Plantation system impacted negatively on the health and social systems of the nation in several ways and, as such, crises were inevitable. There were hardships, empty hospitals, migration of doctors, deteriorating health conditions and widespread epidemiological crises (McCaw-Binns & Moody, 2001). Epidemics affecting the country included typhoid fever (1853), cholera (1850, 1852) and smallpox (1852). For these reasons, mortality and morbidity rates were high and all the parishes were affected. The death rate from cholera was "1 in every 13 of the population" (Black, 2011, p. 118). Of note is that Mary Seacole, one of Jamaica’s first nurses, began her nursing career in 1850 during the cholera outbreak (Black; Swaby, 2005). There is a dearth of information on nurses training during this period of time. However, some training commenced as early as 1856 at the Lady Barkly Training Institution (Hay Ho Sang, 1985; Swaby). It was apparent that a link existed between the post-emancipation reduction in the number of medical officers and the increasing epidemiological crises (McCaw-Binns & Moody). A possible explanation is that no alternative provision was made for the health care of the free slaves generally (Black). Even though there was a lack of alternative health care and shortage of medical officers, the care of individuals affected with yellow fever and cholera was effectively administered by nurses, some of whom were known as “doctresses” at the time (Swaby, p. 16).

British governors continued to rule the country post-emancipation and in 1866 the reigning Governor, Edward John Eyre, replaced the constitution with a Crown Colony government. Under the Crown Colony, the governor formed the government and had sufficient power to make far-reaching changes to the social welfare of the nation (Black, 2011). Eyre became unpopular, and was later dismissed and recalled to England following a Royal Commission into the Morant Bay Rebellion of 1865. The rebellion which took place in Morant Bay, St. Thomas, was the result of deteriorating social conditions in the nation. The commission revealed that Eyre’s authority was a contributing factor to the rebellion. Eyre’s successor, Governor Sir John Grant, was appointed the same year. Grant’s work heralded in the new Jamaica, resulting in the development of organised social and health systems (Black).

Public Health Act and Boards of Health. As the years progressed, the improvements made by Grant reflected advancements in the health system. For example, in 1867, the Public Health Law was enacted resulting in the establishment of the Island Medical Services or Central Board of Health (Health Sector Task Force, 2007; McCaw-Binns & Moody, 2001; Public Health Act, 1985). Parochial Boards of Health were subsequently instituted in all 14 parishes, through which the agenda of the Central Board of Health was implemented. The Parochial Boards had the task to create a link between health and the country’s development, to quarantine and treat diseases, and to provide public health care, including safe water supplies, proper roads and communications (Black, 2011; Health Sector Task Force). The intention of this system was essentially to provide services to free slaves and indentured labourers regardless of their income.

In addition to the establishment of the health boards, there was a proliferation of dispensaries (modern day health centres) in all 14 parishes. These facilities were hospital-outstations, offering health services in Kingston from as early as 1870 (Cover, 1995; McCaw-Binns & Moody, 2001). Information on the exact number and location of these facilities is not available. Some plantation hospitals were reopened with the aim of making health services more accessible to the greater populace. Additionally, 40 medical districts were established among the 14 parishes in 1874, to which District Medical Officers were deployed (Cover; Health Sector Task Force, 2007), and in 1887 the first Lying-In facility, the Victoria Jubilee hospital (VJH) was established in response to a maternal mortality rate in excess of 600/100,000 births. It was so named because construction occurred in the year that Queen Victoria celebrated her Golden Jubilee (McCaw-Binns, 2008).

The National Health Services System (1901 – 1938). By the turn of the century, there was a myriad of noticeable developments in the health system. Firstly, there was rationing of hospital services as a result of overcrowding. This was evident in the revocation of funding allocated for health services to the poor in 1904. Subsequently, funding of health services was replaced with a ticket system in 1933-1934 in an attempt to ensure accessibility (Cover, 1995). Secondly, more hospitals were built across the country between 1916 and 1926, which ultimately resulted in the 'hospitalisation' of the health system. Despite the colossal improvement in public health, there was still discrepancy between the support for community-based and hospital-based health services. Support for hospital-based services was evident in the increased workforce assigned to hospitals versus the limited number of District Medical Officers (DMOs) assigned to community health services. Moreover, the budgetary support for community health services was inadequate. This created a need to forge greater links between the two levels of health services in order to provide a more equitable and accessible health service delivery system. Thirdly, the number of DMOs, private practitioners and other health practitioners increased during this era (Health Sector Task Force, 2007).

Appointment of commissions. An equally significant feature of this period was the appointment of landmark commissions to investigate the health and social conditions of the nation. Widespread riots against ineffective governance and deteriorating social conditions were often catalysts for the appointment of commissions of inquiry (Health Sector Task Force, 2007). Essentially, riots were mechanisms adopted by ex-slaves to attract the attention of the Colonial Government to their situation and have it act in line with the interests of the masses. Key commissions during this period included the Rockefeller Foundation Commission and the Moyne Commission (McCaw-Binns & Moody, 2001).

At the end of World War I, the Rockefeller Foundation Commission (1918-1932) was appointed to investigate the deteriorating public health conditions of the nation. The work of the Commission was significant and involved the investigation of epidemics such as hookworm (1918), tuberculosis (1927), malaria (1928) and yaws (1932) (McCaw-Binns & Moody, 2001). As a result of the recommendations contained in the Rockefeller Commission's report, the Bureau of Health Education was established in 1927 and a new cadre of staff, PHNs and public health inspectors (PHIs) (sanitary inspectors), was introduced. The roles of the new health personnel included management of communicable diseases. Nurses were involved in delivering social services, while PHIs managed the home and community environments (McCaw-Binns & Moody). Sensitising the population about preventive measures was an equally important role for both nurses and PHIs.

Further support from the Rockefeller Commission resulted in the provision of fellowships and grants for the training of additional health personnel and the establishment of health facilities. Facilities established under the support of the Commission included a tuberculosis clinic and tuberculosis sanatorium. Consequently, through the implementation of the recommendations of the Rockefeller Commission there was noticeable improvement in the control of communicable diseases and importantly the eradication of some diseases such as malaria by 1961 (McCaw-Binns & Moody, 2001).

Concerns were again raised in 1938, when there were widespread riots, and infectious diseases were among the five leading causes of death (McCaw-Binns & Moody, 2001; Watson Williams, 2008). These conditions were drivers for the appointment of the Moyne Commission (1938-1939) to investigate conditions in the nation and the West Indies generally. Through the Commission's recommendations epidemiological, social and political strategies were implemented, which resulted in a reduction in mortality and morbidity rates, as well as improved quality of life for the nation's people. Training facilities for health personnel were also established and included the Training Station for

Sanitary Inspectors and Health Visitors (renamed as the West Indies School of Public Health (1957), now known as the University of Technology, Jamaica, School of Public Health. The School enrolled its first entrants in 1944 (McCaw-Binns & Moody). Further recommendations by the Moyne Commission included reorganisation of the health services and allocation of a minimum 10.0% of the national budget to health services (West India Royal Commission, 1945). The Commission also highlighted the "relationship between health and poverty, housing, public health...community development and adequate funding of community health services" (Health Task Force, 2007, pp. 29-30).

Impact of natural disaster. While the deteriorating social conditions could not be attributed to any one factor, one possible reason for the minimal improvement in social and health services during the early 20th century was the impact of natural disasters on the island. Such catastrophes shift the interest of authorities from social and health needs to restoring the affected areas (McCaw-Binns & Moody, 2001). One notable event was the earthquake of 1907 in which the country was devastated (Black, 2011). It is not uncommon for disasters to erase the gains made in the health and social system, further plunging the country into a state that requires the government to seek external assistance. The impact of the aforementioned earthquake overwhelmed hospitals and the number of death was high. External assistance in the form of medical supplies and health personnel was obtained from the USA (Black). In the face of the on-going situations, health services continued to deteriorate, with the greatest impact on the poor and vulnerable.

Pre-Independence – Self Government Period (1939 – 1962). Social and economic development continued throughout this period; however, due to the effects of World War II there was delay in timely implementation of the recommendations of the Moyne Commission. Despite the delay, health services continued to expand and additional commissions of inquiry were appointed including the Irvine Committee in 1944.

The Irvine Committee. This Committee was appointed to investigate the contentious health conditions as part of a larger investigation being undertaken in the British colonies at the time. The recommendations of the Committee were catalysts for the establishment of the University College Hospital of the West Indies (now the University Hospital of the West Indies) and the training of medical doctors, which was initiated in 1948. The training of doctors took precedence because there was sufficient evidence to suggest health conditions in the nation were deteriorating (McCaw-Binns & Moody, 2001).

Crown colony and independence. Amidst the challenges to social and health conditions in the country, the political change process continued. One such change involved embracing self-government in exchange for Crown Colony status. This was achieved under the provision of a new constitution in 1944. Jamaica now had a legislature that included a House of Representatives and Legislative Council. Additionally, the new constitution empowered Jamaicans with additional rights under Adult Suffrage. Jamaicans 21 years and over became eligible to vote during elections (Black, 2011; Health Sector Task Force, 2007). Undoubtedly, this gave voice to the poor in matters of national importance such as issues surrounding health and social conditions.

Additional changes in the health system during this era included the amalgamation of the Medical Department into the MOH in 1955. Accordingly, a leadership structure emerged which included a Minister of Health, a Permanent Secretary, a Chief Medical Officer (CMO), Principal Nursing Officers and Assistant Nursing Officers for secondary and primary services (Health Sector Task Force, 2007).

Another significant milestone achieved by Jamaica in 1962 was independence from British rule. This signalled not only a change in the political structure but also in the health system. The country was now fully self-governing and the Ministry of Health's focus was on hospital services. The hospital-based services offered were influenced by international standards and, as such, were similar to the American hospital-centred model of health system (Health Sector Task Force, 2007). This ultimately resulted in the 'hospitalisation' of the health system to the detriment of PHC.

The Post-Independence Period (1963 – 1971)

Expansion in health infrastructure and services. In the Post-Independence period, additional hospitals were built with the assistance of funding from the World Bank. One such institution was the Cornwall Regional Hospital, a Type A Regional hospital in St. James. This institution was fraught with design faults, which resulted in some departments being abandoned. Possible reasons for the faults included cultural differences, in that the facility was fitted with an infrastructure similar to European hospital design. The design provided for warmth in the winter season, whereas Jamaica is a tropical country. The lack of consultation with main stakeholders such as nurses was also problematic.

Notwithstanding setbacks, advancement in the social conditions continued and there were observable demographic changes such as population explosion. According to the Health Sector Task Force (2007),

> Jamaica entered the stage of a demographic transition. Improvement in health status of the population resulted in lower death rates and greater birth rates with high dependency ratios and demonstrated the inability of the economy to sustain the rapid rate of population increase. (p. 35)

As a result of the increase in birth rates, a Family Planning Service was established in 1967 under the umbrella of the National Family Planning Board, which was supported by the World Bank. In addition to the development in family planning, there were attempts to privatise the system. For example, private beds were introduced into the public health system as a means of encouraging privatisation.

Reform in the governance of the health system. Occurring in the post-emancipation period was a greater separation between Central and Local Boards of Health, whereby the Ministry of Finance now had responsibility for MOH supplies, while the Ministry of Works had responsibility for maintenance, even though artisans were assigned to hospitals (Health Sector Task Force, 2007).

Fundamental changes occurring at this time included special arrangements instituted, by way of a means test, for people who could not afford to pay for health care. Moreover, little or no budgetary assistance was allocated to health centres that functioned in an unplanned manner. A possible explanation for this practice was the strong focus given to hospital-based services.

Development in the health workforce. There was also inaugural training of community health aides (CHAs) in 1967. Their role as members of the health team included working in the community in areas such as maternal and child health, health education and promotion, and disease prevention (McCaw-Binns & Moody, 2001). Additionally, there was the introduction of dental nurses and dental assistants in 1970 (McCaw-Binns & Moody). They functioned primarily in the PHC settings and were instrumental in offering school dental services.

Despite the training of new cadre of health personnel, one should not be oblivious to the effects of the Cold War political tensions of 1962 on Jamaica, which resulted in mass migration of health personnel, similar to the exodus in 1838. As a consequence, a bilateral accord was forged in the 1970s between Jamaica and Cuba for the supply of health workers, among other arrangements, in order to maintain a stable health system (Health Sector Task Force, 2007).

Modernisation of the health system (1972 – 1989). Throughout the 20th century, robust policy initiations further impacted on the development of the health sector. For example, in 1972 the Environment Control Portfolio was placed under the MOH. This move by the government was lauded by some stakeholders, who felt this would impact positively on the development of the nation (Health Sector Task Force, 2007).

New nomenclature, management and fees system in hospitals. A national policy initiative implemented at the local level included new nomenclature for hospitals. The categories were determined by virtue of the services offered and comprised Types A, B, C and D. These categories will be discussed in more detail later. Additionally, hospital boards were established in 1972 and, as such, hospitals were now governed by a Board of Management (Health Sector Task Force, 2007). Subsequent to the establishment of hospital boards, user fees were removed for public health services. This policy change formed part of the on-going reform and hinged on the premise that the revenue generated from user fees was inadequate for an equitable and sustainable health system (Health Sector Task Force).

Green Paper 1974. In 1974 a Green Paper "*The Health of the Nation*" was ratified in parliament. This was a significant event in that the implementation of the Green Paper's recommendations vastly influenced the public health system. Some of the recommendations included introducing charges for drugs, establishing a Central Planning and Evaluation unit to oversee the amalgamation of secondary and PHC services, offering PHC services in health centres, locating health centres to meet the needs of the population within their boundaries, managing pharmaceutical services by engaging advanced techniques and expertise, and retaining staff by adopting measures such as better working conditions, remuneration commensurate to work done and making postgraduate training facilities available for health workers, *inter alia* (Health Sector Task Force, 2007).

New roles and categories of staff. In order to achieve acceptable coverage for maternal and child health services, the role of the midwife was expanded in the 1970s. This move was to provide quality maternal and child health services to the underserved population in the rural areas, as well as to relieve the PHNs of some tasks. PHNs were now able to focus on specialty-oriented tasks. This initiative resulted in increased antenatal visits island-wide (McCaw-Binns & Moody, 2001).

Training of health workers continued in this era. Another category, NPs, commenced training and joined the workforce in 1977. They were deployed to the health system on completion of extensive training. NPs function mainly in the PHC setting with a focus on curative services (McCaw-Binns & Moody, 2001) and deliver specialist health services in various settings. They work in parallel with the medical officer in health centres. NPs' roles were expanded in order to be responsive to the needs of people, especially in certain geographic areas, for example, rural and poorer communities (Safriet, 1992). In addition to providing services in some urban facilities, NPs in Jamaica offer services to individuals living in rural communities. The elderly and the poor benefit the most.

Other important events in the era. Five events occurred during this period. The first main event occurred between 1976 and 1977 and involved some level of organisational reform in the public health system, including the integration of Central and Local Boards of Health. The aim was to reduce the fragmentation in delivery of health services, which had contributed to the lack of proper mechanisms to manage and monitor the transformation taking place. One factor that may have been responsible for this situation was the notion of shared management responsibilities in which the MOH had responsibility for hospital services, while Local Government had responsibility for Parish Health Services (Health Sector Task Force, 2007). Secondly, a National Formulary was established between 1977 and 1980 to strengthen the management and delivery of pharmaceutical services in the country (Health Sector Task Force).

Thirdly, PHC research commenced and was conducted through PHC units. This served as the launching pad for 'The Primary Health Care: Jamaican Perspective' policy that was formulated in 1978. The success of this work influenced the appointment of Jamaicans to serve on the Drafting Committee of the Alma Ata Declaration of 1978 (Health Sector Task Force, 2007). The fourth event was the introduction of compulsory immunisation in 1978 for all Jamaican children in order to prevent childhood immunisable diseases such as tuberculosis, poliomyelitis, diphtheria, tetanus and pertussis. To enforce this law, proof of immunisation became mandatory prior to entry into school and parents had a legal obligation to ensure their children were immunised. As a result of this policy, the rate of immunisable diseases significantly reduced (Health Sector Task Force).

The fifth event was reforms in the hospital system. The aims of these reforms were to achieve a greater level of efficiency in service delivery, as well as to modernise the secondary and tertiary level services. Some hospitals involved in the reform process included the Bellevue Hospital, a psychiatric institution, which changed to a "decentralised therapeutic hospital" with over 1000 beds (Health Sector Task Force, 2007, p. 59) and the May Pen Hospital, where a new hospital was constructed. Construction of the facility was achieved with the assistance of the Inter-American Development Bank (IDB).

The impact of structural adjustment on the health system. The effects of the country's involvement with the IMF must not be ignored, since some reform processes were a direct result of Structural Adjustment in 1979 under the IMF. This resulted in austerity measures, which impacted on the delivery of health services. There was drastic budgetary adjustment (one third reduction) between 1982 and 1987 (Watson Williams, 2008). As an outcome there was a mass migration of health workers and a reduction in the training of some groups such as CHAs and nurses. Additionally, the rationing of the health services resulted in the closure of some training institutions and health facilities. Institutions affected included the Cornwall School of Nursing, The West Indies School of Public Health, and Type D hospitals, as well as some health centres (Health Sector Task Force, 2007). In addition to creating a gap in the health sector's human resources, the quality of services declined and shortages of equipment and supplies was a daily problem (Watson Williams). These issues increased the country's level of susceptibility to health conditions that had either been under control or successfully eradicated. The robustness of the PHC services declined and immunisation rates plummeted in the aftermath of the IMF interventions. Epidemics such as poliomyelitis re-emerged in the 1980s, which had serious implications for the tourist industry, one of the country's main sources of income (Health Sector Task Force).

Modern Health Reform (1990 – 2008)

Regional Health Authorities. In addition to unremitting discussion about the country's PHC system, more health reforms occurred during the latter part of the 20th century. These reforms included regional integration of the management of primary and secondary health care under one umbrella. Integration of the systems was achieved through decentralisation and the enactment of the National Health Services Act in 1997 (National Health Services Act, 1997). Under the provisions of this Act, four semi-autonomous RHAs were established. The RHAs, which are defined by geographical boundaries, are of varying sizes and have overarching responsibility for a number of parishes (Figure 2). It is important to note that the parishes assigned to the RHAs differ somewhat from county parishes mentioned earlier. The four RHAs comprise:

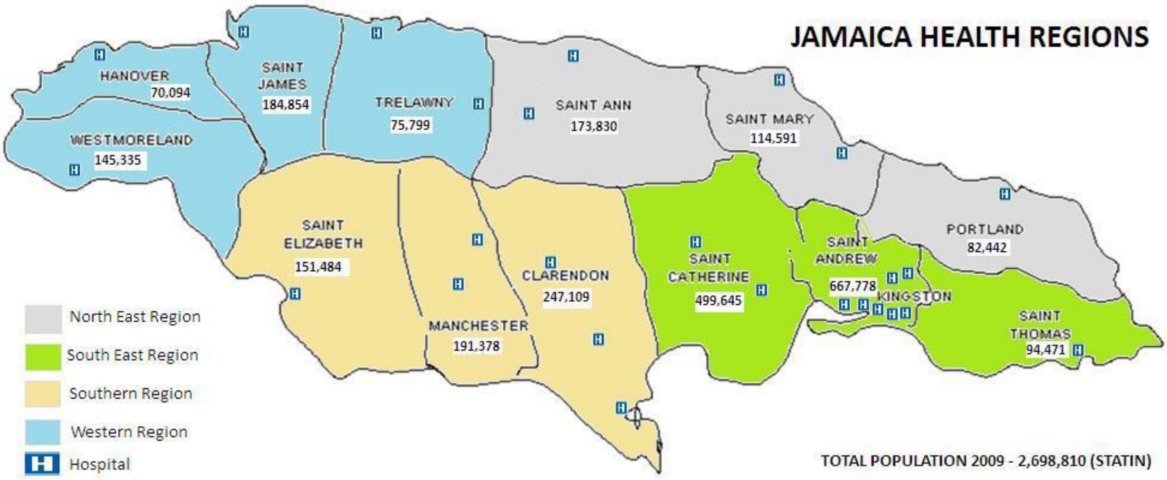


Figure 2. Hospitals and population by parish in the health regions (Source: Auditor General's Department, Jamaica, 2011). Reproduced with permission.

The North East Regional Health Authority. NERHA is mainly rural and has a land mass of 2,637.1 km^2. It consists of three parishes, Portland, St. Mary and St. Ann, and in 2010 served a population of 371,900 (13.7% of the total population). NERHA is the smallest region with four hospitals, three health departments (a health department is located in each parish, is the administrative arm for PHC, is responsible and accountable for supplies such as vaccines for the parish and houses the office of the Medical Officer of Health) and 74 health centres (NERHA, 2009; PIOJ, 2011; Ward & Grant, 2005).

The Southern Regional Health Authority. SRHA is mainly rural and has a land mass of 3,238.8 km^2. It has three parishes, Clarendon, Manchester and St. Elizabeth, and served a population of 591,500 (21.9% of total population) in 2010. The health facilities in this region include five hospitals, three health departments and 73 health centres (PIOJ, 2011; SRHA, 2011; Ward & Grant, 2005).

Western Regional Health Authority. WRHA is mainly rural and has four parishes, Trelawny, St. James, Hanover and Westmoreland. It has a land mass of 2,726.9 km^2 and served a population of 477,300 (17.6% of total population) in 2010. It has four hospitals, four health departments and 78 health centres (PIOJ, 2011; Ward & Grant, 2005; WRHA, 2009).

South East Regional Health Authority. SERHA is mainly urban and has three parishes: Kingston and St. Andrew, St. Catherine and St. Thomas. The region served a population of 1,265,100 (46.7% of the total population) in 2010 and has a land mass of 2,387.7km^2. It is the largest RHA and provides health services through a network of 10 hospitals, three health departments and 88 health centres (PIOJ, 2011; SERHA, 2010; Ward & Grant, 2005).

Structure and functions of the RHAs. RHAs are decentralised bodies with three overarching roles: policymaking, programme formulation, and programme execution (Health Sector Task Force, 2007). Policymaking is, however, not a primary role but rather a function of the MOH. Subsumed under these three roles are the RHAs' mandate to manage the allotted budgetary support, human resources, health related programmes and the delivery of health services within their geographic boundaries generally. They also have a responsibility to ensure that the services offered are affordable, acceptable and accessible to the populations in the areas served (Ward & Grant, 2005).

A significant element of this 1997 reform process was the transfer of the decision-making capacity from the hospitals to the RHAs. The Hospital Boards of Management were dismantled and replaced with a reporting structure that involves the Director of Nursing Services or Matron, the Senior Medical Officer, and other heads of departments reporting to a Chief Executive Officer (CEO). The CEO in turn reports to a Health Committee headed by an administrator. While the CEOs are equipped with management skills, there have been criticisms about their lack of nursing and medical knowledge that some believe is required to effectively oversee a hospital (Health Sector Task Force, 2007).

The move to regionalisation was based on the need to achieve greater efficiency, effectiveness and accountability in the delivery of health care and to reduce the concentration of power at the head office (Health Sector Task Force, 2007). Given the agenda prior to regionalisation, this element of the reform process resulted in devolution of power from the head office to the RHAs. Furthermore, the intention was to relieve the MOH of some of its functions in order to achieve a greater focus on the policy process, monitoring functions, and standards and regulations (Figure. 3) (Health Sector Task Force). The RHAs' management structure comprises a Board to which the Regional Director reports. Additionally, the Directors report to the Regional Directors (Figure 4). The Boards are appointed by the Minister of Health, making each RHA accountable to the minister.

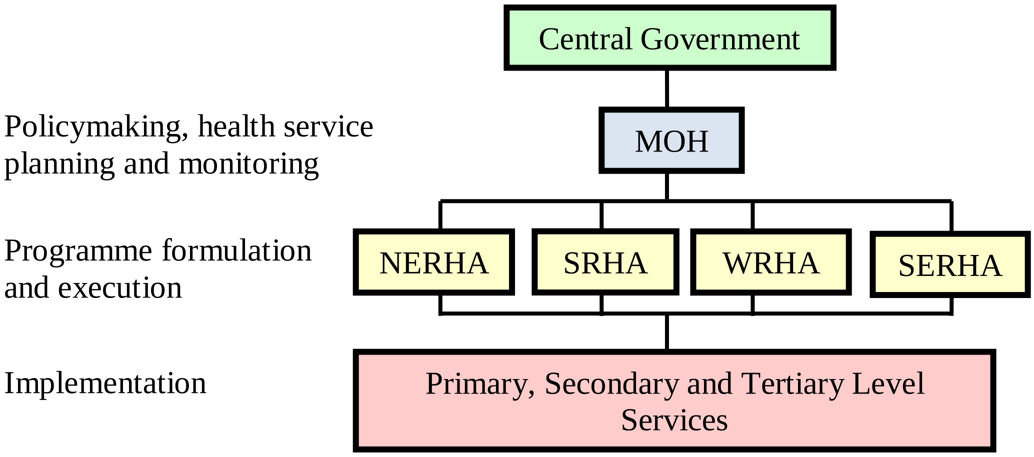


Figure 3. Structure and function of the public health sector

Evaluation of the RHAs. The RHAs have been providing health services for the nation since their inception in 1997, but not without the scrutiny of stakeholders and the population generally. While the intention of the reform was to improve efficiency, it is important to note that concerns have periodically been raised about the operations of the RHAs. Some areas for which they have received disapproval included "health planning, service delivery, accountability, and community involvement" (PAHO/WHO, 2007, p. 459). Additional areas of concern included "moderate successes in cost-containment [and] negative effects shown in areas of personnel capacity, financial management and organisational capacity" (PAHO/WHO, p. 459). As a result of wide-spread discontent, a five-member Health Sector Task Force was appointed by the MOH in 2007 to investigate the RHAs' functions and contribution to the health sector, with a view to modernising the

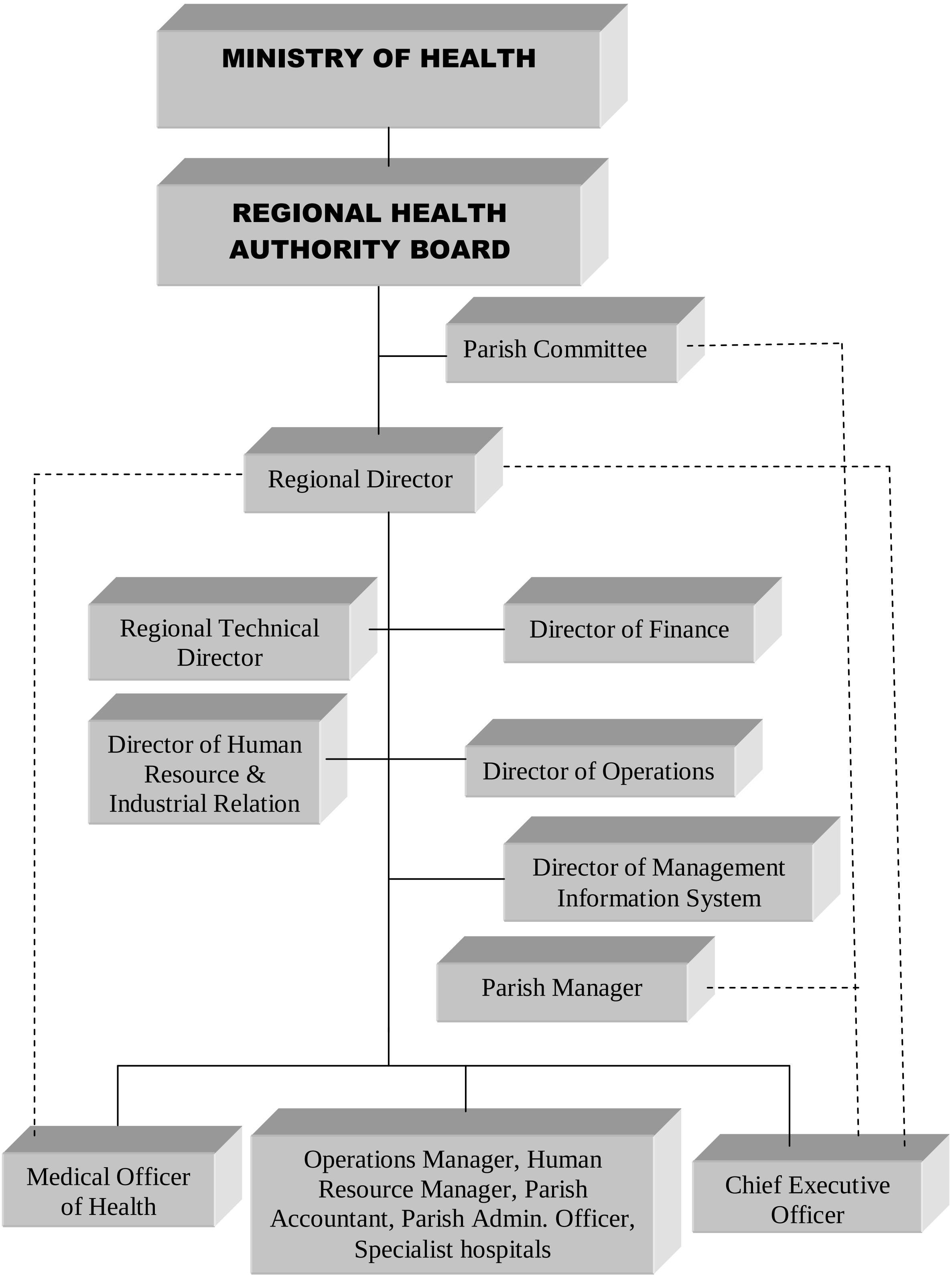


Figure 4. Structure of the Regional Health Authorities, Jamaica

public health sector generally (Health Sector Task Force, 2007). The findings of the Task Force have been reported in the document "*A Healthy Jamaica in a Healthy World*" (Health Sector Task Force) but still await implementation by the policymakers.

Reform of the public health services in 2007 & 2008. Reform of the health services in the 21st century included the abolition of user fees in May, 2007 for children under 18 years and for the Jamaican public in April 2008. The intentions of these policy interventions were to improve access to health care for poor Jamaicans; reduce inequity in accessing health services; reorient the public health system to reflect a primary care focus; enhance staff efficiency by providing the right skill mix for service delivery; and find suitable financing and service delivery mechanisms (MOH, 2008b). Under this new policy a number of health services were now free to users of the public health system.

To finance the latter policy, which was projected to lose $1.7m (approximately 12.0% of the health expenditure) by abolishing user fees, central government injected $3.85m to offset the health budget for 2008/2009 and meet the projected 30.0% increase in patient load (MOH, 2008b). Generally the Ministry of Finance & Planning earmarked $100m to fund the preparatory phase of the policy, which was disbursed to the RHAs incrementally. These funds were to be utilised for infrastructural improvement; purchasing materials, supplies and equipment; and provision of transportation for staff, patients and supplies for efficient service delivery (MOH).

For effective policy implementation, strategies were adopted to address the perennial staff shortages. To respond to the projected increases in patient load, RHAs were advised to recruit and employ personnel such as nurses, doctors, pharmacists, and CHAs on a sessional or temporary basis; redeploy some staff; and employ public/private partnerships to acquire services such as medical and diagnostic (MOH, 2008b).

2.4. Summary

It is apparent that the Jamaican social and health systems have been through a number of developmental stages, each resulting in reform. From the arrival of the Europeans to the gaining of Independence, each stage has been influenced by social, economic and political occurrences locally and globally. The transformation of the country included graduating from colonial governance to self-governance; from an era with limited emphasis on human rights to one in which human rights are entrenched in its constitution; from an *ad hoc* health system to one that is more structured and formalised; from a society, in which health services were hierarchical with provision for select few, to universal health care, despite some inequity remaining in the system. Even though there was no real sense of stability, reforms have resulted in significant improvements in the social and health situations of the nation amidst stagnation in the economy.

2.5. Financing the public health system (17th – 21st Centuries)

Colonial period and charges for health services. Information about funding of the public health system from the 17th-21st centuries is not well documented. Reports suggest that, during the colonial period, financing of the health system was mainly through, albeit negligible, budgetary allocation (Health Sector Task Force, 2007). Medical officers were paid a fixed fee per person to ensure wellness on the plantations (McCaw-Binns & Moody, 2001). Additionally, medical officers who had responsibility for the health care of estate owners and their households could charge a fee for services provided. While there was no formal fee structure, fees were reportedly charged according to the patient's earnings. This was achieved through a means test, which was first introduced in 1867. In addition to the aforementioned, special arrangements were in place for the provision of free health services to indigents, the constabulary, prisoners and persons living in homes for the poor. A ticket system was also introduced in 1904, which made health services more accessible to the general populace (Health Sector Task Force; Cover, 1995). The ticket system was based on income of the patients (Table 4). There was limited change to this until the 1970s.

Table 4

Ticket payment system for outpatients

Income per week (shilling)	Charges
Family member earning = up to 16/-	Free
Family member earning = 20/-	Free
Family member earning = over 16/-to 35/-	1/6
Family member earning = over 35/-to 70/-	2/6

Note. Source: Cover, W.A. (1995). *Handbook of Jamaica 1955. Ministry of Communications and Work. Kingston, Jamaica: Government Printing Office.*

Reform in user fees system. As alluded to earlier, fees were abolished for hospital services in the 1970s; however, limited information is available regarding the success of the policy change. User fees were, however, revised, reintroduced and increased in 1984, 1993, 1999 and 2005 (Barnett, Lalta, & Bailey, 2010; Lewis, 1993). A fundamental reason for the introduction of user fees was to generate revenue in the public health system. Revenue raised from the fees, however, was minimal, and some individuals cited out-of-pocket payment as having an adverse impact on access to health services (PIOJ & STATIN, 2008). Moreover, the exemption process was considered demeaning by some individuals from the lower socioeconomic group. This compounded the problem of access; therefore, successive governments have proposed the abolition of user fees in order to improve access to health services.

The fee payment system was regarded as oppressive for some users, especially the poor, who did not utilise the services although there was a need (PIOJ & STATIN, 2008). For this reason, on May 28, 2007 user fees were abolished for children under the age of 18 years, and on April 1, 2008 for services in the public health system generally. Under this new arrangement, health services at the 23 public hospitals and over 313 health centres were provided without charges to the users. According to the MOH (2008b), the free services included but were not limited to:

> registration, doctor’s examination, hospital stay, diagnostic services (x-rays and laboratory tests of various kinds), drugs, physiotherapy, surgeries, family planning, immunisation, antenatal care, renal dialysis, drugs for chemotherapy, radiation therapy, certain high cost diagnostic services such as MRI [and] certain high cost appliances. (p. 2)

Fees were retained by the public health system for several services. These included fees paid by private patients (persons with insurance and non-residents); fees for morgue services except for specific cases; medical examinations and reports obtained from PHC for business use; food handlers’ fees; and medications and drugs for international travel (MOH).

Other funding initiatives. Other funding initiatives by the government included public-private partnerships, which have contributed significantly to the public health system and initiatives such as the JADEP, CHASE and NHF. The JADEP was established as part of the reform process in 1996. Under this programme, all Jamaicans aged 60 and older benefit from subsidised drugs for 10 chronic diseases including hypertension and diabetes. A JADEP membership card enables beneficiaries to access pharmaceuticals at reduced costs at participating public and private pharmacies (NHF, 2008).

The CHASE Fund of 2002 assists with financing of the public health system. It “receives, distributes, administers and manages monetary contributions from the lottery industry" (CHASE, 2008, para. 1), a percentage of which contributes to national development. The funds are allocated as follows: Sports Development (40.0%); Early Childhood Education (25.0%), Health (20.0%), and Arts and Culture (15.0%) (CHASE).

The NHF, a statutory body, was established in 2003. The fund is generated from "20.0% of special consumption tax charged on tobacco products; 5.0% of special consumption tax collected; and [0.5%] of annual earnings up to $500,000 paid by employee and employer, collected by the NIS" (NHF, 2008, para. 6). It provides additional funding for the health sector by subsidising the cost of drugs and providing support for the training of health workers, as well as providing assistance for the implementation of health-related programmes and infrastructural improvement.

The NHF is the conduit through which patients benefit from National Health Insurance-type services, which constitute a component of the health reform process (PAHO/WHO, 2007) as envisioned in the Green Paper of 1997 (Barrett & Lalta, 2004). The NHF embraced universal coverage for Jamaicans and its main objective is to improve the standard of services in the public health system by assisting individuals and institutions to better manage chronic diseases. NHF offers individual and institutional benefits. Approximately 50.0% of funds support individual benefits, while institutional benefits are available under two arrangements: one deals with health promotion, and the other with health support (Barrett & Lalta).

Beneficiaries access 1300 pharmaceutical services at both private (80.0%) and public (20.0%) facilities with the NHF card, which is also used to monitor individuals' use of services. The facilities are reimbursed on a weekly basis through a managed-fee-for service arrangement (NHF, 2008). Of note is that a co-payment is required from the NHF beneficiaries. People pay the difference between the NHF remuneration and the price charged by the provider (NHF): "This serves as an incentive to be more deliberate in choosing where one gets a prescription filled" (Barrett & Lalta, p. 29).

Divestment of health services. The divestment of some services in the health sector must not be discounted, because it constituted a part of the reform process in the 1990s. Through this mechanism, external resources were mobilised to foster efficiency and sustainability in the public health sector, further reducing health institutions' recurrent expenses. Among the health services divested were training of health personnel, dietary services, janitorial services and pharmaceuticals services (Figueroa, 2001; Shepard, Anthony, McNaught, & Davis, 1998).

Budgetary allocation. The Ministry of Finance has overarching control of the budgetary allocation to the MOH at the central level, which is further distributed to RHAs for service delivery (Health Task Force, 2007, 2009; PIOJ, 2011). Budgetary allocation to the RHAs is based mainly on the population served. RHAs are autonomous and independently allocate funds to the health facilities. Currently, the thrust is to reorient PHC and, as such, much budgetary support is given to curative services (PIOJ). RHAs may also adopt creative means to generate additional budgetary support for the programmes and services they offer.

In addition to the budgetary allocation from the Government of Jamaica, health funding is obtained through health insurance and gifts and donations from non-governmental (NGO) and international development partners such as the NHF, the Global Fund, United States Agency for Development (USAID), IDB, UNICEF, and PAHO/WHO. Generally, the support from these organisations included financing, maintenance, provision of health personnel and training (MOH, 2008a). Approximately 4.0-5.5% of Jamaica’s national budget is spent on health services, which is considerably below the recommended proportion of 10.0-15.0% (PIOJ & MFAFT, 2009). This limited funding is further compounded by the reality that Jamaica is now classified as an upper middle income country and no longer qualifies for assistance from some donor organisations.

Health insurance. Health insurance improves access to health care (PIOJ & STATIN, 2008) and, according to Gertler and Sturm (1997), may be a suitable mechanism to alleviate the financial pressure on the public health sector. A dual health insurance system exists in Jamaica: the British National Health Service model in the public sector, under which individuals obtain care at nominal cost, and the private health insurance model that provides coverage for 10.0% of the population (Health Sector Task Force, 2009). Individuals may have either private or government health insurance coverage. In contrast to public health insurance, private health insurance is largely unregulated (Health Sector Task Force) and obtained individually or cooperatively through an organisation. Health insurance may be obtained by self-employed and informal workers; however, it is mainly available to government and private company employees. The unemployed are usually excluded (Bourne, 2009).

The government's health insurance schemes are collaborative arrangements with private insurance companies. One example is the health insurance coverage for government employees, the Government Employees Administrative Services Only (GEASO) Health Care Programme administered by Sagicor Life Jamaica. Under this arrangement, public sector workers are eligible for health insurance that is funded jointly by the government and the employees. The government makes a monthly contribution of 80.0%, while employees contribute 20.0%. There is also a Pensioners' Plan for retirees who are not eligible for individual or group coverage, and NI GOLD (National Insurance GOLD) for pensioners in the National Insurance Scheme (NIS). These arrangements allow pensioners continued access to health care benefits (Sagicor Life Jamaica, 2012). Health insurance companies work collaboratively with participating health care providers, namely hospitals, pharmacies, private doctors, dentists, laboratories and eye care specialists to meet the health care needs of the insured. Services covered under the health insurance schemes include hospitalisation, outpatient care, surgical procedures, doctors' hospital visits, doctors' home visits, dental services, prescription drugs, diagnostic services and consultation fees (Sagicor Life Jamaica).

Individuals who hold health insurance have easier access to health services in both the public and private health sectors, since it "lowers treatment cost of illnesses...[and] lowers the psychosocial stressor on income, and [on] the family's wellbeing" (Bourne, 2009, p. 197). Individuals also have easier access to more expensive medications, diagnostic investigations and medical procedures. *The Jamaica Survey of Living Conditions 2009* reported that more people in metropolitan areas had higher health insurance coverage compared to those in rural areas. The report also revealed that most persons with insurance had private coverage. Despite an increase in the number of persons with health insurance coverage in the poorest Quintiles (Quintile 1 & Quintile 2) in 2009, this group still had the lowest health insurance coverage generally (PIOJ & STATIN, 2010).

2.6. Health service delivery and utilisation of the health care system

Jamaica operates a health system in which approximately 95.0% of health services are offered by public health facilities, while the private sector provides the remaining 5.0%. The formal relationship between the private and public sectors is, however, negligible, despite the new thrust under the 2008 health sector reform process to forge and strengthen public-private partnerships in areas such as secondary care, and diagnostic and pharmaceutical services (Health Sector Task Force, 2009; Watson Williams, 2008). Among the providers of private health services are eight private secondary level facilities and over 2000 doctors working in urban and rural areas. Additionally, the private sector provides outpatient and PHC services, pharmaceuticals, health insurance and financing. The health services offered are usually more technologically-advanced than those offered in the public sector and include advanced services such as Computer Axial Tomography (CAT) scans, Magnetic Resonance Imaging (MRI), and specialised laser and cardiac surgeries among other cutting edge surgical procedures (Health Sector Task Force). Despite being largely unregulated, the private health sector is accountable to the MOH, which has overarching responsibility for health. Moreover, the private health sector is required to adhere to the laws governing health practice in the country, for example, the Public Health Act.

The private sector is not without its share of challenges. For example, there is a perennial problem of a lack of resources for hospitalised patients and an inability to attract people from all socioeconomic backgrounds to utilise the services offered. This is often due to individuals' inability to afford the services in the absence of health insurance coverage. Policymakers, however, have attempted to alleviate the problems by providing tax relief for the providers of private health services and offering subsidised public health services to private patients. Of note is that information regarding the financing and performance of the private sector is not readily available (Health Sector Task Force, 2009).

Health service delivery. The public health system, the evolution of which was discussed earlier in this chapter, is regulated by the MOH and services are delivered by the RHAs through a network of 23 hospitals and over 313 health centres (Table 5). The services provided by the institutions may be at the primary, secondary, or tertiary level. Primary level services are located in the community at health centres or community hospitals, secondary level services in hospitals, and tertiary level services at Type A public hospitals (e.g. Kingston Public Hospital, Cornwall Regional Hospital). Tertiary level institutions are also referred to as regional or teaching hospitals (PIOJ, 2011).

Types of Hospitals. Type A hospitals are located mainly in major cities and deliver tertiary level services. They receive referrals from Types B and C hospitals. Type B hospitals are also located mainly in urban locales and are the referral institutions for Type

C hospitals. Type C hospitals are usually located in rural communities and deliver general inpatient and outpatient services (Table 6) (SRHA, 2011; Ward & Grant, 2005).

Table 5

Network of service delivery facilities 2010

Regional Health Authorities	Parishes	Population (%)	Facilities	
			Health Centres	Hospitals
North East	Portland, St. Mary, St. Ann	371,900 (13.7)	74	4
Southern	St. Elizabeth, Manchester, Clarendon	591,500 (21.9)	73	5
Western	Trelawny, St. James, Hanover, Westmoreland	477,300 (17.6)	78	4
South East	Kingston, St. Andrew, St. Thomas, St. Catherine	1,265,100 (46.7)	88	10
Total		**2,705,800**	**313**	**23**

Note. Source: Planning Institute of Jamaica (2011). *Economic and Social Survey Jamaica 2010.* Kingston, Jamaica: Author.

Table 6

Classification of hospitals

Classification	**Description**
Type A	• Multi-disciplinary institutions offering secondary and tertiary care. • Final referral points for secondary and tertiary services.
Type B	• Situated in the large urban centres. • Provide inpatient and outpatient services. • Offer services in the following specialties – general medicine, general surgery, obstetrics and gynaecology, paediatrics and anaesthetics. • Offer x-ray and laboratory services to hospital patients, primary care and private sector locally.
Type C	• Basic district hospitals which interface with the primary care. • Offer inpatient and outpatient services • Services offer include general medicine, surgery, maternity care paediatrics • Offer basic x-ray and laboratory services to hospital patients, primary care and private sector locally. • Have a specialist surgeon for emergency surgical services.
Type D	• Closed under the structural adjustment programme

Note. Source: Southern Regional Health Authority, 2011

Types of Health Centres. Similarly, health centres are classified as Type I – Type V based on the type and level of services, as well as the population served. Type I health centres provide services in maternal and child health including immunisation, family planning, nutrition, and health education. Health personnel at these facilities include a registered midwife (RM) and at least two CHAs. The population served should be a maximum of 4000. Type II centres provide services that are similar to but more advanced than the Type I facilities. Additional health personnel at Type II facilities include NPs, PHNs, staff nurses, doctors, PHIs and pharmacists. The population served should be approximately 12,000 (SRHA, 2011).

Type III health centres have a similar staff complement to Type II and serve a population of approximately 20,000. Services offered by Type III health centres include curative, maternal and child health, family planning, immunisation, nutrition, dental, environmental health, treatment of Sexually Transmitted Infections (STIs), contact investigation, pharmacy, mental health, counselling, and child guidance. Type IV health centres are usually administrative departments with service delivery is at the parish level. These facilities are mainly located on a hospital compound for easier access to diagnostic services.

Type IV health centres offer the same services as Types I-III centres with the addition of mental health, Sexually Transmission Infection/Human Immunodeficiency Virus (STI/HIV) and dental services *inter alia*. Other categories of staff such as social workers, contact investigators and nutritionists may work in these facilities. Type V health centres are known as comprehensive health centres and provide all the services offered at the above-mentioned facilities. They are usually found in main cities (SRHA, 2011). Additionally, there are satellite stations among the PHC facilities (Health Sector Task Force, 2007). They offer services that parallel those of Type I health centres. These satellite stations are health centre outstations, which lack a physical structure.

Staffing for health facilities. Staffing of secondary care and PHC facilities is achieved through full-time and part-time employment. The RHAs employ various categories of staff mostly on a full time basis; however, some employees work part time. Individuals may opt to have dual employment status, whereby they work full time in one facility, usually a public facility, and on a part time basis in private facilities, and in exceptional cases they may have two part time jobs. For this reason, it is not uncommon to have health personnel who are employed simultaneously by both the private and public health sectors.

The main categories of health personnel employed in secondary facilities include the director of nursing services or matron who has administrative responsibility for nursing services, medical doctors (including specialists), RNs (including specialists), RMs, enrolled assistant nurses, patient care assistants/ward assistants, emergency response technicians, PHNs (some hospitals), NPs (some hospitals), physiotherapists, speech therapists, radiographers, medical technologists, pharmacists, electrocardiogram technicians, nutritionists, and dieticians (Figure 5). Heads of department in secondary care facilities report to a CEO. Services offered at hospital vary according to the type of facilities. For example a cardiology unit may not be found in a Type C hospital.

The medical officer of health has leadership of the PHC services and works in collaboration with PHNs, NPs and other health practitioners (Figure 6). The requirement for employment in the health sector involves health personnel meeting the eligibility criteria for practice, which entail obtaining the necessary training from accredited institutions, registration, and licensure from the respective regulatory bodies.

Nursing categories. Given this research is mainly focusing on the work of the professional nurse, a brief description of the nurses' main categories is provided. Categories include the staff nurse or Level I nurse, the specialist nurse or Level II nurse, the nurse manager or Level III nurse, the PHNs, and the NPs. Figure 7 illustrates the nursing structure from MOH to hospital and health centres. A Level I/Nurse I/Professional Nurse I is the entry-level professional nurse or staff nurse. As a new graduate, a staff nurse possesses the professional skills to practise within prescribed scope as a member of the health team. A staff nurse has direct and indirect responsibility for the nursing care and management of individuals, families and communities in primary, secondary and tertiary health facilities with the exception of intranatal care/delivery of babies (MOH, 1992).

A Level II nurse or specialist nurse is a staff nurse who has obtained training in a specialised field of nursing. The scope of practice includes administering advanced level care to individuals, families, and communities with life-threatening illnesses, those requiring surgical procedures, or whose health conditions require specialised nursing

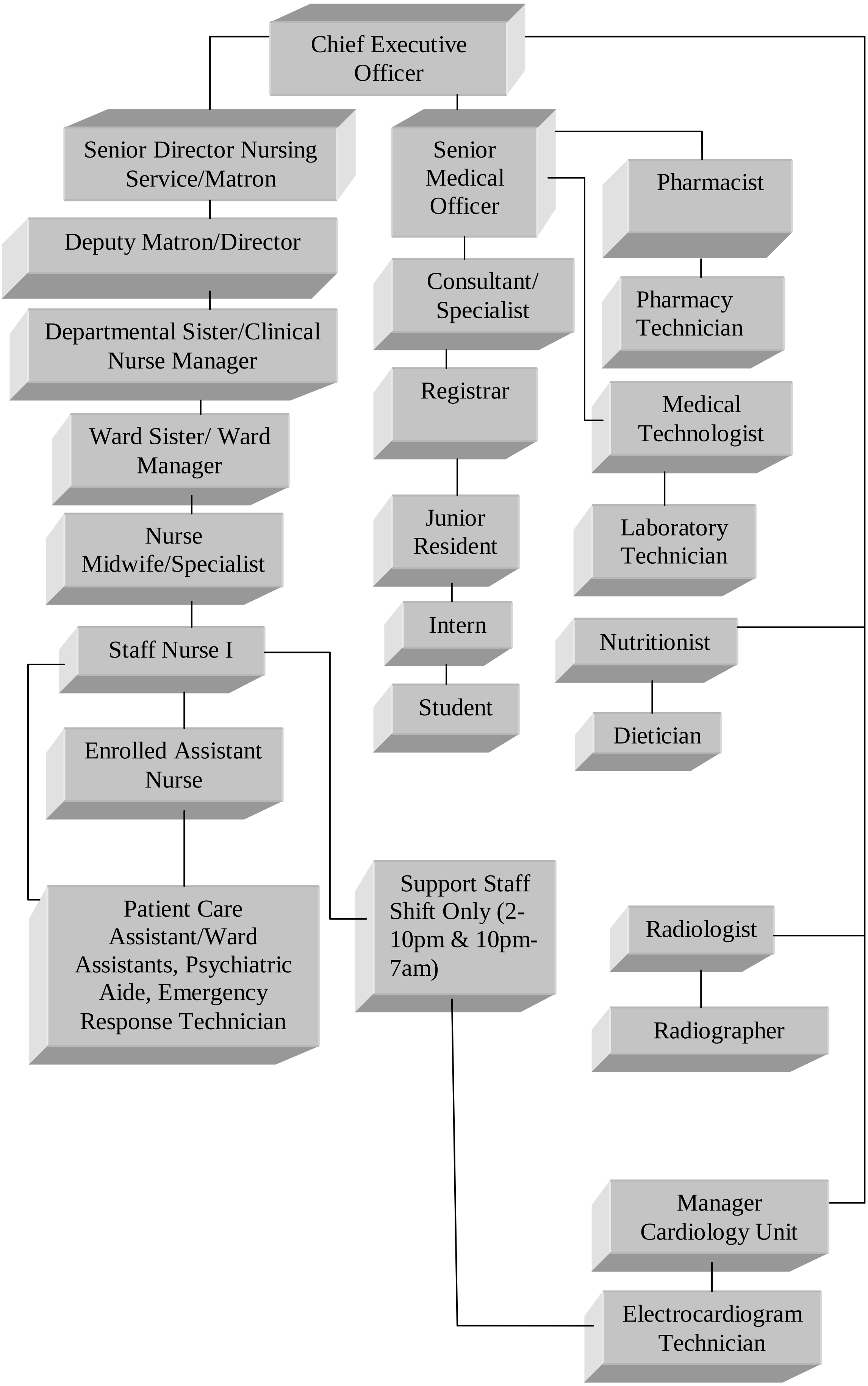


Figure 5. Typical structure of a hospital

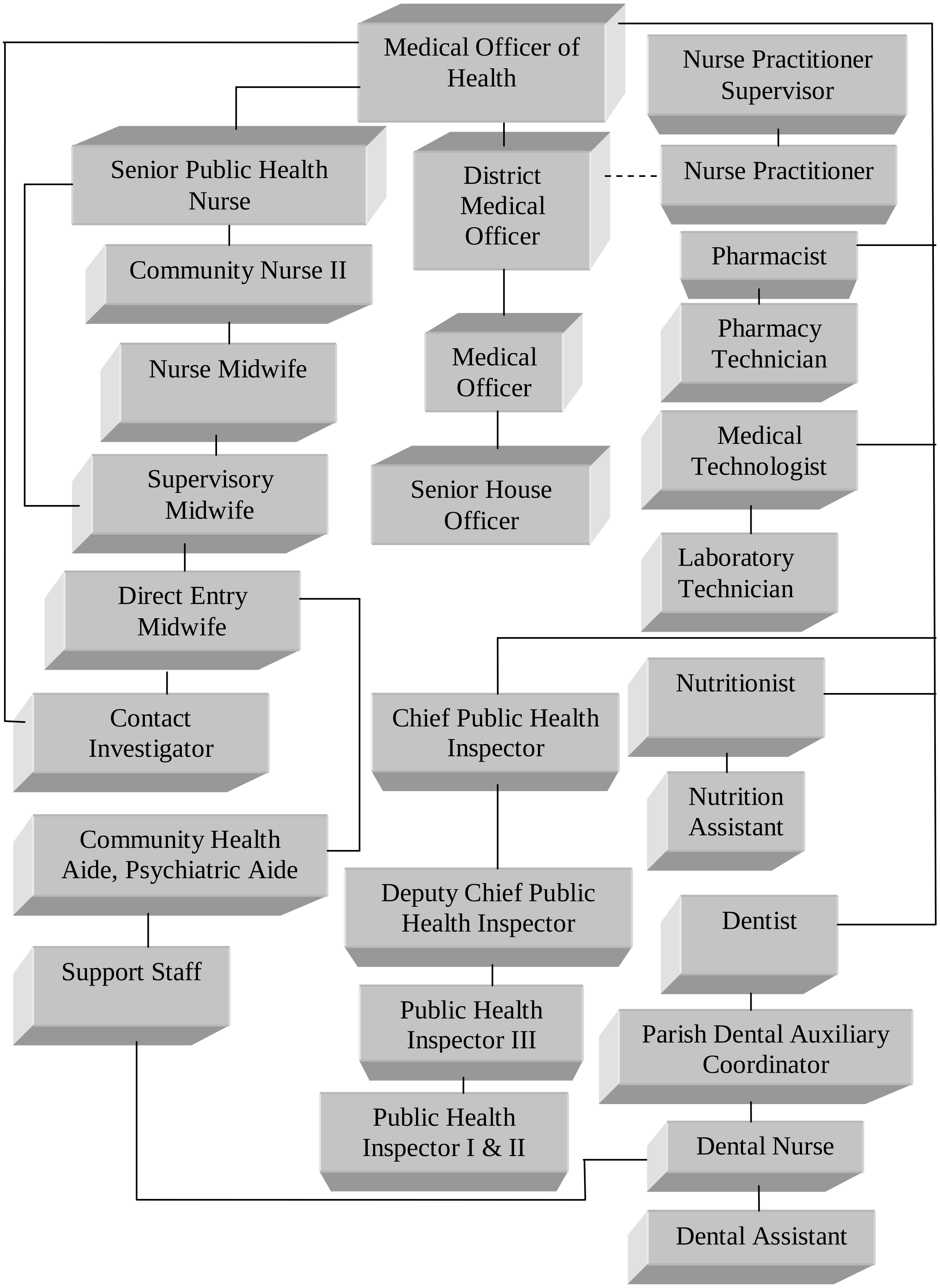


Figure 6. Typical structure of a health centre

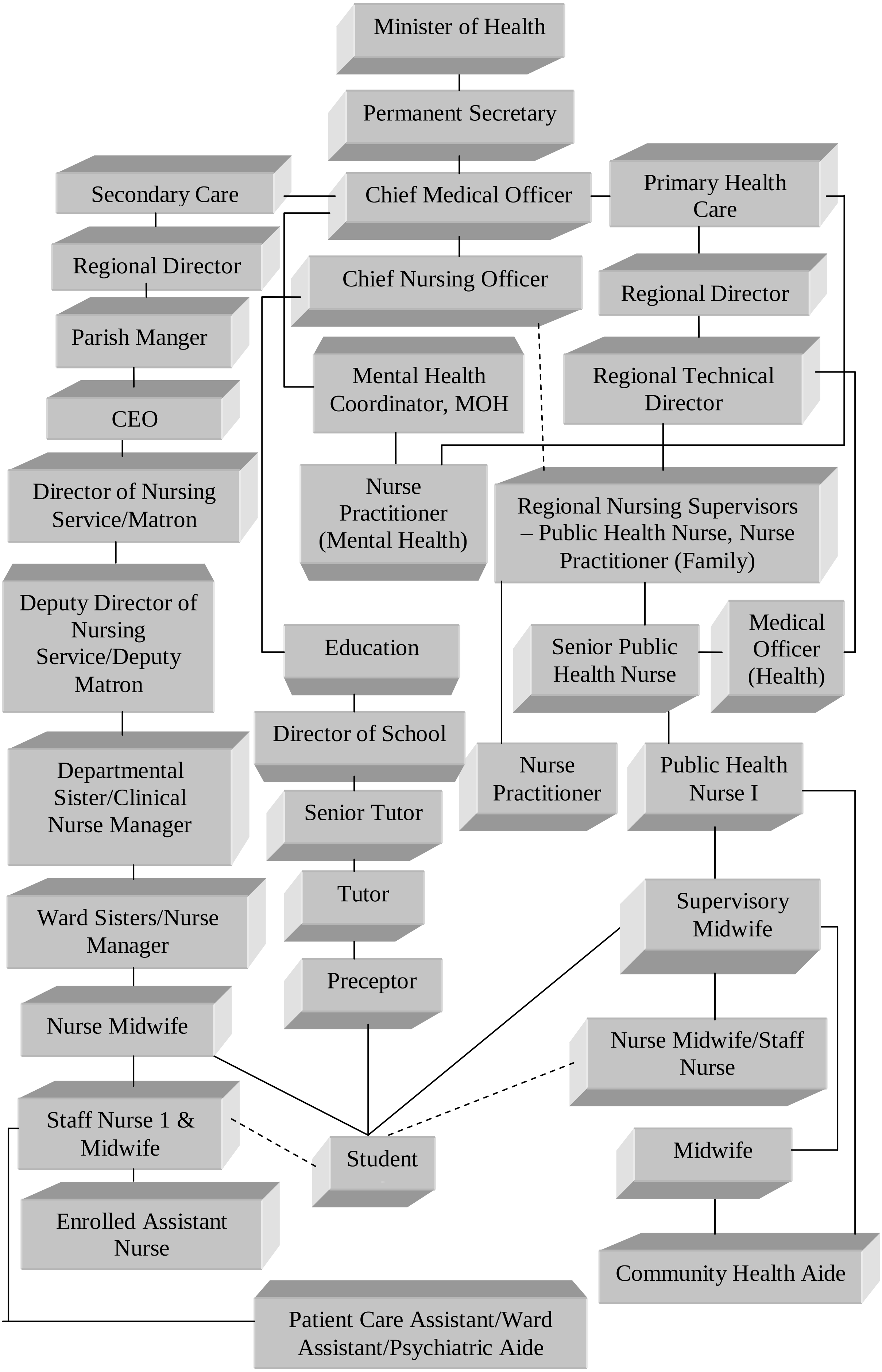


Figure 7. Nursing structure

management. The specialist categories include care of the critically ill, nephrology, operating room, ophthalmology, paediatrics, ear, nose and throat, accident and emergency, care of the burn patient, and midwifery (MOH, 1992).

The Level III/Nurse III/Professional Nurse III/Nurse manager/Ward sister is a staff nurse who has obtained training in midwifery (usually) with a minimum of 5-7 years clinical experience and has completed an approved nursing administration programme. The scope of practice includes planning, organising, coordinating and evaluating the nursing management of individuals, families and communities within the primary, secondary and tertiary care settings. Level III nurses function in key leadership positions in various units with supervisory responsibility for professional nurses, midwives and support staff (MOH, 1992).

The PHN/Community nurse I/Level IV is a registered nurse midwife who has obtained training in community health nursing at the Bachelor of Science level. The scope of practice includes the management, supervision and delivery of maternal and child health, family health, school health, provision of communicable and non-communicable disease control services within the PHC setting and some secondary care facilities. Additional roles include managing Type II health centres, having oversight for Type I centres and active involvement in disease surveillance and investigations (MOH, 1992).

The NP/Level V is a registered nurse/midwife or certified mental health nurse with five years clinical experience who has obtained a Master of Science degree in Family Nurse Practitioner, mental health/psychiatric nurse practitioner or other specialty. The scope of practice includes provision of nursing medical and mental health/psychiatric care to individuals, families and communities as legally permissible. NPs practise in advanced roles and conduct physical/mental examinations of a medical nature, make medical diagnoses, order laboratory and other investigations, interpret findings of these investigations and prescribe medications according to standing orders. Prescribing rights are currently being negotiated for NPs. They work parallel to the doctors in PHC and are sometimes found in secondary, tertiary and extended care settings (MOH, 1992). A CNO has overarching responsibility for professional nursing and midwifery services in the country and advises the government on nursing and midwifery issues. The CNO’s post is within the MOH and reports to the CMO.

The public health system is faced with a chronic shortage of all categories of nurses. Reports have revealed that in 2008 only 53.0% of the required 244 of public health nurses were in the public health system, with registered nurses at 74.0% of the required 2547. The number of midwives was also low at 54.0% of the required 528. This trend is likely to worsen with the annual attrition rate of 15.0% (Watson Williams, 2008, MOH personnel, personal communication, November 16, 2012). This has serious implications for access and the delivery of quality services to consumers.

Utilisation of health services. The choice between public and private health facilities is often influenced by people's perceptions of the quality and efficiency of the services provided. Other factors known to influence the choice of health facility include distance from the facility, availability of transport, diversity of the service, how technologically advanced the service is, operating hours, cost of the service, access to health insurance, preference and the severity of the illness (MOH, 2009c).

Despite the aforementioned factors, many people (especially the poor) mainly utilise the public health facilities. Public sector hospitals continue to be the leading providers of hospital-based care, whereas the private sector is the leading provider of pharmaceuticals, laboratory services, radiographic services and ambulatory services (MOH, 2008a). Some utilisation patterns in the public health system are highlighted below, using pre-reform data from the MOH 2007 Annual Report. Although there were slight variations in utilisation over the period 2003-2007, the patterns were fairly consistent, as shown in Tables 7 & 8.

The report showed that utilisation of health centres had some fluctuation over time; nevertheless, curative services increased marginally in 2006 over 2004 and 2005. There was a 3.9% decline in health centre visits and 2.6% reduction in curative visits in 2006 in comparison to 2003. Additionally, when the data were disaggregated by gender, females were the most frequent users of the facilities. Generally, females accounted for 69.5% of the total number of health centre visits in comparison to 30.5% for males. This observation could be attributed to the fact that maternal and child health visits were subsumed under health centre visits and women were the usual attendees at these clinics (MOH, 2009c).

Table 7

Total health centre and curative visits: 2003 – 2007

Year	Health Centre Visits			Curative Visits		
	Total	Male	Female	Total	Male	Female
2003	1,586,630	480,635	1,105,995	695,125	232,605	462,520
2004	1,535,530	463,592	1,071,938	669,398	220,390	449,008
2005	1,514,415	459,889	1,054,526	654,658	217,683	436,975
2006	1,525,680	464,017	1,061,663	677,435	226,942	450,493
2007	1,490,844	455,171	1,035,673	674,162	226,477	447,685

Note. Adapted: Ministry of Health, Jamaica (2009). *Annual Report 2007.* Kingston, Jamaica: Author

During the same period of time there was a noticeable increase in the total number of visits to the public hospital casualty departments. The report also revealed that self-referral (88.0% in 2006) was the main source of referral to public hospitals' casualty departments (Table 8). While data for the sources of referral to PHC facilities were unavailable, it is likely that self-referral was also the main mode of referral (MOH, 2009c).

Table 8

Attendance and source of referral to public Casualty Departments: 2003 – 2007

Year	Total Visits	Total Receiving care	Total Referral	Referral Source					
				Self	Private Doctor	Health Centre	Police	Other Hospital	Other
2003	746,844	727,977	693,048	88.3%	1.7%	2.0%	2.0%	1.1%	5.0%
2004	775,727	758,835	714,447	88.7%	1.8%	1.8%	1.6%	1.0%	5.0%
2005	694,354	682,009	638,830	87.4%	1.8%	1.8%	1.8%	1.2%	6.0%
2006	715,707	702,783	661,835	88.0%	1.8%	1.8%	1.8%	1.1%	5.5%
2007	785,284	765923	750,930	85.6%	1.7%	1.8%	1.9%	1.2%	7.9%

Note. Adapted: Ministry of Health, Jamaica (2009). *Annual Report 2007*. Kingston, Jamaica: Author.

Health indicators. Health indicators are often used to determine the health status of a nation. Frequently monitored indicators are birth and death rates (Table 9). While attempts have been made to capture the indicators, the data presented may not be accurate.

This is because some individuals do not register births or deaths, or reports may not be completed in a timely manner (MOH, 2008a).

Table 9

Health indicators 2003 – 2007

HEALTH INDICATORS	**YEARS**				
	2003	**2004**	**2005**	**2006**	**2007**
Life Expectancy at Birth (Years)	74.13	74.13	74.13	74.13	74.13
Contraceptive Prevalence (%)	68.80	69.10	69.01	69.01	69.01
Total Fertility Rate (per woman)	2.5	2.5	2.5	2.5	2.5
Crude Birth Rate (per 1,000 mean population)	19.30	17.60	17.25	17.04	17.00
Crude Death Rate (per 1,000 mean population)	6.00	6.30	6.10	5.70	6.40
Infant Mortality Rate (per 1,000 live birth)	19.90	19.90	19.90	19.90	21.30
Child <5 years mortality rate (per 1,000 live births)	n/a	n/a	31.30	32.00	25.40
Maternal Mortality Ratio (per 100,000 live births) (hospital-based)	106.20	106.20	94.80	94.80	94.80

Note. Adapted: Ministry of Health, Jamaica (2009). *Annual Report 2007*. Kingston, Jamaica: Author

In addition to monitoring health indicators, examining the leading causes of death in a country is fundamental to health policy planning and implementation. In 2008 the three leading causes of death in Jamaica were external causes (such as sudden and violent causes reported by police), cerebrovascular diseases and diabetes mellitus (STATIN, 2010). When causes of death were disaggregated according to sex, the leading causes of death among males 2006-2008 were external causes. In contrast, the leading causes of death among females for the same period were cerebrovascular diseases (STATIN). Appendix 1 provides further details on the leading causes of death.

2.7. Patient's journey

Understanding the manner in which users gain entry into a health facility is important, and as such, a brief description is given here of what embodies the patient's journey in accessing the health services. The journey to accessing health services varies among institutions, as well as according to the nature of a user's health condition. Figure 8 describes the typical pathway to accessing a GP, hospital or health centre. On entering the

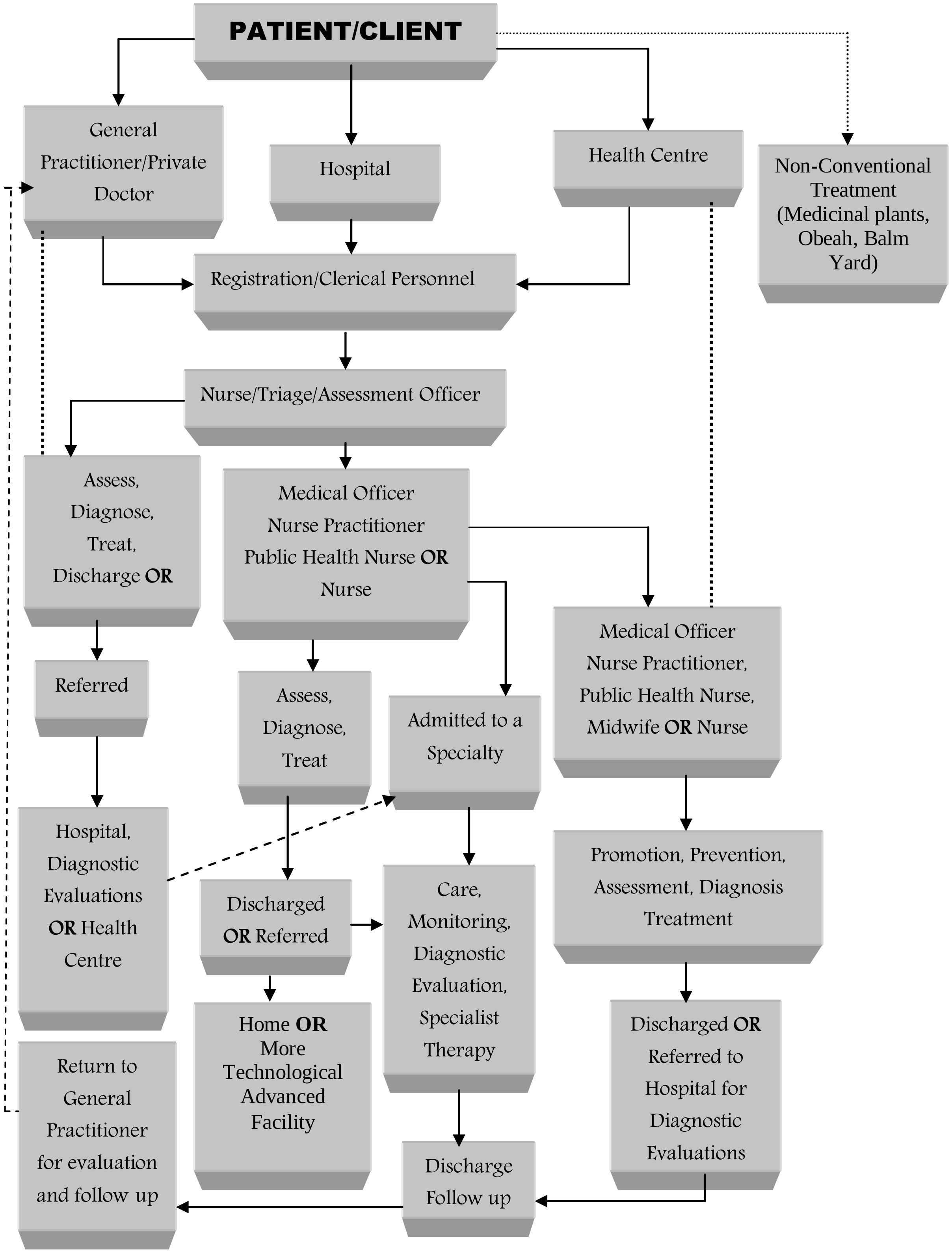


Figure 8. Patient's journey to accessing health care

facility of choice, the process usually follows some organised manner. For example, there would be an initial registration, which entails a cost, then triaging to determine the level of treatment required. Once the treatment modality is determined the patient is treated and discharged, referred or admitted for further management.

While the typical pathway is widely-known and accepted, it is important to mention the alternative pathways frequently adopted to obtain non-conventional modes of treatment. It is not uncommon for individuals across the socio-economic spectrum to concomitantly utilise conventional and non-conventional modes of treatment for their health conditions. Self-medication with medicinal herbs is embedded in the Jamaican culture and was found to be prevalent among retirees and individuals 65 years and over (Picking, Younger, Mitchell, & Delgoda, 2011). In 2009, 49.0% of persons reported using home remedies for their illness instead of seeking care (PIOJ & STATIN, 2010).

Folk culture and health-seeking behaviour. Culturally, elements of African ancestry are threaded throughout the Jamaican experience. This is evident in the country's language, belief system and religion. There is also a strong link between health-seeking behaviours and African traditions, of which Folk medicine remains a popular choice. Despite the advancement in scientific medicine some Jamaicans continue to adopt various forms of traditional healing practices or Folk medicine for their ailments (Seaga, 2005; Weaver, 2003). This practice is not confined to any particular socioeconomic group and is present in both urban and rural communities. Common practices included obtaining treatment from the "doctor shop" (pharmacy) for self-treatment, use of home remediesespecially those made from herbs and medicinal plants, and engaging the services of herbalist, spiritual healers and 'obeah man/woman', albeit in a clandestine manner (Seaga; Weaver).

It is also true to say that the spiritual component of sickness and health is integral to the practice of Folk medicine in Jamaica and its use is not influenced by religious persuasion. Additionally, belief in African spirits has strongly influenced health-seeking behaviour and is evident among individuals who seek treatment at the 'balm yard' for diseases or problems perceived to be the result of a curse. A 'balm yard' is operated by revival/spiritual healers and is a form of Pukumina, which is derived from African religion. Connecting with the spirit world and the gift of discernment are key attributes of spiritual healers and healing ceremonies may take several forms, including baptism, bathing, sprinkling of rum, 'read-up', purification with fire, and herbal drinks and other concoctions considered to have healing properties. Healers may also give their patients prescriptions.

While ceremonies may be held in a ‘balm-yard’, they are also held in churches, offices or public spaces. Venue is often dependent on the nature of the illness. Therefore, it may be on holy (usually in a church) or ordinary ground (Weaver, 2003). Ceremonies are often accompanied by invocation of spirits through singing and beating of drums. In addition, paraphernalia such as consecrated water, bottles of wine and white rum, candles, frankincense and myrrh, herbs and other concoctions are used to achieve spiritual healing. Faith plays a significant role in obtaining the desired effects from spiritual therapy (Seaga, 2005).

2.8. Conclusion

Undoubtedly, the Jamaican public health system has demonstrated resilience over time, responding to changes in the country’s social, economic, and political situations. Several policy directives consistent with national priorities have been promulgated. As a result, the Jamaican health service has seen expansion of the public health system in the post-independence period; contraction under the IMF structural adjustment programme, which resulted in shortage of resources, staff-cuts, closure and downsizing of health facilities and attrition of health personnel such as nurses; changes in modes of funding of the public health system; re-introduction of user fees; training of new cadres of health practitioners; decentralisation and the establishment of RHAs; and the abolition of user fees in 2007 and 2008. These reforms have had significant impacts on the health system.

Despite the promulgation of Acts, the appointment of commissions and implementation of various reform processes to improve efficiency and effectiveness in the public health system, poor access to health services remains a problem for some people; the system is underfunded; and the cadre of health workers, especially nurses, remains deficient. This thesis examined people’s ability to access care, and the work of the professional nurse, since the reform in 2008.

The following chapter presents the literature used to inform this study on the impact of user fees and evaluation of the removal of user fees. It also highlights the search strategy adopted and provides information on the knowledge gaps that exist in this area of study.

Chapter 3: Literature review

3.1. Introduction

This chapter presents an outline of the search strategy, followed by the findings of the literature review employed for the study. It presents the existing evidence on user fees, mainly from a developing world experience. In addition to clarifying the concept of user fees, the review highlights key limitations of the existing literature; the impact of user fees in health systems; the impact of abolishing user fees; and what is known about the Jamaican experience in terms of user fees and the impact of their abolition on work of the health workers and the professional nurse. The chapter also provides a conclusion and serves as a catalyst for the theoretical framework of the study.

3.2. Search strategy

Searching research evidence for this study was undertaken during 2009-2012 and used several strategies. Among the strategies adopted were the use of electronic databases such as Cumulative Index of Nursing and Allied Health Literature (CINAHL), ProQuest, Jstor (Journal Storage), ScienceDirect, Medline Cochrane and Google Scholar. Resources such as books and articles were also obtained from the library, online catalogue, interloan services and international thesis databases. Books from the researcher's collection were also used.

References in relevant scholarly publications were used to find many of the articles used for this review. The literature search was undertaken under the following main headings: funding, access to health care, user fees in developing countries, Jamaican health system, and nursing and health. The search terms used to find literature relevant to each heading included (1) funding - 'user fees', 'charges and health services', 'out-of-pocket payment', 'health financing', 'user fees or charges'; (2) access to health care - 'health care', universal health care', 'access and equity in health' 'equity in health', 'access to health care', 'health disparities', 'determinants of inequity in health', 'barriers to access', 'barriers to equity in health', 'public health care system in developing countries', 'health reform'; (3) user fees in developing countries - 'developing countries and user fees', 'user fees and Africa', 'impact of user fees', 'economic impact of user fees', 'abolition and user fees', 'removal of user fees', 'evaluation of the removal of user fees'; (4) Jamaican health system - 'health system in Jamaica', 'Jamaica and health', 'Jamaica and user fees'; (5) nursing and health care - 'nursing and access to health care', 'nursing and user fees', ‘nurse-led services’, and ‘funding and nursing services’. Additional literature was also sourced from reference lists in books and articles.

3.3. Key limitations of literature review

Although user fees is a mode of funding in several developed and developing countries, the setting for most of the literature accessed for this review was in African countries. Additionally, these studies were often all conducted by the same authors, with some variation in topic, design, setting and co-authorship. A decision was, nevertheless, made to utilise these sources because of the economic similarities between these countries and Jamaica. Generally, the literature reviewed was mainly scholarly and of good standard. Authors were knowledgeable about the topic and engaged the work of experts in the field to identify the existing gaps and conduct scientific work on the topic in their settings.

3.4. Impact of user fees

Modes of financing for health care in both developed and developing countries include direct out-of-pocket payment, user fees or cost sharing, government budgetary allocation, social insurance, private insurance and charitable organisations (Bitran & Giedion, 2002; Health Sector Task Force, 2009; PIOJ, 2011; Powell & Wessen, 1999). Organisation for Economic Cooperation and Development (OECD) countries utilise a mix of taxation, social and private insurance modes of financing for health services (Gordon-Strachan et al., 2010; Scott, 2001). For example, health systems in the United Kingdom (UK) and New Zealand are predominantly financed by general taxation, whereas health financing in the USA is through employment and voluntary insurance largely through private providers, with some federal and state funding for targeted groups. In contrast, the health system in the Netherlands is financed through a mix of social and private insurances, primarily through private providers (Scott; van Doorslaer et al., 1999). The 1948 reform of the UK’s National Health Service (NHS) resulted in free health care at the point of service for the entire population (Powell & Wessen, 1999). Given the different time period and different economic situation within which it operates, a decision was made not to draw on the extensive literature of the UK experience.

User fees are mechanisms adopted by several countries, especially developing countries, to mobilise resources to foster efficiency in health services delivery. This fosters service delivery that is commensurate with demographic changes and demand for health care generally (Bitran & Giedion, 2002; Burnham et al., 2004; James et al., 2006). Despite the plethora of information on user fees, the concept lacks clear definition. For the purpose of this research, James et al.'s definition was used: "user fees refer to official fees charged by public health providers" (p. 139). They also pointed out that this definition of user fees does not include out-of-pocket payments for health services in non-public settings, that is, by privately-owned providers. Their definition captures the manner in which the concept is used and interpreted in most literature (Akashi, Yamada, Huot, Kanal, & Sugimoto, 2004; Asfaw, Braun, & Klasen, 2004; Bitran & Giedion; Gilson, 1997; Hjertqvist, 2002; Messen, Van Damme, Tashobya, & Tibouti, 2006).

To further clarify the concept, user fees have been operationalised as a financing mechanism with two main characteristics: payment is made at the point of service use and there is no risk sharing (Lagarde & Palmer, 2008). Risk sharing is defined as:

> Any system which allows payors to share some of the financial risk associated with a particular patient population with providers. Providers agree to adhere to fixed fee schedules in exchange for an increase in their payor base and a chance to benefit from cost containment measures. Common risk-sharing methods are prospective payment schedules, capitation, diagnosis-related fees and pre-negotiated fees. (Reference.Md, 2012, para 1)

The origin of user fees in developing countries has its link to the IMF. During the 1980s, the World Bank consistently raised concerns about free social services in resource-constrained countries. Ultimately, this resulted in the imposition of user fees for health care in most developing countries. Two models for the implementation of user fees were identified in the African context. These are the standard model based on the premise that user fees mobilise resources, as well as foster efficiency and equity, and the Bamako Initiative model, which emphasises that revenue can be generated and controlled at the community level (Nolan & Turbat, 1995).

As the 'no user fees' versus 'user fees' debate heightens, proponents and critics frequently defend their positions on the possible outcomes of fees for health services or cost recovery. Proponents of user fees have embraced and underscored the potential of this health financing mechanism to:

> increase demand for services owing to the improvement in quality; reduce out-of-pocket and other costs, even for the poor, by substituting public services sold at

> relatively modest fees for higher-priced and less accessible private services; promote more efficient consumption patterns, by reducing spurious demand and encouraging the use of cost-effective health services; encourage patients to exert their right to obtain good quality services and make health workers more accountable to patients; when combined with a system of waivers and exemptions, serve as an instrument to target public subsidies to the poor and to reduce the leakage of subsidies to the non-poor. (Britran & Giedion, 2002, pp. 5-6)

In contrast, critics have argued that user fees:

> are rarely used to achieve significant improvements in quality of care, either because their revenue generating potential is marginal or because fee revenue is not used to finance quality gains; do not curtail spurious demand because in poor countries there is a lack not an excess demand; fail to promote cost-effective demand patterns because the government health system fails to make cost-effective services available to users; hurt access by the poor, and thus harm equity, because appropriate waivers and exemption systems are seldom implemented. (Britran & Giedion, p. 6)

Through the Bamako Initiative, a number of developing countries in Africa adopted user fees policies in the 1980s. The driving force behind this initiative was the loan conditions imposed by the IMF and the World Bank at the time. In Jamaica, the elements of a fee payment structure had already existed under colonial governance, despite occasional suspension of its use. It was subsequently reintroduced, and increased in some cases, under the IMF Structural Adjustment programme of the 1980s. User fees in the public health sector were revised in 1984, 1993, 1999 and 2005, but contributed only a small proportion of the cost of health services. A means test was applied to improve access for those who could not pay. Three key objectives of user fees were identified in the Jamaican context: “(1) to raise revenue through cost-sharing, (2) to deter frivolous demand, and (3) to instil a cost conscious mind-set among providers” (Lalta 1995, p. 15).

Studies have shown that the implementation of user fees has had varied impacts (positive, negative or mixed) on access to health care. For example, in Benin and Guinea, positive outcomes were achieved because the demand for preventive and curative services increased, despite implementation of the user fees policy. The increased utilisation was attributed to the good quality of care being offered, especially the availability of drugs

(Soucat et al., 1997). Equally, countries such as Cambodia, Cameroon, Mali, Mauritania and Niger experienced increased uptake of health services to some extent following the introduction of user fees in the public health system, mainly for PHC services (Akashi et al., 2004; Audibert & Mathonnat, 2000; Barber, Bonnet, & Bekedam, 2004; Chawla & Ellis, 2000; Litvack & Bodart, 1993; Mariko, 2003).

Analyses of the impact of user fees have also shown utilisation of health services tended to decline in some countries following its introduction. This was true especially for developing countries such as Ghana (Biritwum, 1994) and Sudan, in which 70.0% of the poor communities viewed user fees as a deterrent to accessing health care when needed (Yates, 2009). Additionally, individuals with neurological disorders such as epilepsy in Zambia experienced financial barriers in accessing physician consultations (Birbeck & Munsat, 2002). According to the JSLC 2007, approximately 50.8% of Jamaicans in the lower quintiles cited cost as the reason for not seeking care when needed (MOH, 2009c). The negative effects of payment for health services on utilisation are not unique to low income countries; they have also been experienced by some middle income countries, countries in transition, and developed countries such as Thailand and USA (Graham, 2009; Xu et al., 2003).

Even though the effects of user fees in Cambodia were generally positive, it is important to note that the uptake of services by the poor decreased, despite an overall increase in utilisation. The poor often incurred costs by borrowing to pay medical expenses (Jacobs & Price, 2006). While there was an overall improvement in quality of care in the Democratic Republic of Congo, utilisation decreased following the introduction of user fees (Haddad & Foumier, 1995). Similarly, access to health services in other countries was negatively affected by the introduction of user fees. In Burkina Faso, the demand for curative services decreased (Ridde, 2003), and in China utilisation of preventive services declined (Liu & Mills, 2002). In Vietnam, inpatient admissions decreased by 52.0% following the introduction of user fees (Sepehri, Chernomas, & Akram-Lodhi, 2005). Utilisation also fell in Niger, which experienced a 41.0% decline in new outpatient referrals despite some positive effects. More monitoring of quality, more medical equipment, and increased number of drugs were reported prior to nationwide implementation of the user fees policy (Diop, Yazbeck, & Bitran, 1995; Meuwissen, 2002). Uganda and Zimbabwe also experienced a reduction in the utilisation of health services following the introduction of user fees (Kipp, Kamugisha, Jacobs, Burnham, & Rubaale, 2001; Zigora, as cited in James et al., 2006).

Introduction of user fees for services in the aforementioned countries took into consideration those individuals who would be disadvantaged by the policies and, as such, provisions were made for services to be provided free for some groups. For example, in Sudan, exemptions for pregnant women and children under five affected by malaria, resulted in increased utilisation by these groups following the introduction of user fees (Abdu et al., 2004). The exemption policy was an initiative supported by international agencies such as the World Bank. They were of the view that user fees had a negative impact on access for some groups and, as such, suggested that appropriate waiver systems be instituted wherever user fees were implemented (Bitran & Giedion, 2002). However, exemption policies did not achieved the desired effects in countries such as Burundi (Bate & Witter, as cited in James et al., 2006), Ethiopia (Russell & Abdella, 2002), Ghana (Biritwum, 1994; Nyonator & Kutzin, 1999), Kenya (Mbugua, Bloom, & Segall, 1995), Sierra Leone (Fabricant, Kamara, & Mills, 1999) and Tanzania (Laterveer, Munga, & Schwerzel, 2004).

In addition to the ineffective exemption policy in Tanzania, the use of outpatient services decreased by 50.0% in the aftermath of user fees implementation (Hussein & Mujinja, 1997). Noteworthy is that some countries experienced mixed results following the introduction of user fees. For example, in Zambia utilisation decreased for paid services but increased for exempted services (Blas & Limbambala, 2001), while in Nigeria utilisation of malaria services increased. The increase in malaria services was attributed to improved quality services through trained staff and adequate drug supplies. These services were, however, utilised mainly by the rich and educated (Uzochukwu, Onwujekwe, & Eriksson, 2004). Conversely, findings from a study in Mali revealed that, even when the quality of services was satisfactory, it did not mitigate the undesired effects of user fees (Ponsar et al., 2011). A longitudinal study in Zaire on the quality, cost, and utilisation of health services in developing countries further supported the claim that increases in the cost for health care have negative effects on the uptake of services (Haddad & Fournier, 1995).

The demand ‘reduction’ - “number of drop-out from the health care market in favour of self-care”; and demand ‘diversion’ - “diversion of demand from one provider to another provider based on the price and other signals" - (Asfaw et al., 2004, p. 2067) effects of user fees in rural public clinics in Ethiopia were examined. Asfaw et al. found that individuals' decisions to seek medical care over self-treatment hinged on the provider's price, and the poorest households did not participate in the health care market when user fees increased. Furthermore, they found that household income influenced the choice between modern medical care and self-treatment that essentially constituted a barrier to accessing health care when required. Equally, distance from the health facilities and long waiting times to be seen by providers were disincentives even if individuals had the funds to pay for services (Asfaw et al.). This resulted in the assertion that "the demand for public clinics is price elastic" (Asfaw et al., p. 2074), suggesting that, when prices increased, demand for health services declined, thereby demonstrating a crowding out effect (people do not participate in the public health care market because of increasing user fees). In Ethiopia, a high crowding out effect was observed in government clinics. For this reason the authors concluded that:

> the poorest segment of the population is extremely sensitive to price changes in private clinics and that increasing user fees in publicly owned health centres and clinics is likely to drive out a significant portion of the poorest households from the health care market. Poor rural households in Ethiopia are too poor to overcome price barriers in seeking medical care from publicly-owned clinics (Asfaw et al., p. 2075).

In some countries, although user fees were only small in some public health facilities, poor quality of care, under-the-counter payment, and poor access limited the use of public health services by the poor (Bitran & Giedion, 2002; DeVoe et al., 2007; Hardeman et al., 2004; Kiwanuka et al., 2008; PIOJ & STATIN, 2008; Yates, 2006). Furthermore, when the user fees situation was examined in Santo Domingo and El Salvador, even though prices in the private sector were found to be higher than public facilities, most persons obtained care from the private sector (Bitran & Giedion). A possible explanation for this is a preference for quality service in spite of cost. To mitigate the adverse effects of user fees, various governments and international agencies such as the World Bank have now advocated the abolition of user fees, predicated on four factors: (1) user fees are barriers to access; (2) user fees negatively affect compliance with expensive treatment regimes; (3) user fees retard a country's ability to achieve international targets such as the United Nations' MDGs; and (4) the total revenue raised from user fees is generally negligible (Gilson, Russell, & Buse, 1995; James et al., 2006; Russell & Gilson, 1997; Xu et al., 2003).

3.5. Jamaica and other Caribbean countries' experience with user fees

In the 1990s, it was found that the Jamaican public health system was underfinanced. As a result, the system was ailing from the reduced number of qualified staff, unavailability of pharmaceuticals, decreases in the quantity and quality of care provided, and dissatisfaction among workers and the wider populace. These challenges resulted in the introduction of a more extensive use of user fees for public health services. Revenue generated was to be utilised to boost expenditure on primary and secondary care services. The belief was that user fees would not adversely affect access to care or utilisation of the public health services. In addition, it was felt that revenue from user fees would be utilised to support management and overcome some of the challenges such as staff and drug shortages, and staff and patient dissatisfaction (Shepard, 1993).

Exemption Policy. Caribbean countries such as St. Kitts, St. Lucia, St. Vincent and the Grenadines, Dominica and Grenada also resorted to user fees to improve access to basic public health services. Each of these countries had exemptions for those who could not pay. In Jamaica, to enforce the exemption policy whereby people who could not afford out-of-pocket payments received services at no charge or at a subsidised rate, assessment officers were trained and deployed to the public health facilities. This arrangement was often disregarded by health facilities, especially for preventive services (Gordon-Strachan et al., 2010). The ineffective exemption process affected some individuals' ability to access health care, mainly due to their inability to pay out-of-pocket. One factor contributing to the ineffectiveness of the exemption policy was that users were often "afraid of being embarrassed" by assessment officers and health personnel for not being able to pay. This practice negatively affected the success of the policy (Gordon-Strachan et al., p. 147).

Van Doorslaer and Wagstaff measured horizontal equity (where people with equal need utilise the same amount of health care) in utilisation patterns in Jamaica through the application of a comparative econometric test on the *Jamaica Survey Living Conditions 1989*. They found that utilisation of curative and preventive services in the public health system favoured the rich despite the poor having a greater demand (as cited in Gordon-Strachan et al., 2010). This further highlighted the ineffective exemption mechanism, which clearly did not protect the poor from the adverse effects of out-of-pocket payment for health care.

Studies in the Jamaican context on the effects of user fees on utilisation were varied and inconclusive in some cases. For example, Lewis and Parker (1991) found that revenue generated from user fees increased significantly for the period they studied; however, they offered no conclusion regarding the impact on utilisation patterns (as cited in Gordon-Strachan et al., 2010). Additionally, Shepard (1993) examined the impact of user fees in the public health system and found that hospital revenue increased annually following the introduction of user fees. There was, however, an inverse relationship with utilisation, as the utilisation trend of public facilities declined over the period studied. The decline was attributed to the quality of the services provided and not the increase in user fees. Bailey, Wynter, Jackson and Lee (1994) examined the effect of user fees on access to family planning services at a quasi-health facility. Fees for this service were introduced in the facility in 1993. The study found that utilisation decreased by 28.0% between 1992 and 1993, and the decline was more pronounced among new users and users of injectable contraceptives. The authors concluded that users were unwilling to pay for a service that had previously been free. Equally, Alleyne (2010), in examining the impact of user fees on health costs and health burden among patients with diabetes and hypertension, found that user fees had a negative impact on health-seeking behaviour among Jamaicans. Individuals were found to reduce health-related costs by employing practices such as delaying or not seeking care when ill, purchasing only a portion of their prescribed medications, and using home remedies.

User fees were also found to have negative effects on the elderly. Evidence revealed that, despite the JADEP, the elderly who often required treatment for co-morbidities were unable to meet not only the costs for services, but also indirect costs for transportation, especially in rural areas. Elderly persons who were unable to access services in the primary preventive services often resorted to home remedies to manage their health conditions (Gordon-Strachan et al., 2010).

3.6. The impact of the abolition of user fees

Experience has shown that removal of user fees can result in increased access and serve as a catalyst for increased utilisation to health services (Abdu et al., 2004; James et al., 2005). Based on this premise, some countries have abolished charges for health services to facilitate changes in people’s attitudes towards seeking health services, improve access, reduce morbidity, increase life expectancy and achieve better health outcomes, particularly among the underserved and vulnerable (Ansah et al., 2009; Turner, 2009; Yates, 2006). Although removing user fees for everyone may not in itself reduce inequity and disparity, it was hoped in Jamaica that this intervention would enhance equal access for equal need in the health system, as well as reducing disparities among the various social strata.

There is a plethora of literature on the reduction or the abolition of user fees for public health care, especially in African countries such as South Africa, Uganda, Ghana, and Zambia. Due to some similarities in economic status, the experiences of these African countries are among many used to highlight the potential impact of the abolition of user fees policy in Jamaica and to inform this research.

To determine the effects of the abolition of user fees in the public health system, researchers have employed a number of strategies. An evaluation approach with both quantitative and qualitative research methods was the main mechanism through which the desired outcome of the policy change was investigated. Studies were either longitudinal or cross-sectional in nature. National surveys of living conditions or poverty assessment tools were often utilised to obtain population data. Researchers gathered data using interviews (group and individual), participant observation, document reviews and surveys, and key informants were often selected from national, district or health facility levels. Non-probability sampling techniques were generally used and the samples included health workers, health unit management committee members, households and users of the health facilities. Settings for the studies varied and were often dependent on the geographic area of the country in which the policy was implemented. For example, some countries may have abolished user fees for primary care services in rural communities. Therefore, a mix of urban and rural settings, as well as selected private and public health facilities was utilised.

Findings from various studies have shown that utilisation increased considerably in South Africa, Uganda, Ghana, and Zambia following the removal of user fees (Ansah et al., 2009; Burnham et al., 2004; Fafchamps & Minten, 2007; Maisiye et al., 2008; Ridde & Morestin, 2011; Wilkinson et al., 2001; Yates, 2009). The increase in utilisation, however, did not always occur for the “vulnerable” or “underserved.”

South African experience with the abolition of user fees. In 1994, South Africa abolished user fees for pregnant and lactating women and children under six years; in 1997, South Africa then abolished fees for all PHC services. The intention was to increase access to health services by the poorest. When utilisation of mobile PHC services in one health district was evaluated, the findings revealed that removal of user fees resulted in an immediate influx of individuals seeking curative services, a demand that may have been attributed to Human Immunodeficiency Virus (HIV)-related illnesses. There was, however, a noticeable decline in the number of women seeking antenatal care or children being immunised, services that were previously free at the point of service (Wilkinson et al., 2001). Possible explanations given by the authors included the resultant congestion and reduced consultation time users experienced in the clinics. These factors also constituted a deterrent to women seeking antenatal care and child health services such as growth monitoring and immunisation (Jacobs & McCoy, 1997; Wilkinson et al.). Further reports indicated that fertility rates were declining because of HIV, thus reducing the need for maternal and child health preventive services. In contrast, there was a 46.0% increase in utilisation of primary health dental services after the removal of user fees (Bhayat & Cleaton-Jones, 2003). In addition, the above studies have shown that medical attention was sought for non-urgent conditions and hospital referrals declined. The decline in hospital referral was attributed to the early provision of more efficient and effective treatment, thereby reducing the need for hospital referral.

Ugandan experience with the abolition of user fees. Studies have shown that in Uganda, the utilisation of health services increased following the abolition of user fees in 2001 (Burnham et al., 2004; Deininger & Mpuga, 2005; Nabyonga et al., 2005; Xu et al., 2006). One study revealed that, following the policy change, utilisation increased by 10.0% with 18.5% new cases in the under-five age group and 31.0% in the over-five age group. There was also an increase in referrals (26.0%), maternity delivery services (28.0%), and postnatal services (34.0%). When compared to the year 2000, utilisation of public hospitals increased by 25.5% in 2001 and 55.3% in 2002. Utilisation of health centres increased by 44.2% in 2001 and 77.1% in 2002 (Nabyonga et al.).

The social benefits of the policy change in Uganda were estimated to be notably larger than the loss of revenue. This is because the underserved population experienced improved access to health care, resulting in reduced rationing, and the probability of becoming sick fell by 1.5% among adults and 4.4% among children. The latter may be attributed to easier access to the health services, more specifically, preventive measures. The domino effect of the outcome of the policy change led to economic benefits, for example, reduction of work hours lost to sickness by approximately 1.3 days. This finding was more pronounced among the poor. Equally, the number of persons reporting cost as a barrier to accessing health services in 2002 reduced by 15.0% (Deininger & Mpuga, 2005).

One study also found that there was increased utilisation among the non-poor in 2003 over 2000 (Xu et al., 2006). Xu et al. further revealed that, although removal of user fees improved access to health services for both the poor and non-poor, catastrophic health expenditures remained unchanged for the poor and declined for the non-poor. The explanation for this experience for the poor is that lack of drugs in the public facilities necessitated out-of-pocket payments to obtain medications at private pharmacies. Drug availability fluctuated and stock shortages were frequent occurrences. When patients did not receive the prescribed medications, they either forewent the treatment or purchased the drugs from private pharmacies (Nabyonga-Orem et al., 2008). Use of private pharmacies placed further strain on the patients who were required to pay out-of-pocket for expensive drugs. This, however, did not affect the sustained increased in utilisation, which remained higher than during the cost-sharing period (Nabyonga et al., 2005; Nabyonga-Orem et al.).

The reports further noted that drug supply improved in subsequent years (Burnham et al., 2004; Nabyonga et al., 2005; Nabyonga-Orem et al., 2008) and users of public and private not-for-profit facilities experienced improved health outcomes (Nabyonga-Orem et al.). To avert any strain on the resources in the Ugandan health system following the abolition of user fees, the government proactively addressed the issues through increased budgetary allocation to the health sector. Attempts were made to ensure adequate supply of drugs and recruitment of additional health personnel (Nabyonga-Orem et al.) such as nurses (Masiye et al., 2008) was initiated. Despite these efforts, however, one study revealed that supplies such as syringes and needles were often inadequate and the cleanliness of the health facilities was worse after the discontinuation of cost sharing (Nabyonga-Orem et al.).

Even though there was increased utilisation generally following the removal of user fees, a study in Uganda found that the increase was more among adults than children. Additionally, ages and health conditions of patients remained unchanged in the PHC setting. The findings further revealed that outreach services remained the same or better in some areas, while there was discontinuation of some committee meetings, such as those of health units. The policy change also resulted in Central government assuming more responsibility in the administration of health units (Burnham et al., 2004).

Subsequent to the abolition of user fees in Uganda, utilisation of public and private health care providers by febrile children was examined. The findings revealed that caregivers of febrile children sought treatment mainly from drug shops/private clinics (62.7%) and government health facilities (33.1%). Drug shop/private clinics were often the first point of contact for care, despite free health care from government institutions (Rutebemberwa, Pariyo, Peterson, Tomson, & Kallander, 2009). The explanations given for this practice were that the treatment from drugs shops/private clinics was viewed as first aid, and the treatment was nearby, cheap and could be had on credit. The authors further argued that obtaining treatment on credit was suggestive of the caregiver’s inability to pay for treatment or travel when required. This finding further suggested that the abolition of user fees may not have improved access to health services, since there were indirect costs such as travel costs that were associated with accessing care (Rutebemberwa et al.).

Ghanaian experience with the abolition of user fees. In 2003, the MOH Ghana introduced free maternity delivery care through an exemption scheme in order to improve utilisation, access and quality of the delivery services (normal and assisted deliveries, caesarean sections and medical and surgical complications in delivery) (Bosu, Bell, Armar-Klemesu, & Tornui, 2007; Ofori-Adjei, 2007; Penfold, Harrison, Bell, & Fitzmaurice, 2007). The purpose of the policy was to remove financial barriers to maternal services, as well as to increase the number of deliveries attended by a professional health worker, and to reduce Maternal Mortality rates and poverty (Asante, Chikwama, Daniels, & Armar-Klemesu, 2007; Witter & Adjei, 2007). Evaluation of the policy change revealed mixed responses in the various regions in Ghana (Witter, Arhinful, Kusi, & Zakariah-Akoto, 2007a). Nonetheless, there was increased utilisation of health facilities for deliveries among the poor and less educated women, despite the rich benefiting more. As a result of the policy change, there was a reduction in out-of-pocket payments for maternal services and more deliveries were attended by midwives rather than traditional birth attendants (Asante et al.; Penfold et al.). There was also a commensurate decline in the number of delivery-related deaths, contrary to expected increase despite there being an increased patient load. However, respondents expressed dissatisfaction regarding the quality of services provided and the attitude of some midwives (Bosu et al.; Witter, Adjei, Amar-Klemesu, & Graham, 2009; Witter et al.).

While providers in Ghana embraced the policy generally, there were concerns about the implementation process, including inadequate financial support (Witter & Adjei, 2007), the policy being pro-rich in nature, poor quality services, costs of transportation, costs of medicine and supplies, distances to health facilities, cultural and social barriers and preference for traditional birth attendants. The general feeling was that the policy lacked effective monitoring systems; therefore, useful data were not captured. Funds were often reimbursed where user fees were used to offset health facilities' administrative costs. Reimbursement to clinical facilities was, however, untimely, resulting in providers reverting to user fees, thereby making the policy ineffective. One researcher suggested measures whereby policymakers could reduce perinatal and maternal morbidity and mortality within the Ghanaian context (Ofori-Adjei, 2007). These measures included:

> behaviour change strategies for providers and users; improving clinical quality of care and provider competencies; ensuring availability of funds to cover the exemptions; creating an enabling environment to address cultural barriers; identifying ways to improve the imbalance between the rich and the poor; and strengthen[ing] the culture of performing policy analysis. (Ofori-Adjei, p. 94)

In Ghana a study was done to determine the effects of free PHC, drugs and limited free secondary care services on health outcomes and utilisation among under five year old children with anaemia. Participants were enrolled in a household randomised control trial pre-payment scheme. The findings revealed that utilisation increased marginally but there was no appreciable impact on malaria-associated health outcomes (Ansah et al., 2009). This finding suggests that, while removal of user fees may result in changes in utilisation patterns, it may not translate into improved health outcomes.

Another important finding from the evaluation in Ghana showed that, when health care was free, it reduced the probability of households seeking care from the informal health sector. Conversely, when households had to pay for health care or when distances posed a challenge, individuals resorted to "informal care (traditional healers, chemical sellers, and home remedies)" (Ansah et al., 2009, p. 52). The authors concluded that in addition to user fees, there may be other barriers to accessing care in mainstream health system. They recommended the following variables, “distance from the health care facility, lack of knowledge or incorrect perception of health care services and when to utilise them” (p. 55), be accorded some consideration in order to address access issues in an effective manner. Of note is that consumers’ assessment of the quality of care following the removal of user fees appeared to be unchanged in most health facilities in Ghana (Ansah et al.).

Zambian experience with abolition of user fees. User fees were abolished for PHC in Zambia in 2006. Evaluation of the policy revealed a 50.0% increase in utilisation among the poorer rural communities, especially among five year olds, one year after the implementation of the policy. Conversely, utilisation for children under the age of five years declined (Masiye et al., 2008), a phenomenon for which the researchers offered no explanation. There was, however, a contrasting difference with utilisation patterns in the urban communities, where there was no noticeable change in the aftermath of the policy implementation. This trend was suggestive of improved access to public health services in rural communities. The findings of the study, however, offered no conclusive evidence regarding which group of patients was using the system more (Masiye et al.), although the policy was intended to benefit persons who could not afford to pay out-of-pocket for health care.

The quality of services provided after the policy change was also evaluated (Masiye et al., 2008). Findings revealed that drug utilisation among the poor increased by 40.0%. However, 20.0% of people reported unavailability of drugs. Due to increased utilisation, drug supplies fluctuated, resulting in increased procurement of drugs. There were no changes in the waiting times to receive treatment, which ranged from 48–55 minutes. No noticeable changes were reported in health workers’ attitudes or the quality of consultations (Masiye et al.).

Similar to Uganda, user fees were often used to finance various aspects of the health system, including payment of wages to some categories of staff. It was, therefore, not uncommon for health workers in Zambia to lose their jobs following the policy change. Another important role of user fees involved forging community participation. Fees collected in health units were used as incentives for community personnel who mobilised community resources, as well as disseminating health information. As a result of the user fees removal, this community financial incentive was lost, which ultimately affected the continuation of outreach activities. In addition, meetings to foster partnerships among the community, health care providers, and policymakers were no longer held in some situations (Masiye et al., 2008). Furthermore, staff workload, especially in rural areas, increased, albeit this was short lived. Staff workload in urban areas remained unchanged. These reported changes had the potential to jeopardise the success of the policy change in several ways, including forcing facilities to revert to charges for health services. A lack of confidence in the policy also had the potential to limit its effectiveness (Masiye et al.).

Experience in Mali, Madagascar, Niger, Burundi, Kenya and Afghanistan with abolition of user fees. In 2006, user fees were abolished for children under five and for pregnant women in Mali. Utilisation of malaria-related health services in 2007 increased three times more than in 2006 (Ponsar et al., 2011). Equally, when user fees were temporarily abolished in Madagascar in 2002, there was a 22.0% increase in health centre visits (Fafchamps & Minten, 2007). The increase in utilisation was attributed to patients' repeat visits to the facilities for the same ailments (World Bank, 2005).

In Niger, a process evaluation was conducted on a non-governmental organisation user fee-free intervention for children under five and pregnant women. The intervention was introduced in 2006 and had a positive impact on utilisation, which was beneficial to the vulnerable (Ridde, Diarra, & Moha, 2011). Burundi experienced no clear impact on utilisation following the removal of user fees in 2006 for children under five or women giving birth. Possible explanations for this outcome were the hurried implementation process and lack of adherence to "the policy process that leads to the adoption of the reform, setting clear objectives, accurate targeting and the economic consequences of abolishing user fees" (Nimpagaritse & Bertone, 2011, p. 68). The policy change also resulted in reduced funding to health facilities, frequent drug shortages, decreased quality of service, longer waiting times, and decreased contact time with health personnel. Of note is that the decision regarding the policy change was taken at the central government level without the involvement of MOH stakeholders (Nimpagaritse & Bertone).

In Kenya, user fees were removed for dispensaries and health centre services in 2004, with the exception of the 10/20 (Kenya Shillings (KES) 10 and KES 20) policy for registration fees. Evaluation revealed that there was poor adherence to the policy, which was attributed mainly to the shortage of drugs. To overcome this, facilities often increased the registration fee or levied extra charges in order to purchase drugs. Other concerns that hindered the success of the policy included ineffective policy processes, staff attitudes toward the policy, lack of clarity regarding the policy among health workers, lack of knowledge about the 10/20 policy among community members, long waiting times, increased workloads due to increased utilisation and inability of health workers to provide quality health services (Chuma, Musimbi, Okungu, Goodman, & Molyneux, 2009).

Similarly, Afghanistan banned user fees for basic health services in 2008 at some health facilities. Results of a pilot study revealed that the quality of services improved and utilisation increased by 400.0%, creating a demand for additional resources from providers. The findings further revealed that “structural and process quality of care” was not affected because user fees contributed minimally to the operating budget of the facilities (Steinhardt et al., 2011, p. 100). Increase was more pronounced in curative services than preventive and promotion services. The explanation offered for this phenomenon was that promotion services, for example, births in health facilities, were previously free. The utilisation of existing free services such as antenatal care and immunisation increased with policy change; the increase was, however, not sustained. To ensure effectiveness of the policy change, additional inputs such as staff, and resources such as drugs were provided; working hours were extended; and the aesthetics of health facilities were improved (Steinhardt et al.).

A significant point is that most countries that abolished user fees, including Kenya and Afghanistan, often relied on external sources of funding from donors to support the health system and sustain the policy change. For example, the Danish International Development Agency compensated health facilities in Kenya for lost revenue. In addition, some donors also increased their contributions to compensate for lost revenue. This ensured that resources such as drugs were available, as well as staff adequately remunerated (Chuma et al., 2009; Steinhardt et al., 2011).

3.7. Jamaican experience with the abolition of user fees

Examination of the Jamaican health financing and expenditure pattern since the 1980s established some concerns, which undoubtedly affected policymakers’ ability to provide equitable and available health services to the population. The concerns included:

> overall budgetary stringency in the public sector affecting the availability of funds for health services; declining concessional aid; inadequate resources for

> maintenance and supplies; inadequate compensation packages to attract and retain most categories of health professionals; cost escalation of health services in the public and private sectors; inadequate insurance cover among the population; large public subsidies to health insurance companies and to consultants using public facilities for private patients; equity and access with respect to lower income persons; absence of incentives in the public health system for innovativeness and cost effective care. (Lalta, 1995, p. 16)

Furthermore, the political influence on a country's health system shapes the delivery of health care. Maharaj (2010), in addressing the relationship between the health care system and political economy, asserted the following about the Jamaican Post Emancipation (1838-1938) experience:

> Jamaica inherited from its colonial past, a health service system for which money was derived from general tax revenue and spent largely on hospitals and traditional public health measures. Availability and ability to pay for medical services were constraints for local inhabitants. Several variations of "fee-for-service" arrangements did not solve the problem of those unable to pay and thus gain access to acceptable standards of healthcare. (p. 707)

Policymakers have, therefore, attempted to address these issues in order to improve access and equity in the delivery of health services despite the impact of "upheaval in geopolitical and global economic system[s]" (Maharaj, 2010, p. 708). According to Maharaj, during the Post-World War II and New Millennium periods, "successive governments have wrestled with the challenge of access and equity and have succeeded to varying degrees ranging from 'free' healthcare to cost recovery to free access to some services and back to free access to all services" (p. 708). This was evident from the implementation of free access for most health services in 2007 and 2008.

Despite the policy changes being hurried and politically motivated, there were immediate positive results from user fees removal. There were marked increases in utilisation at the Bustamante Hospital for Children in 2007 and in the public health system generally during 2008. Reports from the MOH noted that increases in utilisation were seen in admissions, pharmaceuticals, health centre visits, outpatient and accident and emergency (A&E) department visits (MOH, 2009a).

Noteworthy is that the above report made no reference to which groups in the population were utilising the health services. However, one report stated that the no-user-fees policy "has brought health care within the reach of over 50.0% of the poorest quintile of Jamaicans who previously reported an illness but could not afford to get treatment" (JIS, 2009, p. 1). Due to the lack of data in this area, this current study further investigated the characteristics of the users to provide some insight into the beneficiaries of the policy change.

Drug availability has been used as an indicator to determine the effectiveness of the policy change in Jamaica. Drug utilisation increased, prompting the government to embark on various programmes to improve drug supplies and increase human resources, especially personnel to assist in pharmacies. After the policy change, the MOH launched a new Government of Jamaica (GOJ) Health Card on August 20, 2009 for users of the public health system. The intention was to improve access to prescribed drugs on the *Vital, Essential and Necessary* (VEN) List at all public and selected private pharmacies. Drugs on the VEN list are determined using specific criteria and procured and distributed by the Government. The list contains over 800 drugs, which are dispensed free at public health facilities. Additionally, the card provides a mechanism by which users' drug usage can be tracked. There are no out-of-pocket payments for the drugs and the card can only be presented with prescriptions obtained at a public health institution. This initiative was undertaken in partnership with the NHF (JIS, 2009) but had not yet been fully implemented at the time of data collection for this research in 2010.

The impact of the policy change on the workload of health personnel in Jamaica has not been formally evaluated. However, the government has made attempts to address the critical shortages of certain health personnel through recruitment and training. For example, two initiatives included the drive to train pharmacy technicians, as well as rotating new registered nurses through primary facilities in order to strengthen PHC. There was also a thrust by the policymakers to legally empower NPs with prescribing rights (JIS, 2010). Additionally, infrastructural improvement was made to some facilities such as health centres (JIS, 2009).

Quality of care was also evaluated in 2009 subsequent to the policy change and appeared to have remained unchanged in most health facilities. Users' satisfaction with the quality of care was reported by Turner (2009). Evaluation of the impact of the policy change on waiting times revealed no change, because waiting for extended periods to receive health care was typical of the Jamaican public health system (Turner). Of note is that some of these results are reporting on a similar period as this research.

3.8. The impact of the abolition of user fees on health workers

Generally, the views regarding the impact of user fees removal on health workers in African countries varied. While some health workers appreciated the policy (Witter, Dieng, Mbengue, Moreira, & De Brouwere, 2010), it was unpopular among others (Chuma et al., 2009; Ridde & Diarra, 2009). In addition, ambivalence was evident among health workers in some countries who, on the one hand, expressed being motivated professionally by their ability to assist with improving the health of people but, on the other hand, were dissatisfied with the poor uptake of the services provided and the effects on their work. Some health workers were also not sufficiently informed about the various policies being introduced. As a result, they were unprepared to administer the provisions of the policy and chaos prevailed in some facilities (Gilson & McIntyre, 2005). This section presents an international perspective on health workers' workload, motivation and income following the removal of user fees.

Health workers' workload. In the aftermath of the removal of user fees in African countries, there was increased utilisation of health services. As a result, health professionals experienced increased workload (Bhayat & Cleaton-Jones, 2003; Burnham et al., 2004; Kajula, Kintu, Barugahare, & Neema, 2004; Walker & Gilson, 2004; Witter et al., 2007a). In Uganda, findings revealed increased workload in most facilities (Burnham et al.; Nabyonga-Orem et al., 2008). According to one report, there was a 47.0% increase in workload for some health workers (Burnham et al.). This was attributed to the lack of adequate numbers of health workers in the health facilities to cope with the increased utilisation of services.

To best describe and quantify health workers' workload, researchers examined several factors, including number of clients seen, number of hours worked and involvement with additional tasks. In Ghana, workload equalled the mean client numbers per week for each health worker. Reports were that client numbers ranged from 30- 120, whereas untrained health workers saw only six clients apiece (Chuma et al., 2007). On the other hand, health workers in Senegal experienced mixed results regarding workload following implementation of the free delivery and caesarean policy. While midwives at regional facilities experienced an increase in deliveries from 27 to 31, others had a reduction from 11 to 8 deliveries. At district level, however, deliveries per midwife per month ranged from 12 to 125. Generally, the average increased was from 53 per month in 2004 to 73 in 2005 (an increase of 33.0%) (Witter et al., 2010). Increased work hours varied among health workers. Hours worked were also reflective of the change over a two-year period. Part-timers worked an average of 20 hours per week while full time employees worked an average 129 hours per week (Witter, Aikins, & Kusi, 2007b). Of note is that working hours were extended for some health workers (Steinhardt et al., 2011). Another factor influencing the workload and working hours of health workers was the geographic location of services (Witter et al.).

For some health workers, the increased workload was attributed to additional tasks imposed as a mechanism to enhance smooth implementation of the policy. For example, some health workers engaged in administrative tasks, including processing patients for exemptions in addition to their routine duties of administering health care (Nimpagaritse & Bertone, 2011). Similarly, the work of health workers was reorganised in Niger to accommodate crowds. An NGO triaging system was introduced following the implementation of the exemption policy, in which health workers were actively involved. This system also empowered community health workers to assist nursing staff in carrying out their duties (Steinhardt et al., 2011).

Additionally, the increases in workload and overcrowding in some facilities were attributed to people’s excessive and inappropriate use of services. This was the case in most of the countries, including Afghanistan and Madagascar, where health workers voiced concerns about contact with patients who were not sick. Even more concerning to health workers was patients visiting the health facilities late at nights for minor ailments. Health-seeking behaviours such as these suggested that patients were attempting to abuse the system (Gilson & McIntyre, 2005; Ridde & Diarra, 2009; Steinhardt et al., 2011)

Health workers’ morale. It is apparent that the removal of user fees and resultant increase in workload affected health workers’ levels of motivation and morale (Burnham et al., 2004; Nabyonga-Orem et al., 2008). One factor contributing to this outcome was the lack of consultation with frontline workers prior to the implementation of the policy (Messen et al., 2011). Likewise, there were negative effects of the loss of revenues from user fees on compensation and motivation strategies for some categories of staff (Witter et al., 2010). For example, in Zambia, some health workers lost their jobs following the removal of user fees. The explanation given for this outcome was that the revenue generated from fees no longer existed to support this activity. The funds were normally used to offset the cost of wages for some staff and, as incentives for community health committee representatives, as well as for purchasing resources such as drugs (Masiye et al., 2008). Similarly, in Uganda, revenue from user fees were utilised to pay wages for some health personnel, especially support and technical staff. Therefore, it was not uncommon for health workers to be made redundant following the abolition of user fees. Furthermore, inadequate support services such as poor lighting, inadequate water, insufficient allowances, drug unavailability, limited transport, and reduced staff numbers were concerning to health workers (Nabyonga-Orem et al.).

As a result of the aforementioned conditions, health workers' motivation and morale were negatively affected. For instance, health workers in Uganda were found to lack positive attitudes toward their work (Burnham et al., 2004). One study revealed that staff members were not motivated and their levels of motivation progressively declined. In addition, some health workers felt exploited and raised concerns about working too hard, lacking motivation and contemplating resignation (Ridde & Morestin, 2011). The negative effect on staff members' morale may have affected their interaction with patients. Patients complained about poor treatment and health workers' negative attitude towards them (Gilson & McIntyre, 2005; Ridde & Diarra, 2009). Of note also is that individuals expressed dissatisfaction regarding the quality of services provided and the attitude of some midwives to the women in Ghana (Bosu et al., 2007; Witter et al., 2007a, 2009).

Researchers recommended that, for subsequent policy changes, strategies should be adopted to improve staff morale, and maintain motivation and a supportive work environment. This, essentially, would promote access to free and effective health services (Campbell, Oulton, McPake, & Buchan, 2009). Motivational measures recommended in Uganda included "allowances, verbal appraisal and encouragement, ensuring staff are paid timely, offering free treatment to staff, and allowing them to work elsewhere such as teaching during their free periods" (Nabyonga-Orem et al., 2008, p. 7).

Health workers' income. Health workers' income was also affected by the removal of user fees in most countries. Some reported an increase in salary andothers claimed they had experienced a reduction in allowances. In Ghana and Uganda, health professionals received increased remuneration and incentives following the removal of user fees (Nabyonga-Orem et al., 2008; Witter et al., 2007a, 2007b). This incentive was the mechanism used to reduce potential discontent among health workers, which might negatively affect the success of the policy (Yates, 2006). On the other hand, there were reports of insufficient compensation and loss of revenue available to supplement staff salaries in Uganda and Zambia (Gilson & McIntyre, 2005; Masiye et al., 2008; Messen et al., 2011).

3.9. Impact of the abolition of user fees on the work of the professional nurse

While the direct impact of the abolition of user fees on health workers has been highlighted in international literature, very little is known about the professional nurse specifically. Nurses constitute a significant part of the health workforce; therefore, one can extrapolate from the above findings on health workers that nurses' workloads, motivation and income were also likely to be affected by the policy change. Additional information on the impact of the removal of user fees on the work of the nurse is provided below.

Using a case study approach, a study into the effects of user fees removal on nurses working in large urban community health centres in South Africa was conducted. The findings revealed ambivalence among nurses. While nurses embraced the free health care ideology from a professional standpoint and saw a resultant improvement in access to health care, they also expressed negative views about the policy change. For example, common opinions noted lack of involvement in the policy process prior to its implementation, increased workload, and patients 'abusing' the system (Walker & Gilson, 2004).

Studies have also revealed that nurses in countries where user fees were removed experienced increased workload (Bhayat & Cleaton-Jones, 2003; Walker & Gilson, 2004; Witter et al., 2007b). In Ghana, community health nurses worked an average 56 hours per week and were among the group of health workers who experienced increases in patient numbers, ranging from 7-17 patients (Witter et al.). Nurses in South Africa, in describing the impact of the increased workload, claimed they felt "a strong pressure to spend less time with each patient than formerly and some found their work more frustrating and tiring than it used to be" (Wilkinson et al., 2001, p. 669). Adding to the frustration was the general feeling among nurses that the significant increase in workload was viewed with scant regard by policymakers in some countries (Walker & Gilson).

Morale among nurses was negatively affected following the removal of user fees (Burnham et al., 2004). Contributing factors to the decline in morale included lack of involvement in the policy process prior to its implementation (Walker & Gilson, 2004). Moreover, nurses felt unrecognised. These problems were exacerbated by on-going contentious issues in the work environment such as feeling isolated from other members of the health team; scarcity of resources; lack of sufficient planning; and ineffective communication. A study examining provision of free health services in the Limpopo Province, South Africa revealed that they felt inadequate in their efforts to provide satisfactory primary care services to the patients. This was attributed to the increased workload, inappropriate use of the service, and anxiety resulting from the lack of adequate security in health facilities (Netshandama, Nemathaga, & Shai-Mahoko, 2005).

Nurses' income improved in most countries affected by the removal of user fees. In Niger, nurses received incentives in the form of bonuses, which enhanced the quality of care and contributed to the effectiveness of the policy change (Ridde & Diarra, 2009). Nurses in Ghana received increased salaries and other incentives as motivational measures (Witter et al., 2007b).

Ridde and Diarra (2009) noted the impact on the work of nurses in Niger following the removal of user fees. They reported that the power differences in the nurse-patient relationship portrayed authority and passivity. In addition, another study reported that nurses were of the impression that patients abused the system and only some deserved to benefit from free care. The study further found that nurses imposed their "value systems" on patients, as well as being judgmental of some categories of patients, for example, "pregnant teenagers, teenage mothers, patients with HIV/AIDS and poor patients" (Walker & Gilson, 2004, p. 1259).

3.10. Conclusion

User fees policies were found to have positive, negative and mixed impacts on utilisation of health services. Fees, however, created a barrier to accessing health services by some socioeconomic groups. Experience has shown that abolition of user fees in developing countries served as a catalyst for increased utilisation. Evidence further suggests that the impact of the user fees policy varied with each country mentioned above. While some effects such as utilisation and drug availability were easily determined, key gaps were also apparent. For example, the impact on health workers has been mentioned, but very little information is available on the impact on main categories of health practitioners such as the professional nurse in non-African countries. There was no clear indication regarding which specific groups in the population were benefiting from the policy change. While studies have evaluated the effects of the abolition of user fees in the African context, there is a lack of sufficient data from non-African countries with similar policy changes. Additionally, there were limited studies to provide data on the national and regional policymaker perspectives, or on different categories of practitioners and user perspectives in the one study. Some studies, for example, engaged administrators at the national level who may not have been key stakeholders in the policy process.

Given these gaps, a decision was made to utilise a multi-layered approach to determine the impact of the abolition of user fees at the national and regional policymakers' levels, providers' level and the users' level in Jamaica. The study was designed to examine whether the removal of user fees in the Jamaican context had an impact on utilisation of public health services, access to health care generally, and the work of the professional nurse.

The next chapter presents the theoretical framework for the study. It provides information on the meaning of the concept of access and its multidimensional nature.

Chapter 4: Theoretical framing

4.1. Introduction

Theoretical frameworks serve many purposes, for example, “providing direction and impetus, as well as guiding and generating ideas for research” (Polit & Tatano Beck, 2008, p. 145). The theoretical framework for this study was used to inform the research design, guide data collection, and answer the research questions regarding access to health care. This chapter discusses the concept “access” under the following headings: definition of access, access and consumers (socioeconomic status, geographic location, ethnic background, and gender), providers and access (availability and affordability), policymakers and access, nursing and access, and funding for nurse-led services.

4.2. Access defined

According to World Health Assembly resolution 58.33 (as cited in WHO, 2010b), everyone should have access to health services without incurring any financial burden. The literature is, however, replete with research reports on the disparities in access to health services by some groups of individuals. Policy documents such as the WHO (1978) *Alma Ata Declaration Health For All* clearly addresses this issue. Despite the challenges encountered, it is important to note that access to health care remains a basic human right and is paramount to maintaining good health, gaining improved health and remaining free of sickness (Gulliford, Figueroa-Munoz, & Morgan, 2003). The interpretation of access, however, varies amongst countries; for example, in low income countries access may be understood within the context of availability of basic health services such as an individual’s ability to obtain services from a physician or receive maternal and child health care (Gulliford et al.; Oliver & Mossialos, 2004). In contrast, in high-income countries, individuals have access to a wide range of health services and, as such, the concept is interpreted through a different lens. For example, access is often viewed in the context of how all-inclusive, timely, and equitable services are, as well as the desirability of the health outcomes generated by having good access to care (Gulliford et al.). Even where services are free, access can be compromised by high transport costs, loss of income, unavailability of services, and long distances to health facilities (Asfaw et al., 2004; WHO).

In some countries, universal health coverage, whereby all people have access to health services without incurring financial burden, is non-existent (WHO, 2010b);

therefore, it is not uncommon for some individuals to pay out-of pocket for health services. As a result, those who utilise the health services are often impoverished because of catastrophic spending (Asfaw et al., 2004; Nimpagaritse & Bertone, 2011; Ponsar et al., 2010; WHO, 2010a). For this reason, low-income earners may encounter significant challenges in accessing quality health services, which have implications for the achievement of equal access for equal need. In some countries, “migrants, ethnic minorities and indigenous people use services less than other population groups, even though their need may be greater” (WHO, p. 7). It was found that abolishing payment for health care assists the underserved and vulnerable in obtaining care. Hence, poor access to health care by some individuals has been one of the driving forces motivating policy change regarding universal coverage and free health care by some policymakers (Kiwanuka et al., 2008; PIOJ & STATIN, 2008; Ridde & Diarra, 2009).

The concept of access is a complex one and its interpretation may be influenced by a number of factors or series of events. In addition, it is multidimensional and, as such, a clear definition has eluded many researchers and the concept is often misconstrued. For instance, “access” may be interpreted as meaning availability of resources (material, finance and human resources) (WHO, 2010b). The literature presented in this chapter is used to clarify and simplify the concept access. It also highlights the dimensions that have potential impact on access to health services.

It was a challenge separating out the concepts, of access and availability. However, access has been operationalised by some researchers to mean the appropriate use of services by consumers according to their actual or perceived needs (Peters et al., 2008). Despite the interpretation of this definition being questioned (Guilliford, 2009), a conceptual framework by McIntyre, Thiede and Birch (2009) defined access to health care “as the *empowerment* of an individual to use health care and as a multidimensional concept based on the interaction (or degree of fit) between health care systems and individuals, households and communities” (p. 179). In defining the concept from a patient’s perspective, the Institute of Medicine (1993) stated that access is “the degree to which patients are able to obtain needed services from the medical system and the timely use of personal health services to achieve the best possible outcomes” (p. 4). Equally, access has also been interpreted as the correlation between need, provision and utilisation of health services (Guilliford et al., 2001).

Need. Despite dissimilar views among researchers, some commentators on access to health care argue that care is best distributed based on patients' need, and, as such, the concept is highlighted briefly. Need for care is defined by Culyer and Wagstaff (1993) as one's capacity to benefit from the care provided. The authors further stated that an entity can only be needed if it is an important factor in achieving a goal. Additionally, the authors emphasised that need is not equivalent to ill health. To further expand on the concept, the work of Social Need theorist Jonathan Bradshaw was used to highlight its scope. Bradshaw's need taxonomy distinguishes four varieties of need: normative, felt, expressed, and comparative (as cited in Culyer & Wagstaff). Normative need is defined by experts using professional standards, for example, a diagnosis of hypertension by a medical doctor. Felt need is what the individual perceives, for example, having abdominal pain. Individuals' beliefs of need may significantly influence their felt need. When formulated into demand, felt need is converted into an expressed need, such as individual taking action by seeking treatment for the abdominal pain. Comparative need is defined by comparing the variation in individuals' access to resources, for example, access to health services. In addition, need is described as a "horizontal version (persons in equal need should be treated the same) and a vertical version (persons with greater needs should be treated more favourably than those with lesser needs)" (Culyer & Wagstaff, p. 433).

Utilisation. It is important to make a distinction between access and utilisation because it is often the perception that increased utilisation equates to improved access. Utilisation is the actual use of services and relates to the interaction between availability (supply) of a service and demand for that service. It is often reliant on the affordability, accessibility and acceptability of services and not only the adequacy of supply. Utilising health services hinges on an individual's perception of need, as well as the attitude, belief system and experience of previous encounters with the health system. Access, on the other hand, posits the individual's awareness of health services, and their active use of socially-accepted services to achieve the best possible health outcomes. Additionally, access aligns well with people's familiarity with the health services, as well as their knowledge of available services (Guilliford et al., 2001).

While access may be viewed in relation to the availability of services, the timeliness of these services, as well as their settings should also be given consideration (Rogers, Flowers, & Pencheon, 1999). Moreover, access is frequently used to determine the effectiveness of the services being offered. A Service that is accessible and utilised by the people who require it may positively impact on the quality of service delivery. Furthermore, equity is achieved when people with equal needs utilise equally accessible services. The equitability of the services provided may result in unnecessary consequences, whereby there is uptake by people with minimal capacity to benefit from the offerings. This ultimately compromises the efficiency of the services provided. Similarly, the services provided should also match with and respond to the need of the population if they are to be qualified as accessible (Guilliford et al., 2001). The fact that the uptake of some, such as preventive services, may be minimal among some segments of society should not be discounted.

To fully understand the dynamics at work in the manner in which people utilise health services, the Health Belief Model has been used by some commentators to explain the phenomenon. When the model was applied to people's use of health services, the following barriers to the optimal uptake of preventive services were identified:

> (1) Service provision – the poorer provision and organisation of primary care services, including systems for notification and recall, is identified as contributing to lower rates of uptake of preventive services in disadvantaged areas; (2) Mobility of populations – this presents particular difficulties for preventive services in inner city areas, although the extent to which mobile populations receive services in other areas or miss out on services altogether is not known; (3) Access costs – low rates of car ownership and time off work are identified as important barriers for poorer groups; (4) Attitudes and beliefs – concerns about side effects have formed a deterrent to the uptake of childhood immunisations (and influenza vaccinations for elderly people) among all social groups. A further barrier to the uptake of preventive services among some disadvantaged groups is the existence of a more 'fatalistic' approach to health (i.e. a belief that one has little control or ability to influence events); (5) Knowledge and language – some ethnic minorities and new immigrant groups experience particular barriers to the uptake of services through language problems and a lack of familiarity with services (e.g. knowledge of eligibility for screening). (Guilliford et al., 2001, pp. 28-29)

Access the multidimensional concept. Although dated, the definition of access by Panchansky and Thomas (1981) remains current. They described access as a multidimensional concept, which includes the following characteristics:

> Acceptability - refers to attitudes and beliefs of users and providers about each other's characteristics. Affordability - applies to the cost implications to the patient in relation to need; this includes both direct and indirect costs and perceptions of value. Availability - refers to the adequacy of supply given by the relationship between volume and type of services (provision) and volume and type of needs (demand). Physical accessibility - is defined by the suitability of the location of the service in relation to the location and mobility of the patient (geographical and physical barriers). Accommodation - refers to the way services are organised in relation to the client's needs and the patient's perception of their appropriateness (opening times, booking facilities, waiting times). (p. 128)

Arguably, facilitating access requires empowering individuals to demand quality health care supply for a better health status. Accordingly, access is dependent on factors such as the availability of services; barriers that may prevent access include organisational, financial, social and cultural impediments, the relevance and effectiveness of the service; and the differing perceptions, health needs and the diversity of the population (Guilliford et al., 2001).

Andersen (1995) adopted a behavioural theory approach to capture the fundamental nature of access and described four dimensions of accessibility: potential access, which encompasses the enabling resources required for the use of health services; realised access, which is the actual uptake of services; equitable access, which results when demographics and need influence the variation in the uptake of services; and inequitable access, which occurs when utilisation of health services is determined by social structures, individuals' health beliefs and income.

Andersen's (1995) dimensions of access posit that access may be interpreted through the lens of the inextricable link between providers and clients. This link determines the manner in which health services are utilised. Access is therefore, centred on the processes that influence entry into the health care system. It is not uncommon for the concept to be used within the contexts of '*having access*' and '*gaining access'*. According to Guilliford et al. (2001):

> (1) Having access denotes the theoretical potential to utilise a service if required. To have access to a service means that the service required exists, is available, and that there are systems in place that would allow service utilisation following a contact with the health care service. (2) Gaining access alludes to the actual procedure of admission into the processes of utilising the service. Here, if access has been gained it means that the service has been utilised. (p. 19)

The theoretical positions on access, therefore, have contributed significantly to my understanding of the concept. To adopt a particular position regarding this concept, the definition by the University of North Texas was chosen for this research in order to provide context and avoid any ambiguity. Access is "the degree to which individuals are inhibited or facilitated in their ability to gain entry to and receive care from the health care system" (University of North Texas, 2007, p. 1).

It is clear from the above descriptions of access that a patient's entry into the health system can be influenced by a number of variables at various levels in the system. These variables can be at the policy level, the provider level or the consumer level (Guilliford et al., 2001; Kiwanuka et al., 2008). Inaccessibility to health services and disparities in health care quality and health status have been well documented (Culyer, 2001; Culyer & Wagstaff, 1993; Goddard & Smith, 2001; Guilliford et al.; Kiwanuka et al.; Mooney, 2009). While access can be understood from the perspective of non-use of the health facilities, it is important to highlight that this phenomenon can be understood from various dimensions. This view was used in this study to discuss the access issues in health, including policymakers and access, providers and access, consumers and access, and nursing and access.

Understanding access to health services from the consumer's (user or patient) point of view is multidimensional and involves the socioeconomic status, ethnic background and geographic location of the consumer, as well as gender. The probability that a person will use the health system is dependent on the balance between the person's "biological and psychosocial perception of need and his or her attitudes, beliefs and previous experience with the health system" (Guilliford et al., 2001, p. 21). Additionally, barriers to accessing health services may be encountered at any stage in the person's journey through the process. Barriers may occur while making contact, at the point of entry or during uptake of services, or affect the ability to achieve the desired health outcomes. It is evident that barriers are multi-factorial and may be related to cost, the manner in which the service is organised, location, individuals' knowledge, language problems, cultural practices, belief systems and attitudes regarding health problems, or people's preferences, expectations and main concerns regarding treatment (Guilliford et al.).

4.3. Policymakers and access to health care

Initiatives implemented by WHO and the World Bank, such as the MDGs and the World Bank Reports on Health, to improve access to health care have targeted policymakers to engage them in identifying inequities in health with a concomitant resolve to improve access to health services (WHO, 2000; World Bank, 2006). Although these initiatives have made modest gains, poor access to health services by some individuals globally remains a challenge. To improve access to health services, policymakers need to adopt a participatory type of decision-making strategy where the people are involved in making decisions about their health (Peters et al., 2008). In addition, adequate resources need to be allocated to the health sector, including increased budgetary allocation, proper staffing of facilities, adequate numbers of and improved, well-equipped health facilities, and adequate medical supplies and drugs (Hardeman et al., 2004; Howden-Chapman & Cram, 1998; Klemick et al., 2009; Peters et al.).

Although removal of user fees for services in the health sector has yielded positive results in some countries, policymakers need to address other major issues that segregate groups of individuals, creating a disparity in accessing basic amenities such as health care. Addressing issues such as poverty alleviation, a responsive health care system, a high quality education system, high quality housing and suitable road conditions will make a dent in the disparity to access and health care experienced by some individuals (Hardeman et al., 2004; Peters et al., 2008). Even though cost appears to be the main deterrent to accessing health care, policymakers should take care not to make far-reaching decisions or policy changes without scrutinising the other contributing factors.

4.4. Providers and access

Health care availability and affordability. While lengthy waiting lists and long waiting times can pose a barrier to service utilisation, they may also be suggestive of the "inefficient use of existing capacity or a failure to design services around the needs of patients" (Guilliford et al., 2002, p. 187). Consumers can also be selective in their choice of health care providers. Choice of facility is often informed by variables such as perceived quality of care, availability of drugs, adequately skilled staff, health practitioners' attitudes and knowledge of the services available (Kiwanuka et al., 2008). Moreover, sufficient resources are required if health services are to be accessible to people in need. As a result, availability of services from the provider's perspective involves the location, number and characteristics of health facilities and the services provided. In some settings, availability is measured traditionally by the number of physicians and hospital beds (Guilliford et al.). However, the following characteristics often define the services that should be provided to enhance access: responsive to the needs of the populace, an efficient ambulance service, ease of access to qualified health personnel, and adequate provision of resources such as drugs and technologically updated equipment (Peters et al., 2008).

Health economists have posited that, to determine the availability of health services, the costs for travel and difficulties encountered while obtaining or forgoing care need to be estimated (Mooney, 1983). For example, when distance from health facilities is considered the costs could be astronomical. Individuals who cannot afford to travel sometimes delay accessing care or may be unable to obtain basic services because of the distance from primary and secondary health care facilities available to them in a particular geographic location.

As established earlier, cost may be a deterrent to patients utilising the health services, even in settings where the services are free. Out-of-pocket payment is often required for dental care, drugs, time lost from work, and travel. Financial incentives to providers can impact on the availability, as well as type of services (Guilliford et al., 2002), thereby improving access. It is important for health services to be affordable generally, in order for individuals to access care in a timely manner. In the absence of adequate financial resources, individuals have opted for self-treatment or engaged the services of shopkeepers or traditional healers who may be more accessible in terms of cheaper services (Hardeman et al., 2004; Jacobs & Price, 2006; Peters et al., 2008). These actions are sometimes adopted on the premise that the condition is not serious enough to travel far distances or pay exorbitant costs for health services. It is also thought that traditional healers are more cost-effective, understanding, and familiar with the socio-cultural positions of these individuals and their opening hours are convenient for the users

(Peters et al.; Rutebemberwa et al., 2009). While this practice of seeking alternative treatment may achieve an immediate benefit, it is important to note the long-term deleterious effects on the health of individuals and the burden on the health system. This burden occurs because some health conditions may be in advanced stages by the time an appropriate diagnosis is made. Additionally, disease conditions at an advanced stage require more technologically-advanced therapy and also increase mortality rates (Flores et al., 1998; Hardeman et al.; Peters et al.). Providers, therefore, need to mobilise the necessary resources to ensure services are available and affordable.

Despite untiring efforts by policymakers and health care providers to improve access to health care by underserved populations, a segment of society still experiences inequity and disparity in accessing quality health services. While the abolition of user fees and the provision of universal health coverage in some countries have been advantageous, policymakers and health care providers are still grappling to find innovative means of creating an accessible health care system.

4.5. Consumers and access to health care

Socioeconomic status. Socioeconomic status is a contributing factor to disparities in health and constitutes a barrier to accessing health services (Goddard & Smith, 1998, 2001; Mooney, 2009; Schoen & Doty, 2004). Health disparity, a term used interchangeably with health inequity, occurs when people's characteristics such as race, ethnicity, gender, socioeconomic status, and geographic location constitute obstacles to health. Disparity to access exists when people are hindered from accessing required health services due to unavailability, costs, or lack of insurance (Braveman, 2006; Department of Health and Human Services (US), 2010). Whitehead (1991) defined health inequity as the "differences in health which, are not only unnecessary and avoidable but, in addition, are considered unfair and unjust" (p. 220).

Data gleaned from studies conducted in developed countries suggested that the problem is not unique to developing countries (DeVoe et al., 2007; Hussey et al., 2007; van Doorslaer, Masseria, & Koolman, 2006), despite numerous interventions to improve access to health services. Hussey et al. examined trends in socioeconomic disparities in general health care quality in various countries including England, New Zealand, the USA and Canada, and found divergent socioeconomic situations in regard to quality and health status. While the studies in these countries identified disparity between social status and quality of health care, the phenomenon requires further investigation to fully understand the problem. Given the health systems that operate in these countries, it is of concern that distinct variations in health among people exist. Large segments of these populations continue to receive substandard health care and experience undesirable health status. It is also not uncommon for these segments to be in the lower strata of society and without health insurance (Hussey et al.).

Individuals' ability to pay out-of-pocket for health services hinges greatly on their social status and determines whether they will seek or postpone care when required (Kiwanuka et al., 2008). In the absence of an adequately financed health system, cost becomes a disincentive to positive health-seeking behaviour, as well as to the provision of quality health services (Guilliford et al., 2001). This constitutes an obstacle to accessing health care since consumers will avoid the financial hardship resulting from seeking care. Moreover, indirect costs such as drugs, lost income and travel create additional financial burdens for some persons. Of note is that access to health services is also a problem in countries where even small fees were imposed for health care. In this case, health-seeking behaviours of individuals were linked to their perception of the costs that might be incurred in obtaining care. Furthermore, studies have corroborated the notion that cost, among other factors, is an impediment to accessing health care among the poorer segment of society in some countries (DeVoe et al., 2007; Kiwanuka et al.; WHO, 2010b).

People from low socioeconomic backgrounds were 10.0% less likely to access preventive care at a general practitioner (GP) in the United Kingdom (Goddard & Smith, 1998). Additionally, it was found that people living in deprived communities who were diagnosed with angina had a 50.0% lower revascularisation rate than people living in affluent communities. Equally, lack of health insurance coverage was found to be an obstacle for consumers diagnosed with angina to access health care in the UK, despite a universal health system (Goddard & Smith). In the absence of health insurance, some individuals do not have equal access to health care. This is the reality for people of low socioeconomic status, and a probable explanation for some individuals' apathy in seeking health care, even though there is a need. This represents an important barrier to access that may have eluded policymakers over time. This supports data from other studies, which investigated barriers to access or disparities in access to health care, and found that a lack of insurance coverage constituted a barrier to accessing health care (Flores et al., 1998;

Hussey et al., 2007; Phillips, Mayer, & Aday, 2000). The inextricable link between health insurance coverage and access to health services is unequivocal.

Socioeconomic status has also been shown to influence GPs' decisions regarding patients. For example Scott, Shiell and King (1996) found that, when compared to those of low socioeconomic status, people of high socioeconomic status in Australia had a higher probability of having a diagnostic test but a lower chance of receiving a prescription from a GP. This was especially true among the 15-64 years age group. Furthermore, socioeconomic status was found to relate to the decision for follow-up of patients. These authors argued that these findings substantiated that the socioeconomic status of patients independently influenced GPs' decision making in certain circumstances.

Additionally, health literacy among people of low socioeconomic status was found to impact on their ability to access health services. The minimal degree of health literacy was a concern among the community-dwelling elderly population in the USA. According to Sudore et al. (2006), limited health literacy correlated with disparities in health and access to health service, which, they claimed has the potential to produce undesired health outcomes. Additionally, it is argued that limited health literacy is common among some ethnic minority groups and predisposes the individuals to unacceptable health status and increased risk of admission to hospital (Cooper, Hill, & Powe, 2002).

Yamada et al. (2009), in a study on children's access to health services, concluded that accessibility involved a number of variables such as "paying cash for health care services, family earnings, educational status of caregiver, the type of private and public health insurances, ease of seeing a health personnel and the interface between service provider and users" (p. 448).

Geographic location. Distance from health facilities can be a deterrent to consumers' use of health facilities even though there is a need. This can be understood in terms of the individual's location, nature of the roads to be used, and transportation systems, as well as the communication systems in the areas. Studies have shown that consumers either delay or forgo care if it requires significant loss of time or the travel cost is astronomical. This results in increased mortality in some cases, especially maternal mortality (Hardeman et al., 2004; Jacobs & Price, 2006; Klemick, Leonard, & Masatu, 2009; McCaw-Binns, Standard-Goldson, Ashley, Walker, & MacGillivray, 2001; Peters et al., 2008).

In a study on the impact of geographic proximity to cardiac revascularisation services in the USA, it was found that distance from the patient's home influenced the utilisation of services at health facilities. According to the authors, "geographic proximity of patient's residence to cardiac revascularisation services and availability of these services at the hospital nearest to the patient's residence was found to be strongly associated with utilisation, even across a relatively small geographic area" (Gregory et al., 2000, p. 54).

Ethnic background. The literature is replete with documentation on ethnic disparities in accessing health care, as well as cultural diversities that influence an individual's ability to access health care (Flores et al., 1998; Howden-Chapman & Cram, 1998; Nandi et al., 2008; Phillips et al., 2000). Included among the barriers to access encountered by various ethnic groups are distance, cost, lack of health insurance, culturally inappropriate health services, knowledge deficit regarding services, language barrier, low educational level, individual's attitude, cultural practices and expectations of the service providers. Of equal importance is an individual's responsiveness to or acceptability of the services provided because this may be an obstacle to accessing health care in a timely manner. Additionally, individuals from some ethnic groups are faced with the challenge of receiving poor quality care and having to wait for long periods of time to receive care (Wells, Klap, Koike, & Sherbourne, 2001).

Barriers to health services experienced by some ethnic groups are largely associated with unfamiliarity with the services, apprehension related to the negative perception associated with some diagnoses and anxiety about entitlement to certain services, as well as inequity in the services provided. Despite attempts to minimise the disproportionate use of health services, some ethnic groups continue to experience inequity (Guilliford et al., 2001). Goddard and Smith (1998), in an account on the utilisation of mental health services among some ethnic groups in the UK, stated that "South Asian migrants from India, Pakistan, Bangladesh, [and] Hong Kong have relatively low hospital admission rates for mental illness relative to people born in England (average of 283 admissions per 100,000 population compared with 504)" (p. 56). Of note also is that socioeconomic status, negative perceptions and meanings attached to mental illness may have contributed to the poor uptake of the services (Lipsedge, 1993). Moreover, studies to investigate the high rates of schizophrenia and psychosis among Caribbean people living in the UK found that recorded rates were potentially affected by variations in patients' presentation and doctors' diagnostic and management practices (Cochrane & Sashidharan, 1996).

In the USA, a study on ethnic disparities in unmet needs for alcoholism, drug abuse and mental health care revealed dissimilarities among Hispanics, African Americans and whites. Hispanics and African Americans were found to have "less access to care, poor quality of care, and greater unmet need for alcoholism, drug abuse, and mental health treatment" when compared to whites (Wells et al., 2001, p. 2030). Equally, a study on access to care for children with special needs found that disparate access to and utilisation of health services existed among racial and ethnic minority children in comparison to white children. In addition to racial and ethnic disparity, income and insurance coverage were also shown to contribute to poor access to health services by children with special needs in the USA (Newacheck, Hung, & Wright, 2002).

In New Zealand, when the interface between ethnicity and the health system was analysed, it was revealed that Māori (indigenous people) uptake of GP services was less than non-Māori; they had greater mortality from unavoidable deaths than other groups; they accessed specialist care for some chronic diseases less; they might not be treated for conditions such as myocardial infarction and received less advanced treatment for conditions such as coronary artery bypass (Howden-Chapman & Cram, 1998).

Gender and access to health care. Gender plays a role in creating disparities for access to health, in that women are sometimes marginalised (Flores et al. 1998; Howden-Chapman & Cram, 1998; Nanda, 2002; Nandi et al., 2008; Phillips et al., 2000). Conversely, research has shown that women utilising GP services in Australia were more likely to receive a prescription regardless of health or socioeconomic status (Scott et al., 1996) than their male counterparts. Additionally, a study examining factors associated with gender differences in having health insurance coverage and a usual source of medical care in low-income communities in the USA found that employed women had more insurance coverage than employed males. While there was no means by which to explain the gender differential, the author concluded that private and public health insurance should be more available to men in low income communities (Merzel, 2000).

Having examined all the above descriptions of the concept of access, one can conclude that it is indeed a complex term to capture in any one definition. Undoubtedly, the barriers described above negatively affect individuals' ability to access health services, as well as contributing to delayed health care access (Goodard & Smith, 2001; Guilliford et al., 2001).

4.6. Nursing and access

The nursing workforce is fundamental to achieving access to health care by vulnerable groups. While employing more nursing personnel constitutes part of the solution, it is also prudent to mention that nurses themselves have adopted new roles, expanded the scope of their practice, relocated where services are being delivered, and have targeted at risk groups in order to improve access to health care. The literature is replete with information on myriads of innovative strategies that have been adopted by nurses globally to meet the health needs of the vulnerable population (Chapple, Rogers, Macdonald, & Sergison, 2000; Dick, Clarke, van Zyl, & Daniels, 2007; International Council Nursing [ICN], 2009; Miles, Clutterbuck, Seito, Sebego, & Riley, 2007). This research only highlights a few.

The theme for International Nurses Day 2009 was *Delivering Quality, Serving Communities: Nurses Leading Care Innovation* (ICN, 2009). This theme was indeed a timely reminder of the contribution nurses were making to improve access to health care that is cost-effective, as well as improving and preserving the quality of care offered to consumers, especially the most vulnerable groups (ICN, 2009). According to the ICN (2009), "nurses worldwide are engaged in innovative activities on a daily basis; activities motivated by the desired to improve patient outcome and the need to reduce costs to the health care system" (p. 1). Nurses are leading the charge as the first point of contact for individuals who encounter difficulties accessing mainstream health services (Minami & Benton, in ICN, 2009)

Nursing innovations or nurse-led services have had positive effects on the lives of underserved populations. Some examples of nurse-led services include the following. In Papua New Guinea, a nurse-led PHC service utilised community leaders, women and youths in several villages to raise consciousness regarding HIV and AIDS. Short wave radios, outdoor remote broadcasting systems, newspapers and workshops were used to disseminate information on HIV and AIDS and other preventable diseases, such as diabetes and hypertension. The nurses also operated remote clinics in these villages. This initiative was successful in changing the lifestyles and health-seeking behaviours in this community (ICN, 2009).

Nurses in Botswana have taken on the role of managing HIV and AIDS patients on Antiretroviral Therapy (ART) in rural areas. Nurses were equipped with the necessary knowledge and skills and deployed to manage patients clinically. This service resulted in reduced waiting lists and improvement in the monitoring and follow-up services for the patients (Miles et al., 2007).

In South Africa, PHC nurses improved the provision of equitable health care. This was achieved through combined efforts in implementing an outreach programme among poor and underserved farm workers. In order to combat noncompliance to anti-tuberculosis (TB) medication and further control the disease among this group, nurses trained farm workers' peers as community lay health workers, with a view that peer groups would effectively assist to control TB. The lay health workers were involved in health promotion and social development activities. Using this group of health workers improved the management and control of TB, as well as reducing costs to the health authorities (Dick et al., 2007).

Nurses have offered services to populations in areas that physicians have chosen not to serve (Safriet, 1992). For example, in New Zealand the Tairawhiti Innovative Nursing Team offered outreach services, health care management and counselling to deprived and underserved members of the population. This project resulted in reduced morbidity and a decline in certain diseases. Nurses in New Zealand have also been engaged in a number of additional services to improve access, including nurse-led newborn resuscitation in an urban neonatal unit (Neal, Stewart, & Grant, 2008) and the use of telenursing triage, especially among disadvantaged groups (St. George et al., 2008). Nurses are also offering cardiovascular disease risk management intervention for patients with gout (McLachlan, Kerr, Lee, & Dalbeth, 2011) in addition to being the main providers of diabetes services in PHC (Kenealy et al., 2004).

Similarly, practice nurses in the UK were improving access to health services by managing diabetes services to provide better quality services and foster patient-centred care (Robinson, 2004). Moreover, nurse-led services were channels that fostered patient satisfaction through continual health-related and social support (Chapple et al., 2000). Nurses are continually seeking novel strategies to achieve this goal. For example, the use of telephone nursing and triage in ambulatory and PHC services to improve access has been well documented. Nurses utilise the telephone to conduct counselling sessions, triage, give advice and do health status checks (Huber & Blanchfield, 1999). These services are cost-effective and patients experience a high level of satisfaction due to their capacity to use the nurse-led services (Chapple et al.).

Clearly, the literature comprehensively covers the many areas in which nurse-led services are dominant. While these services may be offered by various categories of nurses, the scope and practice of NPs are integral to this type of service delivery. NPs are employed as a substitute for the doctor in some practice settings, especially in areas where there may be increased burden of certain health challenges (Safriet, 1992). Additionally, NPs were sometimes the sole health care worker delivering health services in rural areas with individuals of low socioeconomic backgrounds (Bednarski, 2009). They increased access to essential health services in various geographic and practice settings and have established a reputation for delivering quality health care and services. Of note is that NPs often took on medical responsibilities and offered quality care and services despite the lack of legislative endorsement in some practice settings. It is also true that NPs were more strategically positioned than doctors to deal with culturally-related access barriers in order to improve patient outcomes (Safriet).

Funding for nurse-led services. Health services administered by nurses equal or exceed the outcomes provided by a doctor in most cases. This occurs because of the "patients' adherence to care regimes, the lower cost of training and the collateral benefit of consumer choice and satisfaction" (Safriet, 1992). Even though health services offered by nurses have been innovative and creative with a direct impact on cost, little is documented on incentives for nurse-led services or their funding. Funding for nursing services is often incorporated into the main budgetary allocation for health services in most countries and as such, there is no set budgetary allocation for nursing services. Nevertheless, nurse administrators prepare a budget for the day-to-day operations in nursing services.

In New Zealand, the Ministry of Health's Elective Services Initiatives (ESIF) provided financial support for nurse-led initiatives, to assist with training of staff and offset wages (Dellagiacoma, 2007). Of note also is the funding provided by the

Department of Human Services, Victoria, to improve health outcomes for a nurse-led asthma management programme in Australia (Wyatt, 2006). Support for nurse-led services may also be obtained through collaborative efforts. A case in point is a nurse-led outreach programme targeting street sex workers in Australia which obtained support from stakeholders such as public health partners and advocacy groups (Bush, Moss, & Wallis, 2006).

The areas of incentive and funding for nursing services are not adequately captured in the literature. Furthermore, there is limited recognition or publicity among nurses and the public regarding nurses' contribution to health care innovation and the health system as a whole (ICN, 2009). It is, therefore, important for the funding of nursing services to be extensively explored in order to highlight nursing's contribution, as well as policymakers' funding arrangements for nursing innovations.

4.7. Conclusion

The concept of access is elusive, despite attempts by scholars over recent decades to simplify it. While improving access is concerned with empowering individuals to take responsibility for their health, as well as the manner in which health care resources are offered, some individuals continue to experience poor access to health services. Barriers to access may be associated with the characteristics of the policymaker, the provider or the consumer, and challenges can be encountered at any stage on the journey to accessing care. Therefore, in this study access was investigated from three levels: (1) policymakers' perspective, (2) providers' perspective, and (3) users' perspective. This framework was also used to inform the research design and provide direction for the research generally.

The next chapter provides details about the methodology for the research. It presents information on the mixed methods evaluation multi-layered study, research design, and ethical considerations.

Chapter 5: Methodology and research design

This chapter presents the methodology and methods used to answer the research questions. It commences with an overview of the evaluation study and clarifies concepts where appropriate. It provides information on the study design, including sampling, instruments, data collection, data analysis, ethical considerations for the study, and how rigour and validity were achieved. The study used a multi-layered mixed methods evaluation design from national, provider and user perspectives. The decision to use this method was informed by the literature. While a multi-layered study was not adopted in most studies, some scholars adopted both qualitative and quantitative data collection techniques to evaluate the impact of user fees. Additionally, no formal evaluation of the policy change had been conducted in Jamaica prior to the time of data collection in 2010. Therefore, an evaluation study was appropriate for this project.

The design, while intended to capture wide perspectives across RHAs, facilities, professional groups and users did not explore a number of variables due to the time frame within which the study had to be conducted and the years examined (2006 and 2009) in the study. Variables such as health outcomes were not explicitly examined however, views expressed by practitioners regarding health status by some users and user's views on satisfaction with their current health status were obtained.

5.1. Evaluation

Evaluation is defined as investigation into the extent to which a policy, practice, or programme is effective (Polit & Tatano Beck, 2008). Additionally, it is described as a methodical assessment of the worth of something (Brophy, Snooks, & Griffiths, 2008). Owen (2006) posited that evaluation should be viewed as "the production of knowledge, based on systematic inquiry to assist decision-making about a programme" (p. 18). In other words, knowledge gained from evaluation will result in improvement in planning and implementation of other policies, allow modification to be made and inform the decisions regarding continuation and expansion of the policy (Brophy et al.).

Evaluation seeks to gather data to inform and make effective decisions about a policy or programme at varying stages and, as such, there are different types. The categories include proactive, which is conducted prior to the design of the programme; clarificative, which focuses on the internal structure and function of a programme; interactive, which concentrates on stakeholders' responsibility to manage and control the evaluation of the interventions; monitoring, which is done after the intervention has been launched and is progressing; and impact, which determines the effectiveness of an on-going intervention (Owen, 2006). An impact evaluation was utilised in this study to examine the outcomes after the implementation of the abolition of user fees policy. According to Khandker, Koolwal, and Samad (2010), impact evaluation helps

> policymakers decide whether programs are generating intended effects; to promote accountability in the allocation of resources across public programs; and to fill gaps in understanding what works, what does not, and how measured changes in wellbeing are attributable to a particular project or policy intervention. (p. 3)

This type of evaluation is aimed at facilitating learning and accountability. As a result, the findings may be used as a guide for future policy processes and monitoring. Additionally, it is expected that stakeholders should take responsibility for the outcome of the policy change. The major focus of the evaluation was implementation versus outcome. Therefore, the overall approach to this evaluation study was a process-outcome approach. Evaluation was selected as the appropriate design for this study because the outcome of a programme was judged against the objectives it intended to achieve. Future decision making regarding the policy may hinge on the study's findings, in addition to adding value to future programmes (Weiss as cited in Vedung, 1997).

For an evaluation to be effective, it requires achievable objectives, adequate planning, and appropriate design and methods. Similarly, a well-designed evaluation permits the involvement of all stakeholders in a programme. For example in this policy evaluation, policymakers, practitioners and patients shared varying perspectives. Furthermore, the need for the evaluation and the intended use of the results shape the evaluation questions (Brophy et al., 2008).

This study aimed to determine the impact of the abolition of user fees in the Jamaican public health system at three levels: 1) national and regional policymakers, 2) providers in both urban and rural hospitals and health centres, and 3) users in both urban and rural health facilities (Figure 9). Trends regarding utilisation patterns, impact on the work of health care providers, specifically the professional nurse, and patients' access to health services since the abolition of user fees were examined. The study focused on the use of the public health system before and after the policy change.

5.2. Mixed methods

Many evaluation studies adopt a mixed methods approach because of their intricacies and the policy's or programme's area of focus (Polit & Tatano Beck, 2008). A mixed methods approach was, therefore, used to obtain a broad view of the user fees policy's effectiveness (Khandker et al., 2010). Despite the debate regarding incompatibility between quantitative and qualitative research's paradigmatic underpinnings, mixed methods were adopted to enrich the study generally and to enhance the robustness of the findings through triangulation (Polit & Tatano Beck). Triangulation is the practice of using multiple data sources or referents to draw conclusions about what constitutes the truth in a study (Hastings, 2010; Polit & Tatano Beck). Triangulation is often used interchangeably with mixed methods and multi-method research. Using mixed methods involved gathering, analysing and converging both quantitative and qualitative data in the study. It also allowed the researcher to comprehend the research problems in a meaningful way (Creswell & Plano Clark, 2007).

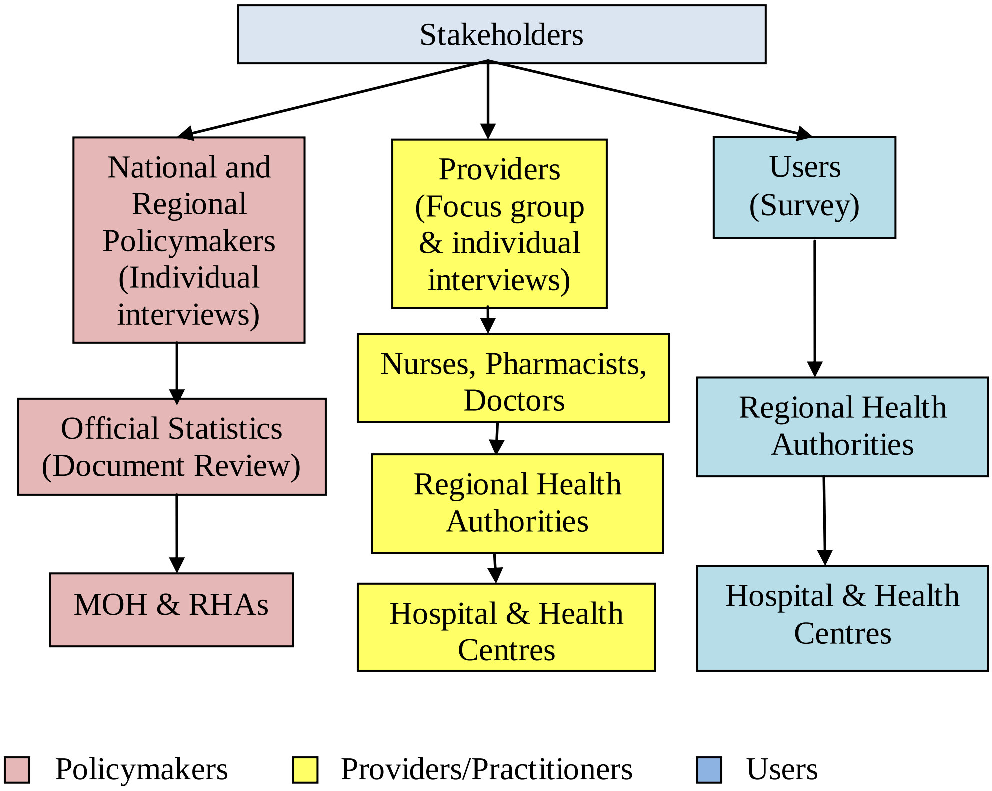


Figure 9. The multi-layered approach to the research

In mixed methods design there are three major strategies to the inquiry. They include sequential – in which one method is used to extrapolate about another; concurrent

– in which data from different sources are converged for a thorough analysis of the research problem; and transformative – in which a theoretical framework is used to underpin the procedure (Creswell, 2003). The research methods commonly adopted for a mixed methods approach include “a) predetermined and emerging methods, b) open and closed-ended questions, c) multiple forms of data drawing on all possibilities, d) statistical and textual analysis and e) across databases interpretation” (Creswell, 2009, p.15).

The researcher who utilises a mixed methods approach is involved in the research process in several ways. For example, the researcher has to be involved in gathering both quantitative and qualitative data, substantiating the use of the chosen method, combining data at different stages of the research process, presenting diagrammatic representation of the procedures in the study, and adhering to the ideologies of the qualitative and quantitative inquiries (Creswell, 2003).

While a mixed methods approach may be a useful approach it has some weaknesses. Common weaknesses that need to be managed for rigorous findings are that 1) data collection is widespread and time-consuming; 2) analysing both qualitative (text) and quantitative (numeric) data is a lengthy process; and 3) the researcher has to be *au fait* with the approaches involved in both quantitative and qualitative inquiries (Creswell, 2003).

For this study a concurrent triangulation mixed methods strategy was used in which quantitative and qualitative data were collected concurrently. Each method was weighted equally in that neither the quantitative nor qualitative approach was given priority in the study. The results were analysed in a multi-layered manner: 1) national level (policymakers), 2) provider level (practitioners), and 3) user level. Data were analysed within and across data sets, then within and across the levels. Integration of the findings was done during the interpretation phase (Creswell & Plano Clark, 2007; Onwuegbuzie & Johnson, 2006) (Figure 10). The process was further guided by a selected philosophical assumption.

5.3. Philosophical underpinning

Research designs require interaction among worldviews, strategies of inquiry and appropriate methods. In research, philosophical assumptions such as postpositivism, constructivism, and pragmatism are often used to guide the inquiries. These knowledge claims help researchers to frame up the research regarding what knowledge will be gained and how it will be gained from the process (Creswell, 2003). In addition, strategies of inquiry include “qualitative strategies (e.g. ethnography), quantitative strategies (e.g. experiments), and mixed methods (e.g. sequential), and research methods include questions, data collection, and data analysis” (Creswell, 2009, p. 5).

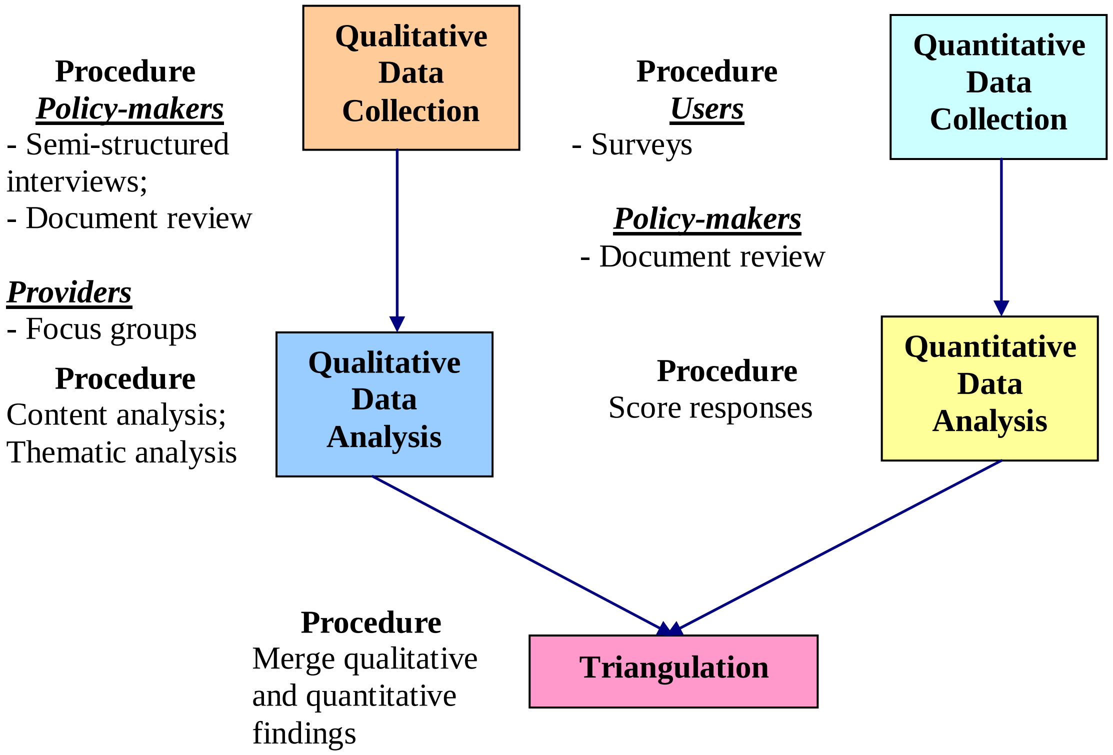


Figure 10. Diagrammatic representation of the mixed methods procedure used in the study
Note. Adapted from *Research design: Qualitative, quantitative and mixed methods approaches* (2nd ed.), by J.W. Creswell, 2003. Thousand Oaks, California: Sage Publications. (p. 214).

A pragmatic worldview underpinned the study. A pragmatic worldview is derived from John Dewey’s theory of knowing and asserts that knowledge is generated from “actions, situations and consequences” (Creswell, 2003, p. 11). Pragmatism is viewed by some commentators as a suitable philosophical underpinning for a mixed methods approach (Tashakkori & Teddlie, 1998) because the pragmatic researcher is not restricted by any one viewpoint and ideology regarding reality; rather decisions are made based on what data are potentially available and useful. Having no restrictions means the researcher can employ both quantitative and qualitative methods to gather the data regarding a phenomenon. A pragmatic approach empowers the researcher to remove any distortion associated with the statistical results of both qualitative and quantitative methods

(Creswell). Biesta (2010), in explaining another view on the usefulness of pragmatism to mixed methods research, suggested that the philosophy does not offer a "paradigmatic underpinning or a wholesale justification of mixed methods research, but rather a set of insights that can help us to have a more precise discussion about the strengths and weaknesses of mixed methods approaches" (p. 97). This observation by Biesta was used to determine the strengths and manage the weaknesses of this mixed methods study.

5.4. Design

The study was conducted in selected health facilities in the public health system in all four RHAs and at the MOH in Jamaica during 2010. Of note is that the policy change was implemented in 2008. Both probability and non-probability methods of sampling were utilised to determine the sample for both the qualitative and quantitative methods. For example, both systematic and purposive sampling techniques were used. Participants were selected from among key policymakers at the national and regional levels, various categories of practitioners in hospitals and health centres, as well as users of the public health system. Participants for the survey were selected from among patients attending the health facilities on the day of the survey using every 5th patient on the patients' register, while participants for the interviews and focus groups were selected based on their level of involvement in the health system and policy process.

Quantitative and qualitative techniques were used to determine utilisation patterns, effects on the work of the practitioners especially the professional nurse, and users' access to health services (Table 10). Data sources included interviews, review of documents, focus groups and surveys. Discussions and interviews were audio-recorded and notes were taken. Prior to the interviews, focus groups and surveys, all participants received an information sheet outlining the terms and conditions of the study. This provided sufficient information that enabled them to sign the consent forms and allowed the participants to accept or refuse to participate in the study (Fink, 2003; Polit & Tatano Beck, 2008). Analysis focused on the changes that have occurred since the removal of user fees in the public health system.

National level (Policymakers). A purposive sample of key stakeholders was selected from the MOH and the RHAs. Participants were recruited through a letter of invitation, which explained the purpose of the project and invited them to participate (Appendix 2). Key stakeholders in the MOH included the Minister of Health, the

Table 10.

Summary of the actual design for the study

Research Questions	**Participants**	**Sampling Technique**	**Data Sources**	**Data Gathering Tools**	**Data Analysis**
What is the impact of the abolition of user fees on the utilisation of health services?	National	Purposive sample of key policy-makers (n = 8)	- Minister of Health; - Permanent Secretary; - Director of Policy & Planning; - Chief Nursing Officer; - Regional Directors	- Semi-structured interviews - Document review	- Content analysis of responses - Textual analysis of documents (Annual reports) - Statistical analysis (Official statistics) - Within and across analysis on data set
What is the impact of the policy change on the work of the professional nurse?	Providers	Purposive sample of providers in urban and rural secondary and primary health care settings. (n = 62)	- Nurses (different categories); - Doctors - Pharmacists	Focus groups (n=9) Individual interviews (n=4)	- Content analysis - Within and across analysis on data set.
What is the impact of the abolition of user fees on users' access to health services?	Users	Systematic sample of users of health care system. (n= 200)	Users of both urban and rural secondary and primary health care settings who are present on the day of data collection	Face-to-face surveys	- Inferential and descriptive statistics including measures of central tendency. - Within and across analysis on data set
What are the lessons learned from this policy change?	All the above	Samples as above	Sources as above	Tools as above	- Within and across analysis on data set for all the levels (triangulation)

Permanent Secretary, the Director of Policy and Planning, the CNO and the Regional Directors of the four RHAs. These key stakeholders were interviewed. Data on national perspectives were also obtained from document review. Each participant was provided with an information sheet (Appendix 3) outlining the study, which was read prior to signing the consent form (Appendix 4).

Interviews are data collection methods that enhance flexible, one-one interaction with the participants (Yin, 2009). This fosters guided discussion in a non-threatening environment where individuals are free to express themselves and the interviewer can extract more information from participants through follow-up questions. Interview guides ensure that important areas are covered in the interview. Key stakeholders were asked about their perceptions of the policy change and its impact (Yin). Semi-structured interviews give the interviewer the freedom to manage the progress of the interview, as well as use prompts to generate further discussion (Vanderstoep & Johnston, 2009). Open-ended questions were used and responses were audio-recorded; in addition, notes were taken systematically to enhance the analysis process.

Questions asked concerned the stakeholders' roles in the development and implementation of the policy; their understanding of the policy objectives; the implementation plan for the policy change; whether the policy objectives were achieved; how monitoring of the policy change is occurring; current challenges to accessing the health care by other consumers; other policies regarding education, road infrastructure, and housing, which could be implemented to ease the problem with access to health care by the vulnerable; and their general impression of the policy change to date (Appendix 5). The stakeholders were also asked their views on affordability of services and available resources, including manpower, materials such as medical equipment and funding of the health service. The interviews were audio-recorded with permission from participants, who signed the consent form.

National level (Document review for official statistics). Document review is a discreet and inexpensive means of gathering data from existing documents in order to determine trends since the implementation of a new policy. Data from documents can substantiate and supplement data from other sources. Conclusions can also be drawn regarding a particular phenomenon (Yin, 2009). Document review was useful in answering some evaluation questions, as well as influencing the questions for the interviews. Documents reviewed included annual reports of the MOH and the RHAs. A checklist (Appendix 6) was used to obtain the required data.

Despite user fees being abolished in 2008 for all persons utilising the public health system, it is important to note that in 2007 user fees had been abolished for children under the age of 18 years. It was, therefore, imperative that this study examined the utilisation pattern of the public health system prior to any form of abolition of user fees and for a full year after the policy change. To achieve this, the years 2006 and 2009 were included in the document review. Although it was arguably too early to evaluate the impact of the policy change on health outcomes in 2009, the manner in which people used the public health system was apparent early in the change process.

The MOH Annual reports included the health statistics obtained from the RHAs while the Annual reports for the RHAs included health statistics obtained from the secondary and PHC facilities in each parish. Additionally, data were provided by other personnel from the MOH and RHAs. Some MOH data were extracted from the published 2006 and 2007 Annual reports. The data for some indicators for 2009 were obtained from the STATIN. Data obtained included utilisation patterns for 2006 and 2009, health conditions currently seen at the health facilities, main health indicators such as mortality rates, and the various modes of referral to the health facilities. The accuracy of the findings hinged on the data provided by the personnel at the MOH and the RHAs. Some statistics were preliminary data and in some cases there were areas of inconsistency. Where inconsistencies were detected, the MOH data were utilised.

Provider level (Practitioners). A purposive sample of professional nurses, doctors and pharmacists from selected urban and rural hospitals and health centres in all four RHAs was used. Participants were selected based on their professional levels in terms of job classification, as well as level of involvement in the health system, for example, those with administrative responsibility. Participants were recruited through a letter of invitation, which invited them to participate and explained the purpose of the project (Appendix 7), and they were required to sign a consent form before participating (Appendix 4). Group and management meetings, such as NPs quarterly meetings, were targeted to obtain the sample. In addition to ensuring homogeneity of the sample for each focus group, it was a convenient way of having the groups together in one setting. Data were collected using focus groups.

Focus groups involved group interviews that engaged 5-10 professional nurses, doctors and pharmacists in selected health facilities. Nine focus groups were conducted. Five were conducted in urban settings, while four were conducted in rural settings. Despite the urban-rural mix, it was not uncommon to have practitioners from a rural health facility participating in an urban focus group. Not only were the participants attendees at their regional group meetings, but the RHAs comprise urban and rural facilities at which the participants were employed. According to Posavac and Carey (2007) focus groups "serve particularly well in learning about reactions to potential services or changes in current services of community agencies or private organisations" (p. 124). Focus groups also enhance careful reflection by participants about their opinions, which may not be achieved in an individual interview (Posavac & Carey).

Questions focused on practitioners' roles in the abolition of user fees policy process; changes in work since the introduction of the policy; satisfaction with the current work environment; current quality and effectiveness of the care provided; contribution to improving access to health services; experience with funding and resources in the public health system; and general impressions of the free health care policy (Appendix 8). The researcher facilitated the focus groups while a scribe recorded the key points from the discussions. The interviews were audio-recorded with permission from the participants. Guidelines consistent with the conduct of a focus group were discussed prior to the start of the session (Brophy et al., 2008; Davies, 2007; Owen, 2006; Polit & Tatano Beck, 2008). Group sessions lasted a minimum of 60 minutes. Participants' perspectives were sought on issues concerning the participants' work, types of conditions and number of people seen daily, morale, job satisfaction, funding of the health services, quality of care, health outcomes, waiting times, referral processes, and innovations to improve access to health care.

User level. A systematic sample of 200 users of the public health system was identified from selected urban and rural hospitals and health centres. Two hospitals and two health centres were selected from each of the four RHAs. This sample was not a population sample since participants were only selected from the users at the health facilities on the day of data collection. Participants were recruited using the registration book, which consisted of the list of users who were registered for the day. From the lists of registrants every fifth user was selected for the project. Each user was provided with the information sheet about the study, which they read or was read to them. According to Fink (2003), "survey participants must give their informed consent before taking part in a survey" (p. 91), and, as such, each respondent signed a consent form prior to completing the questionnaire (Appendix 9).

Data were collected using face-to-face questionnaire surveys. Surveys are useful to capture quantitative information regarding trends, distribution, opinions, attitudes, and interrelations of variables within a population (Creswell, 2009; Polit & Tatano Beck, 2008). In addition they are conducted for a specific reason and are extensively used for political-related objectives and policy research (Davies, 2007; Posavac & Carey, 2007). This method is advantageous for studies intending to cover a broad geographic area. Furthermore, surveys are flexible and broad in scope. Survey data may be collected through self-administered surveys, self-reports, personal interviews, telephone interviews, structured observations, structured record reviews, and computer assisted interviews (Creswell; Polit & Tatano Beck). Information was obtained from respondents by way of self-report. In this survey, self-administered surveys (Appendix 10) were used. Close attention was given to the development of the instrument in order to avert ambiguities or complexity.

Face-to-face surveys were chosen in order to accommodate participants with low reading ability. The survey was pre-tested at a hospital and a health centre, which were not included in the sample. No changes were made because the questions were understood by respondents and answers were consistent with the questions asked. This pre-test was to ensure reliability of the data. The survey was administered either by the researcher, a trained nursing student researcher, or the individual user. Training sessions were held for nursing students who participated in surveying people. Where users independently completed the survey, the surveys were usually checked for completeness by the researcher or a nursing student. Despite being checked at the time of completion, there were some missing responses; therefore, the denominator changes in the reporting of some data. There was no consistent pattern to the missing data, but for one respondent two pages of responses regarding utilisation, affordability, quality of service and availability of service were missing due to the pages sticking together. All 200 surveys were sufficiently completed for them to be used in the analysis. Where literacy levels were low, respondents were assisted with completion of the surveys. The researcher posed the questions and recorded the responses in writing. Of note is that nursing student researchers assisted with the data collection process initially, but following a State of Emergency, data collection was conducted by the researcher without assistance. This did not compromise the process in any way.

Questions focused on the impact of the abolition of user fees on users' access to health services. Answers were sought for issues concerning people's socio-demographics and health history, access to health care, availability of drugs, perceptions regarding health personnel, waiting times, the referral system, use of alternative methods of treatment, distance to health facilities, aesthetics of the health facilities, satisfaction with the services, knowledge about the health services, expectations of the health system, social status and involvement in the decision-making process (Appendix 10).

5.5. Data analysis

In the pre-analysis stage, administrative tasks included organising the surveys, as per identification numbers, according to RHAs and health facilities; listening to the audio-recordings to get acquainted prior to transcription; transcription; entering data into the statistical package and cleaning the data where applicable; perusing official statistics from the annual reports and obtaining additional information from Jamaica. Data were analysed in a multi-layered manner using a triangulation approach at all three levels to compare and cross check among data sets. Analysis was done within and across data sets at each level, then within and across the different levels. The focus was on 1) whether or not the policy was implemented as planned; 2) how differences between the original plan and implementation of the policy affected the outcomes; 3) the extent to which the objectives had been achieved; 4) the extent to which the policy change was benefiting the target group; and 5) whether there were unintended outcomes and cost implications. The aims, generally, were to identify participants' perceptions regarding the impact of the policy change and determine if factors other than user fees were contributing to poor access to health services. Examples were selected to elucidate important findings.

National level (Policymakers). The recorded interviews were transcribed to identify what participants had to say and to organise the data for analysis (Brophy et al., 2008). Coding and analysis of the data were enhanced by content analysis techniques (Carley, 1993). Content and thematic processes were used to analyse the policymakers' data: "Content analysis is a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the context of their use" (Krippendorff, 2010, p. 2). It captures patterns and recurring themes in qualitative data, while thematic analysis determines regularities, trends and inconsistencies for the themes (Polit & Tatano Beck, 2008).

Emergent ideas were extracted and coded into themes for interpretation. Coding is done to reduce large amount of data into a form that gives an accurate description of the variety of responses (Brophy et al., 2008; Davies 2007). Codes are labels assigned to sentences, phrases or words from the information obtained in interviews and focus groups (Miles & Huberman, 1994). Miles and Huberman (1994) asserted that "coding is analysis...which involves how you differentiate and combine the data you have retrieved and the reflections you make about this information" (p. 56). For ease of interpretation and confidentiality, alphanumeric characters were used to identify the national and regional policymakers' interviewees, for example NPM1 (national policymaker 1) and RPM1 (regional policymaker 1). The main themes identified are presented in narrative form. Direct quotes are used to substantiate each theme.

Challenges encountered with interviewing the policymakers included some being new in their position, who, as such, had different experiences of the abolition of user fees policy. Besides, some had minimal involvement with the policy process. In addition to policymakers' inability to articulate sufficiently about the policy process, it was evident they had disparate views on some issues. When the transcription notes were sent to participants for amendments, additional information and comments, only one was returned.

Official statistics were extracted from annual reports using a checklist. Textual analysis was undertaken on the documents to determine trends: "Textual analysis is a method of data analysis which closely examines either the content and meaning of texts or their structure and discourse" (Lockyer, 2008, p. 2). Following analysis, the data were summarised statistically and presented graphically and in narrative form. Data reflected utilisation patterns of the public health system, key health indicators such as infant and maternal mortality rates, death rates and prevalent health conditions such as hypertension, diabetes mellitus and asthma one year prior to any abolition of user fees – 2006, and one year after the policy change – 2009. Of note is that the data presented for 2009 are preliminary reports; therefore, there may have been adjustments to this data subsequent to it being published by the MOH. While attempts were made to obtain complete and accurate information some data may be incomplete and inaccurate. There were also inconsistencies with the statistics from the MOH and RHAs. To obtain additional data and determine the accuracy of those previously collected, regular updates were sought from Jamaica via telephone calls and emails. This was often a tedious task.

Provider level (Practitioners). Data from audio-recording the focus groups were analysed using content and thematic analyses as described above. Emergent ideas extracted from transcription notes were coded and organised into themes for interpretation. For ease of interpretation and confidentiality, alphanumeric characters were used to identify the focus groups and the interviewees, for example, RNFG1 (registered nurse focus group 1) and Pharm1 (pharmacist 1). Determining the unit of analysis for each focus group was sometimes a challenge during this phase. Results are presented in narrative form, in which direct quotes are used to substantiate main themes.

Challenges encountered with sampling practitioners including difficulties obtaining certain categories, such as pharmacists and doctors. This was due mainly to a shortage of qualified personnel. Practitioners' focus group notes were transcribed and checked against the audio-recordings, after which the notes were sent to participants for additional information and comments. Of the 13 transcription notes sent out only two were returned.

Generally, coding of the policymaker and provider data produced a number of categories. Both emerging (extracted from the interviews) and predetermined (extracted from the interview schedule) codes were adopted. The codes were then clustered into topics to address the questions asked in the interview. The topics were then used to create themes, sub-themes and subsequently the headings for the policymaker's and provider's findings section. Quotations were further utilised to convey the findings of the analysis for each theme. Themes that are presented in this study reflect the topics in the interview schedule as well as support and strengthen the access theoretical framework.

User level. There was a 100.0% completion rate for the survey. Surveys were organised according to RHAs and health facilities and identification numbers affixed. Data from the surveys were analysed using the Statistical Packages for Social Sciences (SPSS) version 18. SPSS is a tool widely used for data analysis among survey researchers (Davies, 2007). Inferential and descriptive statistics, including measures of central tendency, were employed. Descriptive statistics involves statistical techniques such as mean and standard deviation to describe and summarise data (Kato & Bart, 2008; Polit & Tatano Beck, 2008). Inferential statistics, on the other hand, involve the process of induction, in which results from a sample are used to make conclusions about a population (Polit & Tatano Beck; Thorndike, 2008). A two way Analysis of Variance (ANOVA) test was used to determine the level of variability of variables such as access and quality of care across RHAs and facilities. ANOVA is a statistical measured utilised to examine the differences among groups by determining the variability between and within groups (Polit & Tatano Beck).

Challenges encountered with the surveys included incomplete data, despite the survey being sufficiently completed to be included in the analysis, and superficial answers to questions. More in-depth answers by users would have added to the robustness of the data. Managing the data, as well as the output statistically was sometimes a challenge. This was due to the number of layers and the many tables and charts.

5.6. Triangulation

In addition to using multiple methods to conduct the study, through the process of triangulation, the national, provider and user perspectives were analysed. Triangulation was used to determine the level of compatibility among the various data sets. This meant identifying the similarities and differences in what the different levels of stakeholders reported about the policy change. This comparison increased the credibility of the study; aligned all three levels of data to enrich the manner, in which the research questions were answered; and provided multiple lenses through which to understand the impact of the policy change (Hastings, 2010). To achieve this, within and across analyses were done for all three levels of data set. For example, policymakers' data were analysed separately, then compared with providers' data to answer the research question regarding the work of the professional nurse since the policy change. Furthermore, national and regional policymakers' perspectives, official statistics, providers' and users' perspectives were analysed and cross-checked to identify consistency in the information regarding utilisation and access to health services since the policy change.

5.7. Ethical considerations

Research that involves human subjects requires consideration regarding ethical issues, for example, protecting the rights of participants (Polit & Tatano Beck, 2008). In explaining the concept, Israel and Hay (2006) asserted that "ethics is about what is right, good and virtuous" (p. 1). In addition, the authors stated that "ethical behaviour helps protect individuals, communities and environment and offers the potential to increase the sum of good in the world" (p. 2). Researchers are, therefore, expected to embrace ethical behaviour, which includes protecting the research participants, fostering a trusting relationship, and maintaining the veracity of the research.

In observing good ethical practice for this research, considerations were given to possible ethical issues throughout the entire research process, for example, in the statement of problem, purpose, research questions, data collection, analysis, interpretation and manner in which the data are being disseminated. Approval to conduct the study was, sought and obtained from the Human Ethics Committee, Victoria University of Wellington (Appendix 11); and the Ministry of Health, Jamaica (Appendix 12). Permission was also obtained from each of the RHAs and selected secondary and primary health care facilities, Jamaica.

There was a delay in obtaining ethical approval from the MOH and RHAs. The delay was further compounded by a State of Emergency triggered by social unrest, a problem that was not envisaged. This disrupted plans regarding gaining assistance from the nursing student researchers who were scheduled to administer the survey. Data collection was, nevertheless, completed in the specified time. Nursing student researchers had to sign a confidentiality agreement prior to assisting with the survey (Appendix 13). They assisted with only three health facilities.

Informed consent was obtained from all participants. Confidentiality was maintained through de-identifying and strict handling and management of data. Confidentiality was assured during the surveys and personal names were not affixed to the surveys. Confidentiality, however, could not be assured for the interviews, in which key stakeholders might be identified by virtue of their positions, not by their names. To control for confidentiality issues, an alphanumeric naming system was used to identify the national and regional policymakers, as well as interviewees and focus group participants. For example, NPM1 stands for National Policymaker one, RPM1 for Regional Policymaker one, and FG1 for focus group one. Participants in the focus group who largely knew each other were advised that issues discussed in the session should not be discussed externally. No control can, however, be exercised over the participants outside of the focus group settings, and as such, confidentiality cannot be assured.

It is not anticipated that any cultural, social or legal impediments will affect the reporting of this study.

5.8. Rigour/validity

Despite suggestions for the concept '*Legitimisation'* (Onwuegbuzie & Johnson, 2006) to be used to describe validity in mixed methods research, lack of an acceptable concept still exists. This study, however, observed procedures that ensured the validity or trustworthiness of the findings. To avert any threat to the validity - "the extent to which a finding is well-grounded, justified, [and] under-pinned" (Vedung, 2009, p. 312) - of the study, a number of measures were adopted. This was to enhance generalisability and make the findings persuasive (Polit & Tatano Beck, 2008). These measures included ensuring proper procedures were used during the development of tools. This included researcher's frequent consultation with her supervisors. Requirements for developing semi-structured interviews, checklist and survey were ascertained (Creswell, 2009; Davies, 2007; Polit & Tatano Beck). Appropriate tools were adopted where necessary. For example, a survey was used to capture opinions from a wide cross-section of people (Mrug, 2010). To refine the tools, pretesting was conducted before administration. This was to achieve reliability.- "the degree of consistency or dependability with which an instrument measures an attribute" (Polit & Tatano Beck, p. 764). In addition, there was audio-recording of focus groups and interviews to accurately capture participants' perspectives. Notes were taken and kept in the strictest of confidence. The notes were then transcribed and summaries sent to participants to determine accuracy, as well as to obtain their feedback regarding any area of concern. Draft transcripts were read by the researcher and discussed with her supervisors to ensure proper procedures were adhered to. Notes were returned to participants for feedback and additional comments to ensure accuracy of recorded data.

During the analysis stage, emerging transcribed themes were coded for accurate analysis and interpretation. The process entailed a systematic process to ensure that the participants' voices were evident. Additionally, the researcher made frequent checks with her supervisors during the analysis phase to ensure that the procedures being used were accurate. To further ensure confidentially and anonymity while managing the data, access to data was restricted and identifying features were removed. Survey data were also reworked and some variables recoded to ensure accuracy. Recoding is data transformation which included creating *dummy variables* and new variables. For example, levels of satisfaction were recoded to reflect very satisfied and satisfied as 'satisfied' and very dissatisfied and dissatisfied as 'dissatisfied' in order to enhance statistical analysis (Polit & Tatano Beck, 2008). Triangulation was also done to ensure validity.

5.9. Conclusion

This chapter outlined the mechanisms adopted to structure and conduct the study within ethical boundaries, as well as to reduce any extraneous variables that might compromise the reliability and validity of the study. Through this means, perspectives were sought from policymakers, practitioners and users regarding the impact of the abolition of user fees on the utilisation of health services, access, and the work of the professional nurse. The following chapter will outline the results from the national, practitioner, and user perspectives.

Chapter 6: Results – National and user perspectives

6.1. Introduction

This chapter, the first of two findings chapters, presents the results from the multi-layered study on the impact of the abolition of user fees in the Jamaican public health system on access, care provided, and work of the professional nurse. Findings are presented in three sections: (1) policymakers, (2) official statistics, and (3) users. The next chapter will present the findings on the impact of the policy change on the work of main health practitioners (doctors and pharmacists) and the professional nurse as viewed by the health workers themselves. This chapter, however, presents policymakers' perspectives on the issues affecting health workers since the policy change. The qualitative findings are presented according to the themes that were identified. Quotations are used to give meaning to each theme. The quantitative results are presented in tables, charts and narrative form. In addition some supplementary data are located in the appendices.

6.2. Policymakers

This section captures the perspectives of a purposive sample of key policymakers in the MOH (Minister of Health; Permanent Secretary; Director of Policy, Planning and Development Division; and CNO) and key policymakers (Regional Directors) in the four RHAs regarding the impact of the user fees policy. Findings from interviews with the policymakers are presented under 11 headings: involvement in the policy process; understanding of policy objectives; reaching the target group; achievement of policy objectives; funding of the health system within the new policy framework; impact of the policy on service delivery; impact of the policy on the health workforce; monitoring the policy; issues regarding consumers' groups other than the poor; additional policies to assist the vulnerable; and impressions of the policy change generally. Policymakers from the MOH are identified as NPM 1-4 and policymakers from the RHAs as RPM 1-4 (Table 11).

Involvement in the policy process. National policymakers were integrally involved in the policy from its inception. For NPM1, ongoing involvement with the policy development meant setting the policy guidelines and spearheading the implementation phase. None of the regional policymakers interviewed was actively involved in developing the initial policy. This may be due to the fact that the user fees policy constituted a fraction of the broader political agenda, as mentioned by RPM2: *"there was a new administration that came into office in '07 and the removal of user fees was a*

Manifesto commitment." Most regional policymakers talked about their role in enhancing the policy, which was their level of involvement.

Table 11:

National and regional policymaker interviewees

National Policymakers (MOH)	**ID**	**Regional Policymakers (RHA)**	**ID**
National Policymaker 1	NPM1	Regional Policymaker 1	RPM1
National Policymaker 2	NPM2	Regional Policymaker 2	RPM2
National Policymaker 3	NPM3	Regional Policymaker 3	RPM3
National Policymaker 4	NPM4	Regional Policymaker 4	RPM4
Total	**n=4**	**Total**	**n=4**

The roles of the policymakers in the implementation process varied and included chairing committees such as the implementation committee. Others steered important divisions in the MOH:

> *The division looked into the matter. That's what prompted us to go and look at the international experience to see (a) what would be required, (b) what were some of the considerations that you need to take into account, how…in removing the fees, the fees would have to be replaced…so we looked at how that additional source of funding should be costed.* (NPM1)

Informing development and implementation of the policy also required policymakers to research the literature on the experience of the abolition of user fees in other developing countries, including Uganda and other sub-Saharan African countries. The shaping of ongoing service arrangements was among the roles adopted by policymakers in the policy implementation phase. For RPM1,

> *It was a lot of preparing the staff because now you have to motivate them. You have to prepare them individually and collectively as to how you* [are] *going to deal with it...we had customer service training at the grass roots...we had meetings, just to discuss, to sensitise as to how we move forward.*

Contributions to the implementation of the policy were also shaped by how long persons had been involved at the policymaking level, with some having only been appointed to their position eight months prior to this study, while others had held a policy position for many years.

Understanding of policy objectives. There was general consensus among policymakers regarding the objectives for the user fees policy; they all agreed the intent of the policy was to improve access to health care and services for the poor and vulnerable:

> *My understanding is that, based on information that the Ministry of Health had at its disposal, they recognised that there were a number of Jamaicans* [who] *were not presenting themselves for treatment or visiting any of their health facilities because there was a barrier they found and that there was a cost.* (NPM4)

The widespread supposition was that some people had not been accessing health care because of their inability to pay out-of-pocket. This supposition was supported by the *Jamaica Survey of Living Conditions 2007,* which revealed that, despite an exemption mechanism being in place in the public health facilities, the costs of health care and services remained a barrier to some people even though they experienced ill-health:

> *The main objective...is improvement in the access to basic health care...Our Survey of Living Conditions…asked a question about barriers to access...if* [the] *user fee was a barrier….there were a number of responses:*
>
> 1. *that the cost of health care was a barrier*
> 2. *persons said they didn't think they were sick enough to seek health care*
> 3. *some said that they used alternative interventions*
>
> *In my mind, I view...*[these] *as proxies for saying that you can't afford it.* (NPM1)

Although policymakers reported that the overarching objective of the policy was to improve access to health care and services, NPM2 asserted that the policy was also a driver behind the renewed focus to reorient the system to primary health care (PHC). Strengthening PHC was viewed as a necessary strategy because of the worrying recurrent, inappropriate use of the public secondary care facilities by some individuals. Additionally, re-packaging the PHC services in a manner that attracted users was considered one measure that would impact positively on the new policy, as well as on service delivery at the secondary care level:

> *Location of health facilities is very critical not just location of the facilities but what services you offer from where you are located. Because you will have a health centre in a community and people bypass that centre to go to another one because they don't believe that the doctor is going to be there nor the pharmaceuticals are going to be there so they go to one where they can see the doctor, get the drugs, get the x-ray, get everything...So how we offer, the package*

> *of service we offer, where we offer it, is going to in the long run* [to] *dictate how we sustain this policy.* (NPM3)

Reaching the target group. While policymakers reported that one of the objectives of the user fees policy was to improve access to health care and services for persons who experienced cost as a barrier, they could not agree on who constituted the target group. NPM1 commented: "*the only particular group would be the persons who are not private patients and persons who don't have health insurance or persons who are not* [from] *overseas. It was open to all public patients.*" However, several others maintained that the policy was meant to benefit the vulnerable and those viewed as unable to pay for health services. For example, RPM1 intimated that "*The poor are benefiting. The poor have benefited tremendously and as a manager I can look at* [it] *and say it is a good thing for the poor.*" Highlighting the fact that poor people were benefiting suggests that the poor may have been the target group.

Policy objectives achieved. Both national and regional policymakers reported that the objective to make care accessible without immediate cost to the client had been achieved. In effect, the user fees policy created a public health system whereby all Jamaicans could access care without any out-of-pocket payment. The assessment of the extent to which this goal had been achieved ranged from policymakers saying it was fully achieved to others maintaining it was only partially achieved:

> *Access is just one thing you know...it's kinda difficult in two years or three years to say that the objectives have been met because interventions like these are longer term interventions. Access is one but outcome in terms of improvement in health status....We never saw it as an event…we abolished user fees in public facilities…to public patients in '08 and then it's finished…it's still in our mind an ongoing project because this is now the reality that we are experiencing. So we have to ensure that this reality is meeting in essence the health care needs of the Jamaican people.* (NPM1)

In addition to understanding the intent of the policy objectives, policymakers were actively devising and implementing the necessary interventions to mitigate the unexpected outcomes of the policy. The policymakers indicated that they were constantly in reaction mode, often anticipating possible deleterious consequences of the policy on the health system. They instituted creative measures to ensure that the policy objectives could be achieved. RPM1 commented:

> *We have not gotten complaints that people are not getting the care that they deserve. We had, as expected, a run on the health centre during the first couple of months so you would understand that we had to extend clinic hours to evenings, Saturdays, just to facilitate some of the persons that were now coming out...It was not people coming willy-nilly, it was people who really need service...So we had that run on the system, the objectives were met, people were given medication. A lot of people* [who] *came in were hospitalised too...hospitalisation increased.*

All policymakers were concerned with monitoring and managing the changes associated with the policy change, and those in the regions were also proactive in ensuring that service delivery was not compromised, especially in the management of emergency cases:

> *If the aim was to improve access, I think access has certainly increased. A lot more persons are accessing the service. In fact the first year saw a significant increase in the number of clients attending and you would have noticed that even surgical lists would have gotten longer because these patients are now coming in. So access has increased...it's now all a matter of managing the care so the most urgent patients are seen first...We've also noticed a trending up in the number of primary health care visits so that augurs well for our country.* (RPM2)

Funding of the health system within the new policy framework. To further determine the extent to which the objectives of the policy had been achieved, policymakers were asked to provide information on a number of indicators, including funding, for the services being provided, and the responses of the Jamaican public and the health system to the policy as a whole. Arguably, the success of the policy was contingent on how well-resourced and -funded the health system was. There were disparate views among policymakers about the effects of the new policy on health sector funding. One policymaker maintained that funding had not been affected by the policy and that there was an increased budgetary allocation to the MOH to support the policy change. All the other policymakers had different views. National policymakers spoke more about the provision of additional funding, whereas regional policymakers spoke of the shortfalls in funding. RPM2 considered that the cost of health care had risen astronomically on the introduction of the policy:

> *Well, the cost of the service has increased tremendously. In fact the liabilities across regions have grown tremendously because the policy has also been implemented at a time when we were having a global recession...while you are offering care without people paying out-of-pocket, you are also curtailed by budgetary limitations. So while your cost is going up your budget remains relatively flat, compared to what is required. So the cost has certainly increased and that is something that has to be managed carefully.*

This comment by RPM2 does not negate that there had been an increased budgetary allocation to the MOH at some time. Policymaker RPM1 commented:

> *The first year* [after] *abolition of user fees, funding was very good, the government was able to give you what you requested in your budget. The second year the budget was cut and, therefore, it affected...especially the patients who needed appliances. So for example we probably spent* [JM] *$2 billion just buying appliances for patients but after that we don't have that $2 billion to spend. So here we are now, caught* [between] *a hard rock and a deep place and we are saying now, what do we do*?*...So some people choose to buy their appliances themselves.*

Even though there were increases in budgetary allocation, RPM2 emphasised that, *"based on the numbers that have come in, the cost has grown more than the financial resources available...So that is why you end up with liabilities of much more than you would have had in former years."* A different perspective was expressed by RPM3, who intimated that funding for the health sector generally was inadequate, which could not be blamed on the new policy.

Escalating health costs required policymakers to adopt stringent measures and engage creative means, such as private and public partnerships in obtaining funds, to meet the demands of the system:

> *Because we are in an inflationary environment and there has also been some service expansion and improvements...I think we are all aware there are resource constraints...the problem with the financing of health care did not start with abolition of user fees...our current state, I believe, is a testimony to our struggles*

> *over the years. This has placed us in a position of having to deal with inadequacies in our equipment and infrastructure...As stakeholders who play a role in policy decisions, we will continue to seek more funding for health care and we will have to intensify our efforts in forging viable partnerships.* (RPM3)

As users of the public health system could now access care at no cost, the reality was that the demand on the system exceeded the funding allocated, which was of concern to some policymakers. How funds were spent was an issue for one policymaker. NPM3 reported improvements in the MOH's budget but lamented that a large proportion of the budget was being utilised to offset health personnel salaries:

> *Health was one of two or three ministries that did not experience a budget cut. I think though, the resources we need, and how we are deploying the resources we have, must become a matter for serious debate. As it now stands, 76.0% of the budget is* [spent] *on compensation.*

Despite the health system being underfunded, NPM1 was quick to point out that an improved health system was still expected within the allocated budget.

Impact of the policy on service delivery. One major benefit of the user fees policy to the Jamaican public, according to all stakeholders, was people's ability to access health services without any out-of-pocket payment, even though the cost to the sector was escalating. NPM4 commented:

> *We have a wide range of services that patients are offered which include primary and secondary care services....medical services, surgical services…the patients would not need to pay for any…the patients would not be paying for surgical interventions...*[A] *patient who enters the health system at any point is seen by a number of health…practitioners and does not have to pay a registration fee, moves on to get investigations and does not have to pay for these investigations…blood investigations, x-rays, high tech investigations and CAT Scans, etc…and one analysis that was conducted did show that these were substantial to the patient, based on the ability to access these services free of cost.*

Two regional policymakers were of differing views in highlighting the effects of the policy on service delivery:

> *Well, I think the services provided are relatively good and we have pockets of excellence in many places. What has changed is our waiting time. We'll have to*

> *do a lot more to improve on the waiting time, especially in areas like the pharmacy, where there is a major shortage of pharmacists and the increase in patients has not resulted in a major change in the number* [of pharmacists] *so you now have extended waiting times.* (RPM2)

For RPM3, the quality of service was also negatively affected. In particular, there was occasional equipment failure and insufficient capital funding. In RHAs where the service delivery was viewed as adequate by policymakers, they still frequently had to adopt innovative strategies to enhance service delivery and meet the additional demand. Such measures included increasing the number of staff and extending working hours.

Impact on the health workforce. In talking about the impact of the user fees policy on the health workforce, policymakers shared varying perspectives. The health workforce is such that policymakers were forced to rethink how the policy change could be better managed or whether it needed modification:

> *I think the debate still continues: should the user fees* [have] *been abolished for everything in the health service?...Just last weekend some medical group had a conference in which this matter was being debated. So we need to take a look at some of these things*. (NPM3)

It was noted, particularly by the regional policymakers, that the public health system lacked a health workforce complement that paralleled the demands of the policy change. Therefore, the increased demand created pressure on the limited workforce:

> *In the area of drugs, medications, pharmaceuticals supplies...we see tremendous increase in the demand...it has put severe stress on the persons that work in that area because we have not been able to parallel, make more persons available to work in the sector, that's in the pharmacies*. (NPM3)

Policymakers mentioned that some health personnel did not embrace the policy change with enthusiasm. There had been disquiet and 'blame games' regarding the perceived problems associated with the policy:

> *It is time that we shift our focus from the policy of abolition of user fees and stop blaming this policy for all the problems in health care. I believe there is sufficient evidence both in our operations and in our financial statements to indicate that our problems have not changed in any significant way over the years. So I think, for the staff at all levels, we need to get out of the mode of identifying abolition of user*

> *fees as the problem and getting into the mode of seeking and identifying more creative and constructive approaches to address our financing needs.* (RPM3)

Generally, policymakers felt that health workers had responded well to the policy change, despite pockets of disquiet: *"The consensus on the ground was that this was a good policy…The providers themselves were a bit overwhelmed…there were complaints in terms of coping with the numbers"* (NPM3). In addition, RPM2 gave an account of the commitment of the health workforce:

> *The staff, excellent. I think without the hard work and the competence that has been displayed then the policy would have been more difficult to implement and the achievements would have been far less...The staff has...been very professional even amidst major challenges with patient discipline and patients' perception of what should be.*

Policymakers' perspectives on the impact of the policy change on the work of the professional nurse. In talking about the impact of the policy change on the work of the professional nurse, national and regional policymakers made reference to the preparatory phases of the policy, nurses' current workloads, effects of the increased demand for service and various interventions to improve the nurses' work situation generally. NPM2 commented on preparatory meetings held with some stakeholders, including nurses:

> *The nurses, the doctors, the community nurse, the midwife. I had meetings with all these interest groups before its* [the policy's] *rolling out. Therefore, when it was rolled out I had the backing of all the groups. The day before it was rolled out we had a press conference downstairs and all the people endorsed it, because it's a good programme.*

Another policymaker spoke of the effects of the policy change on nurses:

> *I think the challenges that the nurses are facing are not tied specifically to the abolition of user fees. I've not heard a lot of complaints about workload. Even that was monitored in the initial stage. The response —'burn-out we heard for some people', 'overwhelmed' and those kinds of terms. But now we are not hearing such complaints in a long time.* (NPM1)

In talking about creative means to enhance the work of nurses, the following areas were highlighted:

> *This is an area that speaks to a critical component of service delivery. We are caught in what's called the MoU* [Memorandum of Understanding]. *Salaries, which* [are] *one of the boosting factors for any health care practitioner,* [are] *at a stage that could be and should be improved...The next area would be the environment in which our health care providers work. There have been complaints in terms of equipment that are needed in the facilities to allow systems to function better and the Ministry has embarked on a project to upgrade our facilities with equipment, etc. These are actually positive things for the workers, for the nurses, to allow them to work better, in a better environment, with the equipment that is needed to actually deliver the care.* (NPM3)

Furthermore, it was felt by NPM4 that the division of labour among the categories of nurses needed to be examined, as well as providing legislative protection for NPs' prescribing. As a result, NPs would have more autonomy in prescribing, further increasing the capacity of the facilities to deal with the increased patient load.

One regional policymaker commented on the ripple effects of the increased workload on the nurses: *"They are stretched to the limit. At one time we saw where absenteeism had increased. People were asking for vacation time. It has been tight because we haven't increased the numbers* [of nurses] *either or by much"* (RPM4). Additionally, RPM3 gave an account of the policy impact on the nurses:

> *The health sector has always experienced a shortage in many of our technical groups, nurses being one. Hence, an increase in the usage of our services will further stretch our limited nursing resources. We have a number of complaints from our nurses, including having to work multiple sessions to compensate for the shortage. This not only results in burnout of the individuals, but it impacts on our costs, as the sessions attract a premium rate*.

Policymakers commended nurses, alongside other health professionals, for their work since the policy change: "*I think we have to give credit to the health care professionals. They do well with the little they have and they always display resilience despite the constraints"* (RPM3).

Policymakers considered measures that could be implemented to specifically enhance nurses' work, which included improvements in equipment:

> *We have increased technology. For example, where the nurse would have to be fanning a thermometer, the nurse* [now] *has a monitor that she just connects up to the patient and she gets pulse, blood pressure that sort of thing*.

In addition to improved equipment, policymakers noted that more nurses had been employed in the system:

> *One of the things that happened is that we have gotten more nurses in the system since February of this year* [2010] *from the nursing schools and I think that has helped tremendously in terms of that burnout that we would have gotten complaints about*. (RPM1)

One policymaker talked about the creativity of nurses in steering the health units, as well as the regions' pre-policy preparation for nurses:

> *I think the nursing staff have been very creative in managing their areas and we'll continue to add more nurses. There have been very limited complaints. In addition we have created 'restrooms' for all the nurses with all the necessary facilities. That was in preparation for the policy*. (RPM2)

Monitoring the policy. It was apparent that no formal monitoring system had been put in place to capture the effects of the policy change. Monitoring, therefore, was done in an *ad hoc* manner, with no on-going or active evaluation:

> *While a system was not implemented to monitor this particular policy, the normal monitoring systems do capture the changes in the relevant variables. We also intend to conduct a before and after evaluation to make an assessment of the effects of the policy and to inform our continuous improvement efforts going forward...At our quarterly regional reviews we do evaluate the statistics and use them to put measures in place to improve our operations and mitigate negative impacts.* (RPM3)

Despite having no formal monitoring system, some policymakers and administrators, such as the CMO and the CNO in the MOH, were charged with responsibility to monitor the system. Data gathered were channelled or communicated to those in the health hierarchy. These individuals were also expected to intervene to ensure there was no major fallout from the policy change. Monitoring of the policy was also done at the regional level:

> *We have the parishes…a Parish Manager, you have the Medical Officer of Health in each parish, you have the hospital and the CEOs, you have the other people in the whole system that you're utilising to make sure that things are in place.* (RPM4)

Policymakers also relied on the statistics that were available at their disposal. These data were used to guide them in managing problems encountered with the policy change. For example, RPM2 talked about examining the number of people utilising A&E and the abandonment rate as a guide to the decision-making process.

Meeting the needs of consumers other than the poor. The aim of the user fees policy was to improve access for public patients. The unavailability of separate private facilities in the public system was a challenge for 'non-public' patients. Discussion with policymakers regarding the challenges encountered by persons who were often classified as private patients revealed that they were benefiting from the policy change. RPM3 noted:

> *Well, if they* [other users] *come, they will get the service. It is likely, however, that, because of the resource constraints, the waiting time would be longer than in the private sector. For this reason, persons who can afford to pay might opt to go to a private provider. They would definitely have to join the waiting line and conform to the normal public health procedures.*

NPM4 also agreed that private patients were benefiting from the policy change:

> *Overall, I would say the cost of health services across the world is very high so, even if people do not fall in category listed poor, accessing health care would be a challenge to other strata of society...all levels of society would benefit from this policy.*

Policymakers were not equally aware of the public system arrangements for private patients. RPM1 commented: *"What we do not have, is we do not have private service in the public system. So people coming in must know that we do not offer private service in the public system."* On the contrary, RPM3 commented:

> *We do have a facility though where persons can be private in the public system. Doctors at a certain level have Private Practice privileges. So they are able to do surgeries and they are able to have patients on the wards that are private patients and paying. That is one privilege they are allowed.*

To accommodate this arrangement prior to the policy change, a fees schedule system had differentiated between the two types of users:

> [There was] *a set of fees for public patients and a set for private patients. Now the private patient fees would relate to persons, who have health insurance, would relate to persons from overseas who are in Jamaica and needed to…it also related to private patients because, in our system, physicians have dual practice, so their clients using the public facility pay private fees.* (NPM1)

Other policies to assist the vulnerable. The abolition of user fees in the Jamaican public health system may not be the solution to patients' inability to access health services when required. This is because fees for services may only be one of many barriers to access. In addressing what could potentially ease the problems associated with accessing health care, national policymakers identified other policies that could be implemented to further improve access. All other policies were, however, linked to the health portfolio:

> *There are other policies that we can't touch…if they have transportation issues in terms of fares to get to point A to point B…we can't do anything about that...The process is outside our mandate and scope* [because] *we are trying to put a primary health care facility within 5 kilometres of a community. What can be examined though…and that's a policy intervention to be pursued…mobile type…taking the service to the patient...The other thing that could be used too is to encourage more self-care…it's not really addressing the vulnerable but it is empowering the individual to take responsibility for their care.* (NPM1)

NPM3, in addressing other health-related policies, also raised the need to have services in the right locations. In addition, there were concerns about the manner in which health care was offered to individuals:

> *For example, our elderly, they sometimes would not be able to access care simply because...caregivers are not in place to assist them with accessing care...We have adolescents who feel uncomfortable coming into the facility with adults…How do we treat that group of persons? How do we treat people who are HIV positive? What HIV policies can be put in place that will allow for that population or any other population to want to access care. When people come into the system, they* [should] *feel that they are welcome...that they are there because they need care. And they* [should] *feel confident in the health care provider that they are going to*

> *give them the best of service, regardless of the fact that they are not paying directly out of their pockets for it.*

Some areas of concern raised by regional policymakers included the 40 hour work week policy, the roles of some health personnel, inadequate diagnostic facilities such as MRI, and the manner in which A&E services were utilised and offered:

> *Well, we could look at...no direct entry to your A&Es without it being a genuine emergency, so you'd have to go through primary care, but of course would include significant improvement in the primary care infrastructure; we could look at the role of Family NPs in delivering care and how they could work in places like Accident and Emergency; we could look at things like nurse triage; things to make the job easier; you could review the role of pharmacy technicians to see how they can even provide a better role; nurses could look at the role of their ward assistants in doing some checks.* [I] *mean, really looking at job enlargement. Sometimes we tend to sort of embrace some activities, not realising that we can empower people to do other things to make our work easier and to make the patient experience better.* (RPM2)

Policymakers' overall impression of the policy change. In reporting their impressions of the user fees policy, policymakers were generally of the view that the policy had resulted in improved access to health services. In addition, the change was considered worthwhile in meeting the needs of the nation's people, and equitable in that receiving care was no longer dependent on people's ability to pay. Policymakers, however, considered that a number of systems were required to ensure efficiency and sustainability. The policy was also viewed as a conduit to establishing public/private partnerships to improve efficiency and service delivery in the public health system. Although the impression of the policy was favourable, policymakers identified service and administrative areas that could further improve access to health services:

> *The community health system has to be improved...it mightn't be always that the patient can come for varying number of reasons, so there must be a system in place whether community health aides or until we have the doctors and nurses on hand to visit and follow up.* (NPM2)

> *I believe we are a little slow in ensuring that the parallel systems are put in place so that the policy can run efficiently. I'm not so convinced that it is an absolute lack of financial resources why we are not doing better.* (NPM3)

In conclusion, RPM2 noted that, *"The policy change has helped to improve access but it has also opened our eyes to the need to invest heavily in capital improvement, staff development and* […] *quality assurance and monitoring of our health system*."

National statistics obtained from the MOH and RHA Annual Reports, as well as documents provided by personnel from the MOH, are presented in the next section.

6.3. Official statistics from Document Review

This section addresses the utilisation patterns of the public health system, key health indicators such as infant and maternal mortality rates, death rates and prevalent health conditions such as hypertension, diabetes mellitus and asthma in 2006, one year prior to the abolition of user fees for children under 18 years, and in 2009, one year after the general abolition of user fees for the remainder of the population (Table 12). To fully understand how people utilised the public health system, it is necessary to present the data on the population for Jamaica generally, as well as for each RHA. In 2009, the population was 2,698,810, which reflects a 1.1% growth compared with that of 2006.

Utilisation of the public health system 2006-2009. Findings from the data provided revealed that, one year after the abolition of user fees, utilisation of public health facilities had increased. This was reflected in the number of persons who were admitted to hospital for treatment or observation. Of note is that one person might have been admitted to the same facility on several occasions, with each admission counting as an individual admission. There was a 12.1% increase in hospital admissions in 2009 over 2006. During 2009, there were 175,546 admissions to public hospitals, excluding the University Hospital of the West Indies, while there were 156,538 discharges from public hospitals in 2006. SERHA, the largest RHA, had the greatest number of admissions, with 78,009.

The average time in hospital for inpatient treatment and observation was 5.4 days in 2009, a decrease from 6.4 days in 2006. The average length of stay among RHAs in 2009 ranged from a high of 5.7 days to a low of 4.6 days. Secondary care facilities experienced an increase in the number of persons utilising the outpatient department for health conditions that did necessitate admission for treatment. Total outpatient visits increased by 28.3% in 2009 when compared to 2006.

Table 12.

Utilisation patterns of the health system

Year	2006	2009					
Characteristics	MOH	MOH*	% Increase	NERHA	SRHA	WRHA	SERHA
Population	2,669,542	2,698,810	1.1	370,863	589,971	476,082	1,261,894
Hospital Admission	156,538	175,546	12.1	28,645	33,105	35,787	78,009
Length of Hospital Stay	6.4	5.4	-	4.6	5.0	5.7	5.7
Outpatient Visits	395,987	507,996	28.3	54,167	81,745	129,217	242,867
Accident and Emergency Visits	520,957	891,281	71.1	184,290	245,454	209,644	251,893
No. of Surgeries	41,069	47,608	15.9	6,757	11,588	10,124	19,139
No. on Waiting List for Surgeries	Not Available	Not Available	-	3,000	Not Available	Not Available	Not Available
Pharmacy Utilisation	682,203	1,211,915	77.6	227,653	307,541	259,367	417,354
Health Centre Visits	1,525,680	1,946,398	27.5	308,643	447,565	373,628	816,562

Sources: Ministry of Health (2007). *Annual Report 2006*. Kingston, Jamaica: Author.
Ministry of Health. (2010). *Annual Report 2009.* (Unpublished, Preliminary report). Kingston, Jamaica: Author.

- *MOH statistics are based on 2009 preliminary report. NB: Total utilisation patterns for MOH do not include University Hospital of the West Indies which is a semi-private facility.

Reports also show that in 2009, 98,201 new cases accessed outpatient services, reflecting an increase of 5.1% over 2006 which had 93,455 new cases. Although WRHA had a smaller population than SRHA, it had larger number (129,217) of outpatient visits, while NERHA had the fewest visits (n=54,167). There was also an increase in the number of individuals seeking medical attention for trauma, acute health conditions and non-urgent health conditions. The findings showed that utilisation of A&E Departments accounted for 891,281 (MOH preliminary report) of all hospital visits in 2009, an increase of 71.1% over the 2006 utilisation rate.

There was a moderate increase in the number of individuals who utilised secondary care facilities for both elective and emergency surgeries. Major, minor and day surgeries accounted for 47,608 surgeries performed in public hospitals in 2009. This reflected an increase of 15.9% over 2006, which had 41,069 surgeries. Attempts to obtain information about the number of persons on waiting lists for surgeries proved futile. Only NERHA provided data, which revealed that there were 3,000 patients on their waiting list for surgeries.

Utilisation of the pharmaceutical services in both hospitals and health centres for 2009 almost doubled the rate of 2006. The findings revealed that, in 2006, a total of 682,203 individuals were seen at pharmacies in the secondary and PHC settings, while 1,211,915 were seen in 2009, an increase of 77.6%. Equally, there were increased numbers of individuals utilising primary care facilities for services such as curative, dental, maternal and child health, family planning, and some screening tests such as papanicolaou smears. The data revealed that in 2009 there were 1,946,398 health centre visits, an increase of 27.5% over 2006.

Common health conditions presenting at health facilities. While patients received care for a range of illnesses during the period being investigated, this study focused on the use of the public health facilities for four main health conditions, namely hypertension, diabetes mellitus, asthma and malignant neoplasm, one year after the abolition of user fees. These conditions are among the leading causes of morbidity and mortality in Jamaica. The data regarding these conditions reflect the statistics for public hospital inpatients and outpatients and for health centres for the year 2009 (Table 13). The data revealed that a number of persons obtained care at hospitals or health centres for varying health conditions, among them chronic lifestyle disorders and malignant neoplasm. An important observation is that the treatment for malignant neoplasm was administered exclusively in hospitals.

In 2006 people seeking hospital care for diabetes was 2.2% of total discharges (156,538) while 25,454 accessed PHC facilities. Others sought hospital care for hypertension (1.6% of total discharges), malignant neoplasm (Inpatient: 25,330; Outpatient: 5,541) and asthma (A&E: 35,601; Outpatient: 1,511). Utilisation of PHC services for hypertension was 123,521 and asthma 9,750. Noteworthy is that, during 2009, most patients with health conditions such as diabetes mellitus, hypertension and asthma accessed care as hospital inpatients or outpatients and at PHC facilities. More patients accessed hospital outpatients' services for hypertension (167,246) and diabetes mellitus (31,186) than PHC services. NERHA, relative to other RHAs, had more (602) individuals accessing care as hospital inpatients for diabetes mellitus. SERHA, the largest RHA, had more individuals (16,026) accessing care for diabetes mellitus at PHC facilities. Equally, SERHA had more persons (68,643) accessing care for hypertension at PHC facilities, while there were approximately 47.0% fewer persons accessing care for the same health condition in SRHA and WRHA. Some patients (207) obtained care for hypertension as hospital inpatients in WRHA. Some health centre and outpatients' data were similar due to the mechanisms used by the MOH to record utilisation.

Table 13.

Types of cases seen at health facilities during 2009

Year	**2009**									
Regions	**NERHA**		**SRHA**		**WRHA**		**SERHA**		**MOH***	
Population	370,863		589,971		476,082		1,261,894		2,698,810	
Facility / **Cases**	Hospital Inpatients/ Outpatients	Health Centre	Hospital Inpatients/ Outpatients	Health Centre	Hospital Inpatients/ Outpatients	Health Centre	Hospital Inpatients/ Outpatients	Health Centre	Hospital Inpatients/ Outpatients	Health Centre
Diabetes Mellitus	602/4,769	990	584/4,913	5,790	381/5,478	5,778	552/16,026	16,026	2,119/ 31,186	28,584
Hypertension	396/28,143	6,921	270/ 36,638	36,100	207/33,822	36,128	408/68,643	68,643	1,281/ 167,246	147,792
Asthma	432/2,718	2,856	180/2,445	2,477	106/1,826	1,946	381/8,081	8,081	1,099/ 15,070	15,360
Malignant Neoplasm	511	-	471	-	293	-	798	-	2,073	-
Other	NA	60,898	NA	119,967	NA	NA	NA	NA	NA	NA

Source: Ministry of Health. (2010). *Annual Report 2009.* (Unpublished, Preliminary Report). Kingston, Jamaica: Author.

- Data obtained from the RHAs
-*Excludes cases seen at the University Hospital of the West Indies
- NA – Not Available

Of the total number of patients accessing health centre services, 8,081 accessed care for asthma in SERHA. Only WRHA reported the number of patients treated in A&E for asthma:12,007 in 2009. Nationally, more patients (15,360) accessed PHC services for asthma than hospital outpatient services (15,070). When the number of persons accessing treatment for malignant neoplasm was examined, the findings revealed that 2,073 were seen as hospital inpatients in 2009. When hospital inpatient data were compared, the findings showed that more persons received treatment for diabetes than for other health conditions.

An attempt was made to obtain data on the other health conditions that were seen in the health facilities, but this information was not forthcoming, except for two RHAs, which provided the data for health centres. NERHA reported that 60,898 persons were seen with other health conditions, while SRHA reported that 119,967 individuals with other health conditions accessed care.

Mode of referral. The process by which individuals gained entry into the public health facilities was examined to better understand the main sources of referral. The published data were minimal and included the modes of referral to A&E or Casualty departments in public hospitals. The 2006, 2007 and preliminary 2009 MOH Annual reports were utilised to calculate the referrals for 2006 and 2009. The Annual reports provided an overall total number of visits, but percentages only for each mode of referral.

Various modes of referral were adopted to facilitate access to the health services required. The modes of referral to A&E (also referred to as Casualty) included individuals referring themselves or being referred by a hospital, health centre, private doctor or other persons including the police (Table 14).

Table 14.

Modes of referral to Casualty in 2006 & 2009

				Modes of referral				
Region	Year	Total referral	2006-2009 Increase (%)	Self	Hospital	Health Centre	Private Doctor	Other (including police)
MOH	2006	661,835		88.0%	1.1%	1.8%	1.8%	7.3%
	2009	891,281	35.0	88.5%	1.1%	2.0%	1.2%	7.1%
NERHA	2006	138,157		78.5%	0.4%	0.8%	0.5%	19.8%
	2009	184,290	33.4	82.7%	0.3%	0.7%	0.3%	16.0%
SRHA	2006	178,526		92.3%	0.6%	1.5%	2.2%	3.5%
	2009	245,454	37.4	85.6%	1.7%	2.7%	1.3%	8.8%
WRHA	2006	149,773		93.0%	0.9%	1.7%	1.4%	3.0%
	2009	209,644	40.0	95.0%	0.7%	1.5%	0.9%	1.9%
SERHA	2006	195,379		86.9%	2.2%	3.0%	2.7%	5.2%
	2009	251,893	29.0	90.2%	1.5%	2.7%	2.1%	3.5%

Source: Ministry of Health (2007). *Annual Report 2006.* Kingston, Jamaica: Author.
Ministry of Health (2009). *Annual Report 2007.* Kingston, Jamaica: Author.
Ministry of Health. (2010). *Annual Report 2009.* (Unpublished, Preliminary report). Kingston, Jamaica: Author.

In 2009, there were 891,281 referrals to public health facilities, a 35.0% increase when compared to the 661,835,012 referrals in 2006. Self-referral was the main mode across all RHAs, a 0.5% increase in 2009 over 2006. Hospital referrals remained at 1.1% in 2009. SRHA had 0.9% increase. Health centre referrals increased by 0.2% with SRHA having a 1.2% increase. Conversely, private doctors referrals declined by 0.6% generally. Referral by other sources was 7.1% of total referrals when compared to 2006. When the RHAs were compared, in 2006 NERHA had 138,157 referrals (lowest) while SERHA had 195,378 (highest). The data also showed that SERHA had the highest number of referrals (251,893) in 2009. WRHA had a 40.0% increase in total referral over 2006.

Health indicators 2006 & 2009. The effect of the user fees policy on some of the main health indicators such as Infant Mortality, Maternal Mortality and the Crude Death rate are presented in Table 15. When the number of deaths of children under one year of age per 1000 live births was examined, the findings revealed that most RHAs experienced a reduction in Infant Mortality rates for 2009 generally, when compared with 2006. Infant Mortality rates in 2006 ranged from a low of 6.79 to a high of 33.6 per 1,000 live births. WRHA had the highest Infant Mortality rate in 2006 (33.6 per 1,000 live births), while NERHA had the lowest (6.79 per 1,000 live births) for the same period. In 2009 the Infant Mortality rate ranged from a low of 8.38 to a high of 31.2 per 1,000 live births. WRHA continued to have the highest Infant Mortality rate of 31.2.

Table 15.

Health indicators for 2006 & 2009

Regions	**NERHA**		**SRHA**		**WRHA**		**SERHA**		**MOH**	
Year	2006	2009	2006	2009	2006	2009	2006	2009	2006	2009
Total No. of Registered Live Births	6,014	6,432	10,694	9,834	8,313	8,515	21,641	20,451	46,662	45,672*
Infant Mortality Rate per 1,000 live births	6.79	8.38	15.80	11.09	33.60	31.20	15.34	12.72	21.70	22.57
Maternal Mortality Rate per 100,000 live births	53.80	35.90	103.50	117.40	67.80	13.00	19.70	44.10	84.70**	94.8*
Crude Death Rate per 1,000 mean population	5.10	10.87	2.10	2.30	37.00	38.00	5.48	12.72	5.69	6.48

Sources: Ministry of Health (2007). *Annual Report 2006*. Kingston, Jamaica: Author
The Statistical Institute of Jamaica. (2010). *Demographic Statistic 2009*. Kingston, Jamaica: Author
Data obtained from the MOH and RHAs
*Preliminary Data
**Estimates

Despite the Infant Mortality rate trending down for most RHAs, it is important to note that the Infant Mortality rate for NERHA was on the increase: 6.79 per 1,000 live births in 2006 and 8.38 per 1,000 live births in 2009. These rates are comparable to global trends.

When the number of maternal deaths per 100,000 live births was examined, the data showed that, while the rates were trending down in some RHAs, the converse was true for others. In 2006, the Maternal Mortality rate ranged from 19.7 to 103.5 maternal deaths per 100,000 live births. SRHA had the highest Maternal Mortality rate for both years, increasing from 103.5 in 2006 to 117.4 maternal deaths per 100,000 live births in 2009. SERHA also experienced an increase in Maternal Mortality rates, from 19.4 in 2006 to 44.1 maternal deaths per 100,000 live births in 2009. Rates were, however, trending down in NERHA, from 53.8 in 2006 to 35.9 maternal deaths per 100,000 live births in 2009. WRHA saw a major reduction in the Maternal Mortality rates, decreasing from 67.8 in 2006 to 13.0 maternal deaths per 100,000 live births in 2009. The overall Maternal Mortality rate showed improvement when compared to global trends.

The total number of deaths per 1,000 people was examined for both 2006 and 2009 to determine any change since the abolition of user fees in the public health system. The results showed that crude death rates increased in all RHAs. In 2006, the rates ranged from 2.1 to 37.0 deaths per 1,000 mean population. SRHA had the lowest Crude Death rate in 2006, whereas WRHA had the highest at 37.0 deaths per 1,000 mean population. In 2009, the Crude Death rate ranged from a low of 2.3 to 38.8 deaths per 1,000 mean population. The crude death rates for NERHA and SERHA increased exponentially in 2009. NERHA recorded an increase in Crude Death rate of 5.10 in 2006 to 10.87 deaths per 1000 mean population in 2009, and SERHA’s rate increased from 5.48 in 2006 to 12.72 deaths per 1000 mean population in 2009 (Table 26). The increase in the other two RHAs was marginal. Crude death rates were consistent with global trends.

While it is apparent that changes in health indicators have occurred since the policy change, and that the user fees policy may have exacerbated the conditions influencing health indicators, these changes cannot be exclusively attributed to the policy.

6.4. User results

This section presents data obtained from the survey of 200 patients who used the public health system. Table 16 shows the sample distribution across the RHAs and facilities for the survey used in this study. Due to the number and size of tables, some findings are presented as narrative only with further details available as appendices. Additionally, the focus is on the statistically significant differences among variables.

Table 16.

Facilities used for patient survey

RHA	Facility	Type	No. of respondents	Total
NERHA	St. Ann's Bay Hospital	C	10	**40**
	Port Antonio Hospital	B	10	
	Highgate Health Centre	3	10	
	St. Ann's Bay Health Centre	4	10	
SRHA	Mandeville Hospital	B	20	**60**
	Lionel Town Hospital	C	10	
	Maggoty Health Centre	3	10	
	May Pen Health Centre	4	20	
WRHA	Cornwall Regional Hospital	A	10	**40**
	Noel Holmes Hospital	C	10	
	Wakefield Health Centre	3	10	
	Savanna-la-mar Health Centre	4	10	
SERHA	Kingston Public Hospital	A	20	**60**
	Princess Margaret Hospital	C	10	
	Linstead Health Centre	3	10	
	Comprehensive Health Centre	5	20	
Total				**200**

Biographical data. Biographical data for the respondents are presented in Table 17. The respondents were all Jamaicans and all had been born in Jamaica. Respondents generally accessed care within the boundaries of their RHAs. They were mostly (87/43.7%) in the age group 30-49 years (Figure 11). The mean age was 46.7±SD 16.6 years. Females accounted for the larger (68/34.0%) proportion in this age group. More (15/7.5%) respondents in the 65+ age group accessed care in SRHA. The majority (155/77.5%) were females. Males (6/3.0%) accounted for the lowest number of respondents in WRHA.

When marital status was examined, the findings revealed that two fifths (40.2%) of the respondents were single and 44 (22.1%) were married. Of those who were married, the majority (n=29) were women. Thirty-eight (19.1%) were living in common-law relationships. Nearly all respondents (193/96.5%) reported completing some form of education while only seven (3.5%) reported having had no education. Six of the respondents with no education were males. Of the 193 who had completed education, 13(6.5%) had completed tertiary education. Four (2.0%) people were currently studying. Of note is that 35(58.4%) of the respondents from SERHA had no or only primary education.

Table 17.

Biographic data for the respondents who completed the survey by RHA

Characteristics	**NERHA n=40*(%)***	**SRHA n=60*(%)***	**WRHA n=40*(%)***	**SERHA n=60*(%)***	**Total N*(%)***
Gender					
Female	27*(67.5)*	46*(76.7)*	34*(85.0)*	48*(80.0)*	155*(77.5)*
Male	13*(32.5)*	14 *(23.3)*	6*(15.0)*	12*(20.0)*	45*(22.5)*
Marital status					
Married	9*(22.5)*	15*(25.0)*	10*(25.6)*	10*(16.7)*	44*(22.1)*
Common-law	4*(10.0)*	14*(23.3)*	5*(12.8)*	15*(25.0)*	38*(19.1)*
Single	23*(57.5)*	17*(28.3)*	17*(43.6)*	23*(38.3)*	80*(40.2)*
Widowed	1*(2.5)*	7*(11.7)*	4*(10.3)*	5*(8.3)*	17*(8.5)*
Divorced	1*(2.5)*	1*(1.7)*	1*(2.6)*	3*(5.0)*	6*(3.0)*
Other	2*(5.0)*	6*(10.0)*	2*(5.1)*	4*(6.7)*	14*(7.0)*
Missing			1		1
Education					
None	2*(5.0)*	3*(5.0)*	1*(2.5)*	1*(1.7)*	7*(3.5)*
Primary	12*(30.0)*	26*(43.3)*	14*(35.0)*	34*(56.7)*	86*(43.0)*
Secondary	25*(62.5)*	25*(41.7)*	20*(50.0)*	24*(40.0)*	94*(47.0)*
Tertiary	1*(2.5)*	6*(10.0)*	5*(12.5)*	1*(1.7)*	13*(6.5)*
Current Study	2*(5.0)*	1*(1.7)*	1*(2.5)*	0*(0.0)*	4*(2.0)*

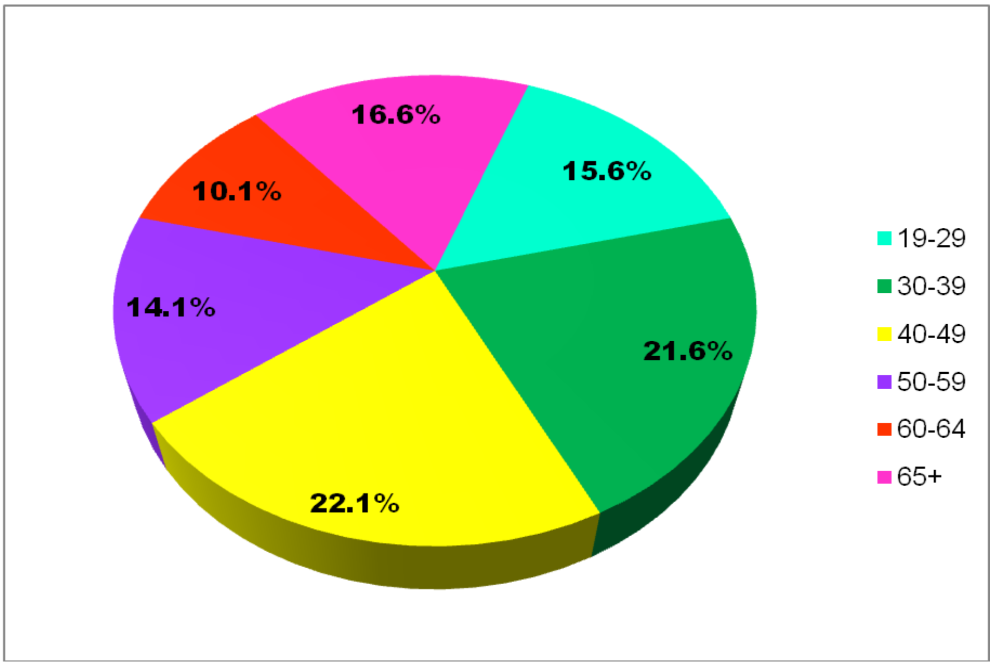


Figure 11. Age of respondents

Household composition and standard of living. It was clear from the data that respondents had varying household sizes and different standards of living (Table 18). The majority (162/81.0%) of households had 1-3 adults while (159/80.0%) had between 1-3 children. The maximum number of children living in a household was nine.

Table 18.

Household composition and standard of living of the respondents by RHA

Characteristics	**NERHA n=40*(%)***	**SRHA n=60*(%)***	**WRHA n=40*(%)***	**SERHA n=60*(%)***	**Total N*(%)***
Number of adults in household					
1-3	36(*90.0*)	41(*68.3*)	33(*82.5*)	52(*86.7*)	162(*81.0*)
4-6	3(*7.5*)	17(*28.3*)	6(*15.0*)	7(*11.7*)	33(*16.5*)
7-9	1(*2.5*)	1(*1.7*)	1(*2.5*)	1(*1.7*)	4(*2.0*)
10+	0(*0.0*)	1(*1.7*)	0(*0.0*)	0(*0.0*)	1(*0.5*)
Number of children in household					
1-3	30(*75.0*)	47(*78.3*)	33(*82.5*)	49(*81.7*)	159(*79.5*)
4-6	9(*22.5*)	11(*18.3*)	6(*15.0*)	10(*16.7*)	36(*18.0*)
7-9	1(*2.5*)	2(*3.3*)	1(*2.5*)	1(*1.7*)	5(*2.5*)
Total number of persons in each household					
1-3	17(*42.5*)	17(*28.3*)	16(*40.0*)	25(*41.7*)	75(*37.5*)
4-6	16(*40.0*)	29(*48.3*)	16(*40.0*)	27(*45.0*)	88(*44.0*)
7-9	5(*12.5*)	12(*20.0*)	6(*15.0*)	7(*11.7*)	30(*15.0*)
10+	2(*5.0*)	2(*3.3*)	2(*5.0*)	1(*1.7*)	7(*3.5*)
Breadwinner in each household*					
Self	27(*69.2*)	35(*59.3*)	24(*64.9*)	38(*64.4*)	124(*63.9*)
Parents	7(*17.9*)	4(*6.8*)	3(*8.1*)	1(*1.7*)	15(*7.7*)
Spouse	8(*20.5*)	15(*25.4*)	9(*24.3*)	16(*27.1*)	48(*24.7*)
Children	2(*5.1*)	3(*5.1*)	3(*8.1*)	8(*13.6*)	16(*8.2*)
Other	4(*10.3*)	6(*10.2*)	3(*8.1*)	6(*10.2*)	19(*9.8*)
Missing	1	1	3	1	6
Home ownership					
Owned	21(*52.5*)	27(*45.0*)	21(*52.5*)	23(*38.3*)	*92(46.0)*
Rented/leased	7(*17.5*)	13(*21.7*)	5(*12.5*)	*21(35.0)*	46(*23.0*)
Rent free	12(*30.0*)	17(*28.3*)	14(*35.0*)	14(*23.3*)	57(*28.5*)
Other	0(*0.0*)	3(*5.0*)	0(*0.0*)	2(*3.3*)	5(*2.5*)
Number of bedrooms in household					
1-3	33(*82.5*)	48(*80.0*)	30(*75.0*)	54(*90.0*)	165(*82.5*)
4-6	7(*17.5*)	12(*20.0*)	10(*25.0*)	6(*10.0*)	35(*17.5*)
Standard of living of the respondents					
High	10(*25.0*)	7(*11.7*)	9(*22.5*)	5(*8.3*)	31(*15.5*)
Average	16(*40.0*)	35(*58.3*)	20(*50.0*)	29(*48.3*)	100(*50.0*)
Low	11(*27.5*)	14(*23.3*)	11(*27.5*)	26(*43.3*)	62(*31.0*)
Unsure	3(*7.5*)	4(*6.7*)	0(*0.0*)	0(*0.0*)	7(*3.5*)

*Respondents named more than one breadwinner

Most respondents (88/44.0%) reported that their household comprised 4-6 persons. While 92(46.0%) reported owning their home, 57(28.5%) reported that they were living rent free in family-owned houses. A further 46(23.0%) either rented or leased the house they were living in. While most (165/82.5%) homes had 1-3 bedroom homes, the total number of bedrooms ranged from 1-6.

When asked about the breadwinner of the house, the majority (124/63.9%) identified themselves as the breadwinner while 48(24.7%) identified their spouse (husband, partner, wife) as the breadwinner. Respondents who reported themselves as the breadwinner were largely female (88/45.4%). In some cases, respondents named more than one breadwinner. In reporting their standard of living, half (n=100) of the respondents categorised their standard of living as average and a third (62/31.0%) ranked their standard of living as low.

Nationality, income and employment status. Nearly half (98/49.0%) of the respondents earned their main income from employment, while just over an eighth (13.0%) were reliant on government benefits and a tenth (n=20) were on a pension. There were no respondents on a retirement pension in NERHA (Table 19). Income was generally low, with the majority (174/87.0%) reporting an income of under JM$200,000 before tax in the last 12 months. For those not earning a regular income, the money available for spending each month was taken into consideration. Only 31.0% (n=62) stated that their income was meeting their daily needs.

Of the respondents who were employed, 79(39.5%) were employed full time, while 23(11.5%) were employed on a part time basis. When the number of hours worked by the 23 part-timers was examined, the findings revealed that they worked between 1-24 hours per week. Some of the 17%(n=34) of respondents who were retirees were still in paid employment. Of the third (n=65) of respondents who were unemployed, 43(66.2%) were looking for a job. Only two (1.0%) respondents reported that they were self-employed and both were looking for a job. Just under a sixth (16.0%) of respondents were working as service, shop and market sales workers, while a tenth (10.0%) reported working in agriculture, forestry, fishing and craft and related trades. Only three (1.5%) were professionals.

The type of work respondents were engaged in prior to being unemployed was also examined. Of the 65 who were unemployed, the majority (n=31) identified their last work as being in the category ‘service worker, shop and market sales worker’ while 11(5.5%)

reported being in the category ‘technician and associated professionals’, while 10(5.0%) identified their last work as being in the category ‘agriculture, forestry, and fishing’.

Table 19.

Nationality, income and employment of respondents by RHA

Characteristics	**NERHA n=40*(%)***	**SRHA n=60*(%)***	**WRHA n=40*(%)***	**SERHA n=60*(%)***	**Total N*(%)***
Nationality & country of birth of respondents					
Jamaican	40*(100.0)*	60*(100.0)*	40*(100.0)*	60*(100.0)*	200*(100.0)*
Jamaica	40*(100.0)*	60*(100.0)*	40*(100.0)*	60*(100.0)*	200*(100.0)*
Main sources of income in the last 12 months**					
Employment	21(*52.5)*	29(*48.3)*	19(*47.5)*	29(*48.3)*	98*(49.0)*
Private savings	5(*12.5)*	3(*5.0)*	6(*15.0)*	2(*3.3)*	16*(8.0)*
Government benefits	3(*7.5)*	10(*16.7)*	6(*15.0)*	7(*11.7)*	26*(13.0)*
Pension	0(*0.0)*	7(*11.7)*	5(*12.5)*	8(*13.3)*	20*(10.0)*
Student allowance	1(*2.5)*	0(*0.0)*	0(*0.0)*	0(*0.0)*	*1(0.5)*
Other	13(*32.5)*	17(*28.3)*	11(*27.5)*	24(*40.0)*	65*(32.5)*
Last 12 months income before tax $					
Under 200,000	26*(65.0)*	58(*96.7*)	35(*87.5*)	55(*91.7*)	174(*87.0*)
200,001-300,000	2(*5.0)*	1(*1.7*)	3(*7.5*)	0(*0.0*)	6(*3.0*)
300,001-400,000	3(*7.5)*	0(*0.0*)	1(*2.5*)	1(*1.7*)	5(*2.5*)
400,001-500,000	1(*2.5)*	0(*0.0*)	0(*0.0*)	2(*3.3*)	3(*1.5*)
500,001 and more	3(*7.5)*	1(*1.7*)	1(*2.5*)	2(*3.3*)	8(*4.0*)
Number of respondents whose income met their daily needs					
Yes	16(*40.0*)	18(*30.0*)	17(*42.5*)	11(*18.3*)	62(*31.0*)
No	19(*47.5*)	42(*70.0*)	23(*57.5*)	48(*80.0*)	132(*66.0*)
Unsure	4(*10.0*)	0(*0.0*)	0(*0.0*)	1(*1.7*)	5(*2.5*)
Not applicable	1(*2.5*)	0(*0.0*)	0(*0.0*)	0(*0.0*)	1(*0.5*)
Employment status*					
Employed full time	15(*37.5*)	23(*38.5*)	16(*40.0*)	25(*41.7*)	79(*39.5*)
Employed part-time	7(*17.5*)	6(*10.0*)	6(*15.0*)	4(*6.7*)	23(*11.5*)
Unemployed	16(*40.0*)	14(*23.3*)	14(*35.0*)	21(*35.0*)	65(*32.5*)
Retired	1(*2.5*)	17(*28.3*)	5(*12.5*)	11(*18.3*)	34(*17.0*)
Full time student	1(*2.5*)	0(*0.0*)	0(*0.0*)	0(*0.0*)	1(*0.5*)

*Respondents named more than one main source of income and employment status

Health status of respondents. Respondents’ rating of their current health status compared to two years ago showed that almost three quarters (73.0%) felt that their current health status was much better; a fifth (20.0%) felt there was no change, and only 14(7.0%) rated their health as worse (Table 20). When disaggregated by health facilities, 82 of the 100 health centre patients reported better health status compared to 32 of the 100 hospital patients.

Three health centre patients felt their current health status was worse, in comparison to 11 hospital patients. Generally, most (142/71.0%) respondents rated their general health status as good. Fifteen health centre patients and a quarter of the hospital patients reported no change in their current health status. The two way ANOVA test for variance on respondents' current health status showed some variability across regions and facilities (F[3, 192]=3.786, *P*=0.011). Appendix 14, Table A1 provides details of respondents' health status.

Table 20.

Current health status of the respondents

Characteristics	NERHA n=40(*%*)	SRHA n=60(*%*)	WRHA n=40(*%*)	SERHA n=60(*%*)	Total N(*%*)
General health status rating					
Excellent	6(*15.0*)	11(*18.3*)	10(*25.0*)	8(*13.3*)	35(*17.5*)
Good	29(*72.5*)	42(*70.0*)	28(*70.0*)	43(*71.7*)	142(*71.0*)
Poor	5(*12.5*)	7(*11.7*)	2(*5.0*)	9(*15.0*)	23(*11.5*)
Current health status compared to two years ago					
Better	28(*70.0*)	40(*66.7*)	32(*80.0*)	46(*76.7*)	146(*73.0*)
No Change	9(*22.5*)	15(*25.0*)	5(*12.5*)	11(*18.3*)	40(*20.0*)
Worse	3(*7.5*)	5(*8.3*)	3(*7.5*)	3(*5.0*)	14(*7.0*)
Screening tests done in the last three years					
Mammogram Yes	5(*13.2*)	3(*5.0*)	8(*20.0*)	8(*13.3*)	24(*12.1*)
No	25(*65.8*)	42(*70.0*)	25(*62.5*)	41(*68.3*)	133(*67.2*)
Not Applicable	8(*21.1*)	15(*25.0*)	7(*17.5*)	11(*18.3*)	41(*20.7*)
Missing	2				2
Pap Smear Yes	15(*37.5*)	18(*30.0*)	16(*40.0*)	22(*36.7*)	71(35.5)
No	12(*30.0*)	*27(45.0)*	17(*42.5*)	27(*45.0*)	83(41.5)
Not Applicable	13(*32.5*)	15(*25.0*)	7(*17.5*)	11(*18.3*)	46(23.0)
Prostatic- Specific Antigen Yes	3(*7.5*)	6(*10.0*)	1(*2.5*)	2(*3.3*)	12(*6.0*)
No	9(*22.5*)	8(*13.3*)	6(*15.0*)	9(*15.0*)	32(*16.0*)
Not applicable	28(*70.0*)	46(*76.7*)	33(*82.5*)	49(*81.7*)	156(*78.0*)

Of the 148 females in the age group greater than 35 years who were eligible for a mammogram test, only 23 had had one. Generally, an eighth (12.0%) of the female respondents had had a mammogram while 71(35.5%) had a papanicolaou smear. Six per cent (n=12) of the eligible males had had a Prostate-specific Antigen test.

Respondents had been diagnosed with a health condition and it is apparent that their health issues were complex, because some were diagnosed with more than one condition (Table 21). For example, half (n=100) of all respondents had been told by a health practitioner that they had high blood pressure, and nearly a third (n=61) that they had diabetes mellitus. Thirty-six (18.0%) respondents had arthritis, approximately one sixth (16.5%) had high cholesterol, and 16(8.0%) had lung disease.

Access, utilisation and quality of public health services. Eighty-three (41.5%) respondents identified the public hospital as their usual place to seek health care, with a

Table 21.

*Diagnosed health conditions of respondents**

Characteristics	NERHA n=40(%)	SRHA n=60(%)	WRHA n=40(%)	SERHA n=60(%)	TOTAL N(%)
Hypertension					
Yes	15*(37.5)*	34*(56.7)*	15*(37.5)*	36*(60.0)*	100*(50.0)*
No	25*(62.5)*	26*(43.3)*	25*(62.5)*	24*(40.0)*	100*(50.0)*
Diabetes Mellitus					
Yes	8*(20.0)*	23*(38.3)*	9*(22.5)*	21*(35.0)*	61*(30.5)*
No	32*(80.0)*	37*(61.7)*	31*(77.5)*	39*(65.0)*	139*(69.5)*
Lung disease – Asthma					
Yes	4*(10.0)*	4*(6.7)*	5*(12.5)*	3*(5.0)*	16*(8.0)*
No	36*(90.0)*	56*(93.3)*	35*(87.5)*	57*(95.0)*	184*(92.0)*
Malignant Neoplasm					
Yes	0*(0.0)*	2*(3.3)*	2*(5.0)*	3*(5.0)*	7*(3.5)*
No	40*(100.0)*	58*(96.7)*	38*(95.0)*	57*(95.0)*	193*(96.5)*
Heart disease					
Yes	3*(7.5)*	4*(6.7)*	1*(2.5)*	2*(3.3)*	10*(5.0)*
No	37*(92.5)*	56*(93.3)*	39*(97.5)*	58*(96.7)*	190*(95.0)*
Stroke					
Yes	3*(7.5)*	4*(6.7)*	1*(2.5)*	2*(3.3)*	10*(5.0)*
No	37*(92.5)*	56*(93.3)*	39*(97.5)*	58*(96.7)*	190*(95.0)*
High cholesterol					
Yes	4*(10.0)*	11*(18.3)*	9*(22.5)*	9*(15.0)*	33*(16.5)*
No	36*(90.0)*	49*(81.7)*	31*(77.5)*	51*(85.0)*	167*(83.5)*
Arthritis					
Yes	4*(10.0)*	15*(25.0)*	7*(17.5)*	10*(16.7)*	36*(18.0)*
No	36*(90.0)*	45*(75.0)*	33*(82.5)*	50*(83.3)*	164*(82.0)*
Depression					
Yes	2*(5.0)*	3*(5.0)*	1*(2.5)*	0*(0.0)*	6*(3.0)*
No	38*(95.0)*	57*(95.0)*	39*(97.5)*	60*(100.0)*	194*(97.0)*
Other					
Yes	5*(16.7)*	20*(33.3)*	7*(17.5)*	13*(21.7)*	45*(23.7)*
No	25*(83.3)*	40*(66.7)*	33*(82.5)*	47*(78.3)*	145*(76.3)*
Missing	10				10

*Some respondents were diagnosed with multiple health conditions

few identifying private doctor or public health centre (Table 22). People mainly saw nurses and doctors when they visited the health facilities. All (n=40) respondents in WRHA and 95.0%(n=57) in SERHA identified the nurse as the practitioner who attended to them during their visit to the health facilities and a slightly smaller number 174(87.0%) identified the doctor. Respondents reported being seen and attended to by more than one practitioner in some instances. Even though the survey was only conducted in public health facilities, over a third (75/37.5%) said their usual provider was a private doctor or private hospital.

Table 22.

Respondents' utilisation of the health facilities by RHA

Characteristics	**NERHA n=40(*%*)**	**SRHA n=60(*%*)**	**WRHA n=40(*%*)**	**SERHA n=60(*%*)**	**Total N(*%*)**
Usual provider of health care*					
Private Doctor	17(*42.5*)	27(*45.0*)	18(*45.0*)	11(*18.3*)	73(*36.5*)
Public Health Centre	15(*37.5*)	14(*23.3*)	9(*22.5*)	28(*46.7*)	66(*33.0*)
Public Hospital	19(*47.5*)	24(*40.0*)	20(*50.0*)	20(*33.3*)	83(*41.5*)
Private Hospital	0(*0.0*)	0(*0.0*)	1(*2.5*)	1(*1.7*)	2(*1.0*)
Other	1(*2.5*)	1(*1.7*)	2(*5.0*)	0(*0.0*)	4(*2.0*)
Practitioner attending to respondents at health facilities*					
Doctor	30(*75.0*)	52(*86.7*)	34(*85.0*)	58(*96.7*)	174(*87.0*)
Nurse	32(*80.0*)	54(*90.0*)	40(*100.0*)	57(*95.0*)	183(*91.5*)
Other practitioners	10(*25.0*)	8(*13.3*)	8(*20.0*)	4(*6.7*)	30(*15.0*)
Quality of care					
Excellent	6(*15.0*)	17(*28.8*)	7(*17.5*)	16(*26.7*)	46(*23.1*)
Good	21(*52.5*)	24(*40.7*)	18(*45.0*)	26(*43.3*)	89(*44.7*)
Fair	11(*27.5*)	13(*22.0*)	13(*32.5*)	13(*21.7*)	50(*25.1*)
Poor	2(*5.0*)	5(*8.5*)	2(*5.0*)	5(*8.3*)	14(*7.0*)
Missing		1			1
Waiting time at health facilities					
≤ 3 hours	31(*77.5*)	39(*65.0*)	32(*80.0*)	24(*40.0*)	126(*63.0*)
4-6 hours	5(*12.5*)	17(*28.3*)	7(*17.5*)	33(*55.0*)	62(*31.0*)
7-9 hours	3(*7.5*)	3(*5.0*)	0(*0.0*)	3(*5.0*)	9(*4.5*)
10+	1(*2.5*)	1(*1.7*)	1(*2.5*)	0(*0.0*)	3(*1.5*)
Length of use of the health facilities					
≤ 2 years	13*(32.5)*	11*(18.3)*	11*(27.5)*	17*(28.3)*	52*(26.0)*
3-5 years	11*(27.5)*	17*(28.3)*	8*(20.0)*	*10(16.7)*	46*(23.0)*
6-9 years	3*(7.5)*	4*(6.7)*	1*(2.5)*	*2(3.3)*	10*(5.0)*
10+years	13*(32.5)*	28*(46.7)*	21*(52.5)*	32(53.3)	94 (47.0)
Ability to access care on weekends, public holidays and at nights					
Easy	14(*35.0*)	12(*20.3*)	13(*32.5*)	10(*16.7*)	49(*24.6*)
Difficult	6(*15.0*)	9(*15.3*)	5(*12.5*)	8(*13.3*)	28(*14.1*)
Not applicable	20(*50.0*)	38(*64.4*)	22(*55.0*)	42(*70.0*)	122(*61.3*)
Missing		1			1
Telephone access					
Yes	18(*45.0*)	28(*46.7*)	23(*57.5*)	39(*65.0*)	108(*54.0*)
No	4(*10.0*)	1(*1.7*)	0(0.0)	5(*8.3*)	10(*5.0*)
Unsure	18(*45.0*)	31(*51.7*)	17(*42.5*)	16(*26.7*)	82(*41.0*)
Helpline access					
Yes	6(*15.0*)	5(*8.3*)	1(*2.5*)	5(*8.3*)	17(*8.5*)
No	3(*7.5*)	2(*3.3*)	7(*17.5*)	2(*3.3*)	14(*7.0*)
Unsure	31(*77.5*)	53(*88.3*)	32(*80.0*)	53(*88.3*)	169(*84.5*)

* Some respondents reported more than one usual provider and practitioner of care

Respondents had three main reasons for preferring a particular health facility: ease of access (96/48.0%), affordability (93/46.5%), and better treatment (32/16.0%). Appendix 14, Table A2 provides more details on reasons for choice of alternate facilities. In general, however, there was a variety of reasons for visiting particular health facilities. Reasons included check-ups (125/62.5%), maternal and child health services (19/9.5%), and medication (16/8.0%). Twenty-four respondents gave more than one reason for being at the health facility at the time of the survey. Details on reasons for visiting a health facility are in Appendix 14, Table A3.

Respondents' rating of the quality of care they had received since the policy change was largely positive (Table 22). Eighty-nine (44.7%) rated the quality of care as good, while 46 (23.1%) rated it as excellent, and 64 (32.1%) rated it as fair or poor. When disaggregated by facilities, (37.0%) hospital (n=100) and (52.5%) health centre (n=99) respondents rated the quality of care as good. While respondents rated the quality of care as good generally, an equal number of hospital-based (23.0%) and (23.2%) health centre-based respondents rated it as excellent, those rating the quality of care as fair were hospitals (31.0%) and health centres (19.2%). Nine hospital patients rated the quality as poor. A two way ANOVA test for variance across the regions and facilities on respondents' perception of quality care since the abolition of user fees showed no significant variability (F[3, 191]= 0.011, *P*=0.998). Appendix 14, Table A1 provides more details on respondents' rating of quality care.

When asked about the time taken to obtain care at the health facilities, respondents reported that waiting time ranged from nine minutes to 12 hours. The majority (170/85.0%), however, reported having to wait for between 1-6 hours. Of these, 108(54.0%) waited between 1-3 hours, while 62(31.0%) waited for up to 6 hours for care (Table 22). Eighty per cent of people in WRHA and 77.5% in NERHA waited ≤ 3 hours to be seen, while 40.0% of people in SERHA had similar waiting times. Although the variability was not significant, 64.0% of people using health centres waited ≤ 3 hours in comparison to 62.0% using hospitals. Mean waiting time was 3.1 hours. More details on waiting time can be seen in Appendix 14, Table A1.

Respondents had been receiving care at the particular health facility for ≤ 2 years up to 64 years. Ninety-four (47.0%) had used the facility for more than 10 years, while 52(26.0%) had used the facility for up to two years. More people in SERHA (53.3%) and in WRHA (52.5%) had used the health facilities for 10 years and more. Length of use did not show much variability by hospital (49.0%) or health centre (45.0%). Mean length of use of facility was 12.3 years. Forty-nine (24.6%) of the respondents said they found it easy to obtain care from public health facilities on weekends, on public holidays, and at night, while 28(14.1%) said they found it difficult. Fourteen respondents in NERHA found it easy to access the facilities on weekends, on public holidays, and at night, as did

12 people from SRHA (Table 22). Comparison between hospitals and health centres is not necessary for these data, because health centres were often closed during these periods unless there was an extended work week.

Respondents used other public and private facilities when they were unable to obtain care at their usual health facility. Among the facilities accessed were public hospitals (83/41.3%), private doctors (64/32.0%), and public health centres (48/24.0%). Eighteen people used other health centres in NERHA and WRHA, while 24 and 23 accessed other health centres in SRHA and SERHA respectively. When respondents were asked to state the last time they had used an alternate health facility, the times ranged from ≤ 12 months to 25+ months. Just over a third (n=138) reported that the last time they had used an alternate health facility was up to one year ago, while others reported up to two years (23/11.5%). Appendix 14, Table A4 provides more details on alternate facilities and last use. Among the reasons for choosing an alternate facility were shorter waiting times (49/24.5%), convenience (46/23.0%), for medical attention (38/19.0%), affordability (35/17.5%), better treatment (18/9.0%), health centre closed (14/7.0%), availability of services (13/6.5%), being referred (9/4.5%), and for medication (4/2.0%).

Telephone and help lines were used in some health facilities to encourage individuals to access public health services. One hundred and eight (54.0%) respondents said that it was possible to contact the health facilities by telephone, but (82/41.0%) were unsure. More respondents had access to telephones in WRHA and SERHA than in the other RHAs. Most (169/84.5%) respondents were unsure about helpline access, with only 17(8.5%) saying there was a helpline. Of these, 11 completed the survey in a hospital and six in a health centre (Table 22).

Respondents' rating of the health services they had received since the policy change indicated mixed experiences on variables such as access and overall satisfaction. Just over half (52.8%) rated access as excellent or good. Two regions (NERHA, SERHA) had higher proportions of respondents saying access was poor (Table 23). When disaggregated by facilities, approximately half of the health centre-based (53.0%) and the hospital-based respondents (52.0%) said access was excellent or good. Seventeen hospital-based patients indicated that access was poor in comparison to 13 health centre-based patients. A two way ANOVA test for variance across the regions and facilities on respondents' perception of access to health services since the abolition of user fees showed no significant variability (F[3, 191]= 0.887, *P*=0.449). Appendix 14, Table A1 provides more details on respondents' rating of access.

Table 23.

Respondents' perceptions of the service they received from the public health system

Characteristics	**NERHA n=40(*%*)**	**SRHA n=60(*%*)**	**WRHA n=40(*%*)**	**SERHA n=60(*%*)**	**Total N(*%*)**
Access to health services					
Excellent	7(*17.5*)	9(*15.3*)	5(*12.5*)	7(*11.7*)	28(*14.1*)
Good	12(*30.0*)	23(*38.9*)	18(*45.0*)	24(*40.0*)	77(*38.7*)
Fair	14(*35.0*)	21(*35.6*)	13(*32.5*)	16(*26.7*)	64(*32.2*)
Poor	7(*17.5*)	6(*10.2*)	4(*10.0*)	13(*21.7*)	30(*15.1*)
Missing		1			1
Respondents' expectation that the health system can meet their need					
Very Satisfied/Satisfied	30(*75.0*)	51(*85.0*)	30(*75.0*)	49(*81.7*)	160(*80.0*)
Neither Satisfied/ nor Dissatisfied	4(*10.0*)	3(*5.0*)	8(*20.0*)	4(*6.7*)	19(*9.5*)
Very Dissatisfied/Dissatisfied	6(*15.0*)	6(*10.0*)	2(*5.0*)	7(*11.7*)	21(*10.5*)
Respondents' satisfaction with the services received					
Very Satisfied/Satisfied	30(*75.0*)	46(*77.9*)	29(*72.5*)	48(*80.0*)	153(*76.9*)
Neither Satisfied/ Nor Dissatisfied	6(*15.0*)	6(*10.2*)	8(*20.0*)	6(*10.0*)	26(*13.1*)
Very Dissatisfied/Dissatisfied	4(*10.0*)	7(*11.9*)	3(*7.5*)	6(*10.0*)	20(*10.1*)
Missing		1			1
Involvement in planning the health services					
Yes	14(*35.0*)	6(*10.0*)	5(*12.5*)	5(*8.3*)	30(*15.0*)
No	23(*57.5*)	52(*86.7*)	34(*85.0*)	54(*90.0*)	163(*81.5*)
Unsure	3(*7.5*)	2(*3.3*)	1(*2.5*)	1(*1.7*)	7(*3.5*)
Easy to get health care in the last two years					
Yes	32(*80.0*)	48(*81.4*)	33(*84.6*)	45(*75.0*)	158(*79.8*)
No	7(*17.5*)	11(*18.6*)	6(*15.4*)	14(*23.3*)	38(*19.2*)
Unsure	1(*2.5*)	0(*0.0*)	0(*0.0*)	1(*1.7*)	2(*1.0*)
Missing		1	1		2
Respondents' awareness of free health care					
Yes	39(*97.5*)	58(*98.3*)	40(*100.0*)	60(*100.0*)	197(*98.9*)
No	1(*2.5*)	1(*1.7*)	0(*0.0*)	0(*0.0*)	2(*1.0*)
Missing		1			1
Distance travelled to the nearest health facility					
0-5 miles	23(*57.5*)	50(*83.3*)	30(*75.0*)	53(*88.3*)	156(*78.0*)
6-10 miles	6(*15.0*)	8(*13.3*)	4(*10.0*)	6(*10.0*)	24(*12.0*)
11-15 miles	6(*15.0*)	1(*1.7*)	3(*7.5*)	0(*0.0*)	10(*5.0*)
16+ miles	5(*12.5*)	1(*1.7*)	3(*7.5*)	1(*1.7*)	10(*5.0*)

Approximately three quarters (n=153) of the respondents were very satisfied or satisfied with the services provided. One tenth were neither satisfied nor dissatisfied and the remainder were dissatisfied. Over a third of hospital-based and two fifths of health centre-based respondents were either very satisfied or satisfied with the services provided. Two fifths of the respondents in SERHA and about one third in other RHAs were either very satisfied or satisfied. A two way ANOVA test for variance across the regions and facilities on respondents' level of satisfaction with the services provided since the abolition of user fees showed no significant differences (F[3, 191]=1.251, *P*=0.293). Scores for this level of satisfaction were combined to reflect very satisfied and satisfied as 'satisfied' and very dissatisfied and dissatisfied as 'dissatisfied'. Appendix 14, Table A1 provides additional details on respondents' rating of level of satisfaction.

In response to the question regarding their expectations of the health system, over three quarters of the respondents stated that they expected quality service; 35(17.5%) expected friendly staff, and just under a seventh (14.0%) expected adequate resources, while others had no expectations. Fifty-eight people in SERHA and 54 in SRHA expected quality service from a health facility, in comparison to 39 in WRHA and 32 in NERHA. Ninety-two respondents in hospitals and 91 in health centres expected quality service from the health facilities. Appendix 14, Table A5 provides more details on respondents' expectations of the health system. One hundred and sixty (80.0%) respondents were satisfied their expectations of the health facilities had been met, while just over a tenth (10.5%) were dissatisfied. Scores for this variable were combined to reflect very satisfied and satisfied as 'satisfied' and very dissatisfied and dissatisfied as 'dissatisfied'.

Being involved in planning is important in order to make health care more acceptable and accessible. The majority (96.5%) of respondents believed that users should be involved in the planning of the health services. They also identified ways in which they could be involved, including talking to and asking questions of health care professionals (63.0%), attending meetings and seminars (19.5%), having suggestion boxes at the facilities (6.0%) and undertaking surveys (3.0%).

On the contrary, a few (3.5%) felt that patients should not be involved in the planning of health services. Appendix 14, Table A6 provides additional responses on patient involvement. Approximately a third (32.0%) of respondents felt that patients' involvement in the planning of health services was happening in the public health system; just over a quarter (27.5%) felt it was not happening, and others were unsure. Appendix 14, Table A7 provides more details. While 30(15.0%) respondents reported having been involved in the planning of the health services offered to them, most (81.5%) said they were not involved, and others were unsure of their involvement.

To access public health services, respondents travelled varying distances (Table 23). Generally, respondents travelled between 0.25 and 40 miles to the nearest health facility. One hundred and fifty-six (78.0%) respondents travelled between 0-5 miles to the nearest health facility of their choice. More respondents in SRHA and SERHA travelled up to 5 miles to the health facility of choice. It is important to point out that this facility was not necessarily the nearest facility to the respondents' home.

The majority of respondents (158/79.8%) reported that they had found it easy to access health care in the last two years, with the remainder saying access had not been easy. Furthermore, the survey ascertained respondents' knowledge regarding free health care. Most (197/98.9%) were aware of the free health care but only a few (15/7.5%) were aware of all the services that could be accessed freely. Sixteen per cent (n=32) of the respondents were able to identify four free services, while 65(32.5%) identified three free services. Twenty six per cent identified two free services and 12(6.0%) were aware that only some drugs could be accessed free. Twenty eight people in SRHA and 25 in SERHA were aware of 2-4 free services, generally in health centres (n=83) and hospitals (n=66) were aware (Table 24).

In talking about their experiences, fewer than half the respondents reported not having had problems with the public health services since the policy change. For others, problems encountered included long waiting times (61/30.5%), drug unavailability (60/30.0%), negative attitudes of health personnel (16/8.0%), slow response times (7/3.5%), limited resources (5/2.5%), overcrowding (5/2.5%), problems retrieving dockets (4/2.0%) and the aesthetics of the environment (2/1.0%) (Figure 12). Appendix 14, Table A8 provides more details on the problems respondents encountered.

In reflecting on their observations since the abolition of user fees, respondents reported that they had observed more people using the health system (164/82.0%), free health care helping those who could not afford it (40/20.0%), good service (25/12.5%), poor service (22/11.0%), and positive staff attitudes (2/1.0%). Other changes reported included health practitioners working faster (8/4.0%), shortage of resources (9/4.5%) and abuse of the system by users (4/2.0%). Six (3.0%) respondents reported not having observed any change in the health system. Additional results regarding changes in the health system are provided in Appendix 14. Table A9. Some respondents (80/40.0%) stated they were now using the system more, others (22/11.0%) were using it less, but most (97/48.5%) said their usage was unchanged. One (0.5%) respondent reported using the system for the first time. Appendix 14, Table A10 provides more results on changes in people's use of the health system.

Table 24.

Respondents' knowledge of free services

	Health Centre				
No. of services identified	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
1	2*(10.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	2*(2.0)*
2	6*(30.0))*	10*(33.3)*	2*(10.0)*	15*(50.0)*	33*(33.0)*
3	6*(30.0)*	15*(50.0)*	6*(30.0)*	10*(33.3)*	37*(37.0)*
4	3*(15.0)*	3*(10.0)*	7*(35.0)*	0*(0.0)*	13*(13.0)*
5	1*(5.0)*	0*(0.0)*	0*(0.0)*	1*(3.3)*	2*(2.0)*
6	0*(0.0)*	0*(0.0)*	1*(5.0)*	0*(0.0)*	1*(1.0)*
7	0*(0.0)*	0*(0.0)*	1*(5.0)*	0*(0.0)*	1*(1.0)*
All	0*(0.0)*	2*(6.7)*	2*(10.0)*	4*(13.3)*	8*(8.0)*
Not sure	1*(5.0)*	0*(0.0)*	0*(0.0)*	5*(16.7)*	5*(5.0)*
KSDKS*	1*(5.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
KTISDrugs**	1*(5.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
	Hospital				
No. of services identified	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
1	4*(20.0)*	2*(6.7)*	0*(0.0)*	1*(3.3)*	7*(7.0)*
2	0*(0.0)*	6*(20.0)*	5*(25.0)*	8*(26.7)*	19*(19.0)*
3	9*(45.0)*	8*(26.7)*	6*(30.0)*	5*(16.7)*	28*(28.0)*
4	1*(5.0)*	*8(26.7)*	3*(15.0)*	7*(23.3)*	19*(19.0)*
5	1*(5.0)*	2*(6.7)*	4*(20.0)*	6*(20.0)*	13*(13.0)*
6	0*(0.0)*	2*(6.7)*	0*(0.0)*	0*(0.0)*	2*(2.0)*
7	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(3.3)*	1*(1.0)*
All	1*(5.0)*	2*(6.7)*	2*(10.0)*	2*(6.7)*	7*(7.0)*
Not sure	4*(20.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	4*(4.0)*
KSDKS	0*(0.0)*	1*(3.3)*	0*(0.0)*	9*(30.0)*	10*(10.0)*
KTISDrugs	0*(0.0)*	1*(3.3)*	0*(0.0)*	7*(23.3)*	8*(8.0)*

*KSDKS – Know only some free services

**KTISDrugs – Know that only some drugs are free

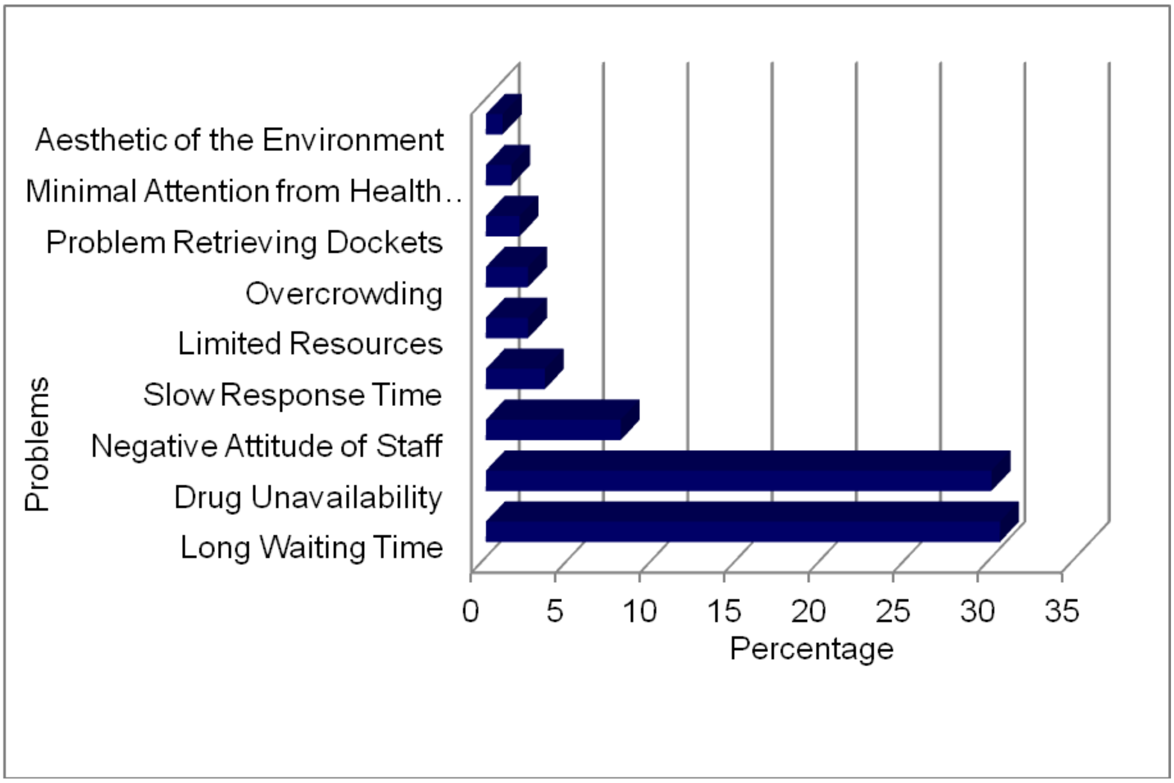


Figure 12. Problems encountered by respondents while accessing care

Access to drugs and alternative treatment. One hundred and ninety (95.5%) respondents had received prescriptions from government pharmacies in the 12 months preceding the survey (Table 25). In response to the question regarding problems encountered the last time they had tried to fill a prescription, nearly one third (61/30.5%) reported no problems. The problems encountered by others at the pharmacy included long waiting times (92/46.0%), drug unavailability (50/25.0%), having to pay for some drugs (18/9.0%), overcrowding (16/8.0%), receiving only some of the prescribed drugs (12/6.0%), and the negative attitude of some pharmacists (3/1.5%). Appendix 14, Table A11 provides additional details on problems encountered when utilising pharmacies.

When drugs were unavailable at the government pharmacy, the majority (176/88.0%) of respondents obtained them from private pharmacies, while a few (32/16.0%) reported doing without the prescribed drugs. Two per cent (n=4) delayed purchasing until the drugs were available at the government pharmacy, and an even smaller number (3/1.5%) obtained the drugs from other public health facilities. Appendix 14, Table A12 provides more details on alternatives adopted when drugs were unavailable.

Table 25.

Respondents who received a prescription and use of alternative medicine

Characteristics	**NERHA n=40*(%)***	**SRHA n=60*(%)***	**WRHA n=40*(%)***	**SERHA n=60*(%)***	**Total N*(%)***
Prescription in the last 12 months					
Yes	36(*90.0)*	56(*94.9)*	39(*97.5)*	59(*98.3)*	190(*95.5*)
No	4(*10.0)*	3(*5.1)*	1(*2.5)*	1(*1.7)*	9(*4.5*)
Missing		1			1
Use of alternate treatment when a health professional was not seen*					
Home remedies	25(*62.5)*	30(*50.0)*	22(*55.0)*	29(*48.3)*	106(*53.0*)
Self-treatment	10(*25.0)*	18(*30.0)*	10(*25.0)*	23(*38.3)*	61(*30.5*)
Herbalist	2(*5.0)*	0(*0.0)*	0(*0.0)*	4(*6.7)*	6(*3.0*)
Traditional healers	1(*2.5)*	0(*0.0)*	0(*0.0)*	1(*1.7)*	2(*1.0*)
Other	5(*12.5)*	2(*3.3)*	1(*2.5)*	0(*0.0)*	8(*4.0*)
None	9*(22.5)*	21(*35.0*)	11(*27.5*)	19(*31.7)*	60(*30.0*)
Remedies used for health conditions in the last two years*					
Home remedies	25(*62.5)*	33(*55.0*)	26(*65.0*)	32(*53.3)*	116(*58.0*)
Herbalist	6(*15.0)*	1(*1.7)*	2(*5.0)*	3(*5.0)*	12(*6.0*)
Spiritual healers	3(*7.5)*	3(*5.0)*	0(*0.0)*	3(*5.0)*	9(*4.5*)
Traditional healers	1(*2.5)*	1(*1.7)*	0(*0.0)*	1(*1.7)*	3(*1.5*)
Other	4(*10.0)*	0(*0.0)*	1(*2.5)*	1(*1.7)*	6(*3.0*)
None	10(*25.0*)	27(*45.0*)	13(*32.5*)	26(*43.3*)	76(*38.0*)
Respondents who saw a health professional while using other remedies					
Yes	10(*25.0)*	18(*30.0)*	10(*25.0)*	16(*26.7)*	54(*27.0*)
No	19(*47.5)*	17(*28.3)*	16(*40.0)*	13(*21.7)*	65(*32.5*)
None	11(*27.5)*	25(*41.7)*	14(*35.0)*	31(*51.7)*	81(*40.5*)

*Respondents named more than one alternate treatment and remedies

When respondents did not receive care from a health professional, they utilised other available treatment options, for example, home remedies (Table 25). Just over half (53.0%) had used home remedies the last time they did not obtain care from a health professional and approximately a third (30.5%) used self-treatment. Almost half (46.7%) of the respondents in SERHA, and nearly a third (18/30.0%) in SRHA and NERHA (13/32.5%) used other alternate treatments when they did not see a health personnel. Just over a quarter (n=59) of the hospital-based and health centre-based (n=57) respondents reported using home remedies when they did not see a heath professional. Similarly, respondents used alternative treatments for health conditions such as hypertension. Most (116/58.0%) had used home remedies such as bush teas for their health condition in the past two years and a few had engaged the services of herbalists (12/6.0%) or spiritual healers (9/4.5%). Just under an eighth of respondents (n=10) in NERHA and seven in SERHA used alternate treatments for their health conditions. More (n=57) hospital-based than health centre-based (n=49) respondents used home remedies for their health conditions. A little more than a sixth of the hospital-based and approximately one fifth of the health centre-based respondents reported that they self-treated their health conditions. Just over a quarter admitted seeing a doctor or nurse while using other remedies.

Referrals, hospitalisation and appointments. Respondents were asked to report whether they had been referred to another health provider at their last visit to the facility or hospitalised for their health condition since the policy change (Table 26).

Table 26.

Respondents who were referred and hospitalised

Characteristics	NERHA n=40*(%)*	SRHA n=60*(%)*	WRHA n=40*(%)*	SERHA n=60*(%)*	Total N*(%)*
Referred on last visit to health facility					
Yes	10(25.0)	16(26.7)	8(20.0)	8(13.3)	42(21.0)
No	30(75.0)	44(73.3)	32(80.0)	52(86.7)	158(79.0)
Provider referred to					
Doctor	6(15.0)	4(6.7)	4(10.0)	5(8.3)	19(9.5)
Nurse	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
Other	4(10.0)	13(21.7)	4(10.0)	4(6.7)	25(12.5)
Not Applicable	30(75.0)	43(71.7)	32(80.0)	51(85.0)	156(78.0)
Appointment for referral					
1-14 days	1(2.5)	6(10.0)	3(7.5)	2(3.3)	12(6.0)
15-28 days	0(0.0)	0(0.0)	1(2.5)	0(0.0)	1(0.5)
29-35 days	3(7.5)	1(1.7)	0(0.0)	2(3.3)	6(3.0)
36+ days	0(0.0)	2(3.3)	0(0.0)	1(1.7)	3(1.5)
Not Applicable	36(90.0)	51(85.0)	36(90.0)	55(91.7)	178(89.0)
Hospitalisation in the last two years					
Yes	18(45.0)	16(26.7)	17(42.5)	17(28.3)	68(34.0)
No	22(55.0)	44(73.3)	23(57.5)	43(71.7)	132(66.0)
Reasons for hospitalisation*					
Child Birth	4(10.3)	26(10.0)	10(25.0)	2(3.3)	22(11.1)
Surgery	4(10.3)	2(3.3)	4(10.0)	8(13.3)	18(9.0)
High Blood Pressure	1(2.6)	2(3.3)	1(2.5)	4(6.7)	6(3.0)
Trauma/Accident	1(2.6)	2(3.3)	2(5.0)	1(1.7)	6(3.0)
Stroke	2(5.1)	1(1.7)	0(0.0)	2(3.3)	5(2.5)
Diabetes	1(2.6)	1(1.7)	0(0.0)	1(1.7)	5(2.5)
Asthma	0(0.0)	0(0.0)	0(0.0)	0(0.0)	2(1.0)
Heart Attack	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
Cancer Treatment	1(2.6)	0(0.0)	0(0.0)	1(1.7)	0(0.0)
Diagnostic Tests	0(0.0)	0(0.0)	1(2.5)	0(0.0)	1(0.5)
Other	4(10.3)	7(11.7)	1(2.5)	2(3.3)	14(7.0)
Not Applicable	23(58.9)	42(70.0)	22(55.0)	41(68.3)	128(64.3)
Missing	1				1

*Some respondents named more than one reason for admission to hospital

The majority (158/79.0%) had not received a referral at their last visit to the health facilities. Fewer than one-tenth (9.5%) who received referrals were referred to a doctor, while an eighth (12.5%) were referred to other health professionals.

Appointments for respondents who were referred ranged from one day to three months ahead. Three per cent (n=6) had a one month appointment wait. Some respondents who received referrals had more than one appointment in the 12 months preceding the survey, more than two-fifths (43.5%) reported having had a health centre appointment, and more than a quarter (28.5%) had had a blood test appointment. Thirty one (15.5%) had had a hospital medical appointment, while (23/11.5%) had had a hospital surgical appointment. In addition, 31(15.5%) had other medical procedure appointments, while just over a fifth (20.5%) had had no appointment. Appendix 14, Table A13 provides more details on appointments.

In reporting their hospitalisation status, 34.0% respondents reported having been hospitalised in the last two years. While there was more than one reason for hospitalisation, more than a tenth (11.1%) reported childbirth as the main reason. Other reasons were surgery (n=18), hypertension (n=6), trauma (n=6), and diabetes mellitus (n=5), with a tenth for other health conditions.

Modes of payment for health services. In ascertaining if respondents were paying out-of-pocket and/or able to afford health services since the abolition of user fees, 80.0% (n=160) reported having made no out-of-pocket payment the last time they sought care, while (22/11.0%) paid over JM$1000 for health services and 7.0% (n=14) paid between JM$100 and $900. Payments were made for medications (16/8.0%), doctors' visits (7/3.5%), transportation and lunch (6/3.0%), registration (5/2.5%) and other payments (5/2.5%). Appendix 14, Table A14 provides more details on payments.

Cost-related problems encountered while accessing care were mainly (103/51.5%) inability to purchase prescribed drugs. Thirty-one per cent could not afford transportation but 71(35.5%) reported having no problem in obtaining drugs. Twelve per cent (n=24) did not take all the doses of the prescribed drugs because they did not purchase the full prescription and 21(10.5%) were unable to seek health care when needed. Cost was cited as the major barrier to respondents' ability to purchase the full amount of drugs and seek health care when needed (Table 27). Of note is that some respondents identified more than one problem.

Table 27.

Respondents' perceptions regarding cost-related problems and access to the health insurance

Characteristics	**NERHA n=40(%)**	**SRHA n=60(%)**	**WRHA n=40(%)**	**SERHA n=60(%)**	**Total N(%)**
Cost-related Problems to Access Care*					
No problems	12(30.0)	19(31.7)	21(52.5)	19(31.7)	71(35.5)
Unable to seek health care when need	6(15.0)	9(15.0)	2(5.0)	4(6.7)	21(10.5)
Inability to buy prescribed drugs	21(52.5)	31(51.7)	13(32.5)	38(63.3)	103(51.5)
Did not take all doses of prescribed drugs	2(5.0)	6(10.0)	11(27.5)	5(8.3)	24(12.0)
Unable to obtain prescribed tests and treatment	4(10.0)	4(6.7)	2(5.0)	8(13.3)	18(9.0)
Did not go for follow-up care	8(20.0)	3(5.0)	7(17.5)	1(1.7)	19(9.5)
Could not afford transportation	20(50.0)	16(26.7)	8(20.0)	18(30.0)	62(31.0)
Other	1(2.5)	8(13.3)	0(0.0)	0(0.0)	9(4.5)
Use of Health Insurance					
Yes	5(12.5)	4(6.7)	8(20.0)	8(13.3)	25(12.5)
No	35(87.5)	56(93.3)	32(80.0)	52(86.7)	175(87.5)
Type of Health Insurance*					
Government	3(7.5)	3(5.0)	5(12.5)	6(10.0)	17(8.5)
Private	1(2.5)	1(1.7)	3(7.5)	2(3.3)	7(3.5)
Both	1(2.5)	0(0.0)	0(0.0)	0(0.0)	1(0.5)
None	35(87.5)	56(93.3)	32(80.0)	52(86.7)	175(87.5)
Payment of Premium for Health Insurance					
Self	1(2.6)	0(0.0)	3(7.5)	3(5.0)	7(3.5)
Family Member	0(0.0)	1(1.7)	1(2.5)	1(1.7)	5(2.5)
Employer	0(0.0)	0(0.0)	2(5.0)	2(3.3)	4(2.0)
Other	2(5.0)	3(5.0)	2(5.0)	2(3.3)	9(4.5)
Not Applicable	35(92.1)	56(93.3)	32(80.0)	52(86.7)	175(88.4)
Missing	2				2
Holders of National Health Fund Card					
Yes	9(22.5)	28(46.7)	15(37.5)	33(55.0)	85(42.5)
No	31(77.5)	32(53.3)	25(62.5)	27(45.0)	115(57.5)

**Some respondents named more than one problem encountered and more than one type of health insurance*

Most (175) respondents did not have health insurance. Of the 25 who did, the type varied: 17 were holders of government health insurance, seven belonged to private companies and one respondent reported having both government and private health insurances. In reporting who was responsible for insurance premiums, seven said they made the payments, while family members (n=5), employers (n=4) and other individuals (n=8) also assisted with payments (Table 27). Thirteen respondents in hospitals and 12 in health centres reported having health insurance.

Most respondents (115/57.5%) were not holders of the NHF card that would have entitled them to subsidised drugs (see Chapter 2). Less than a quarter of the respondents in NERHA and over half (55.0%) in SERHA were holders of the NHF Card.

6.5. Conclusion

This chapter provided an account of the findings from the multi-layered study. Themes extracted from the individual interviews and focus groups described perspectives on the user fees policy from the policymakers’ points of view. Policymakers were generally satisfied with the policy change and the increased utilisation of services by people who required the care. Official statistics from MOH, RHAs and MOH personnel highlighted some of the dynamics in the public health system regarding utilisation of services since the policy change. Although changes cannot be exclusively attributed to the policy, there were noticeable increases in the use of services such as A&E and pharmaceuticals. Referrals to Casualty increased, as well as health indicators such as Maternal Mortality rates.

Equally, the findings from the survey revealed users’ interactions with the public health system within the new policy framework. It was apparent that people were satisfied with the new policy arrangements, changes in their health status, and the quality services provided. Ironically, this was, despite long waiting times, inability to access some services such as drugs, travelling far distances, negative attitude of some staff and not being adequately involved in planning the services offered. Findings regarding the impact of the policy change on the work of main health practitioners and professional nurses will be discussed in Chapter 7. To make sense of the data for future practical and theoretical utility one needs to further interpret the findings. This will be set out in Chapter 8.

Chapter 7: Impact of the abolition of user fees on the work of main health practitioners and the professional nurse

7.1. Introduction

This section captures the main health practitioners'(doctors and pharmacists) and professional nurses' perceptions regarding the impact of the user fees policy under the following seven headings: involvement in the policy process; changes in their work since the policy change; funding and resources in the public health system; quality and effectiveness of care; contribution to improving access to health services; satisfaction with their work environment; and overall impression of the user fees policy generally. Policymakers' perspectives on the impact of the policy change on practitioners were highlighted in Chapter 6.

Data were obtained through focus groups with the three main practitioner groups in the public health system. Focus groups involved *nurses* (Registered Nurses [RN]), who were selected based on their levels of professional classification. RNs at Levels 1, 2 and 3 (ward managers) participated in the discussions. Additionally, there were focus groups with PHC Public Health Nurses (PHN) and PHC Nurse Practitioners (NP), *medical doctors* (DR) and *pharmacists*.

To maintain confidentiality, practitioners are identified by their Focus Group number (FG1-9): for example, RNFG1-2 comprised RNs assigned to hospitals; PHNFG3-4 consisted of PHNs from various PHC settings, NPFG5-6 comprised Family NPs from various PHC settings, DRFG7-8 consisted of doctors from primary and secondary care facilities, and PharmFG9 comprised a mix of pharmacists from primary and secondary care settings. In addition, due to the shortage of pharmacists in the public health system, three pharmacists from one RHA were interviewed. These pharmacists are represented as Pharm1-3 and comprised a mix of primary and secondary care pharmacists. The individual doctor, represented as DR1, was employed at a hospital (Table 28). The results are presented according to the themes extracted from the discussions with practitioners and nurses about their level of involvement with the policy process. Quotations from the focus groups and interviews are used to support each theme.

Table 28.

Practitioners focus groups and individual interviews

	Focus Groups				
Practitioners	**ID**	**No. of focus groups**	**No. of participants**	**RHA**	**Facility**
RNs	RNFG 1-2	2	14	NERHA & WRHA	Hospital
PHNs	PHNFG3-4	2	13	SRHA & SERHA	Health Centre
NPs	NPFG5-6	2	11	SRHA & SERHA	Health Centre
Doctors	DRFG7-8	2	14	SRHA & SERHA	Hospital & Health Centre
Pharmacists	Pharm9	1	6	SERHA	Mixed
Total		**9**	**58**		
	Individual Interviews				
Doctor	DR1		1	SERHA	Hospital
Pharmacists	Pharm1-3		3	SRHA	Mixed
Total			**4**		

7.2. Practitioners' and professional nurses' involvement in the policy process

Practitioners were from different RHAs and health facilities and included doctors, nurses and pharmacists. They played different roles in health service delivery. Chapter 2 provided details of the different roles for nurses. Despite having diverse profiles, practitioners held similar views in describing their roles in the policy process. Most practitioners considered the policy a political decision, and highlighted the point that the policy change was reactionary in nature, one that staff had to accept. According to PHNs, *"It was an autocratic decision that was made by the government and the policymakers and it was actually entrusted upon us and we had to fall in line, had no choice, had no say"* (PHNFG4). Medical doctors described the lack of involvement prior to the policy change: *"There was no consultation and even if there was any consultation it was minimal"* (DRFG8). Despite the policy change being described as political in nature, one practitioner admitted that, although they were not involved in the policy processes, they had been informed of the impending change.

The positions practitioners held in the health system also determined whether or not they had been invited by policymakers to be part of the discussions regarding the impending policy change:

> *I think I was invited to a meeting here at the hospital to give my perspective on the pros and cons of it and I did make that submission orally at that meeting. There was a subsequent meeting at the Ministry of Health with the Minister in which we aired our concerns. A number of pharmacists met with him and aired our concerns as to how it would have impacted*. (PharmFG9)

The hospital-based doctor also commented on the role administrators played in the policymaking process:

> *I was part of the team that led to the implementation of the policy. The policy was only passed down to myself and other administrators...well the idea...and we should find ways to implement the policy. The guidelines were given to us...what guidelines we should work with...so we took part in the implementation process and of course ongoing evaluation of the project.* (DR1)

The practitioners' role in the policy change was largely at the implementation phase and included anticipating the increase in the number of persons using the health facilities, as well as effectively managing the increased patient load. Essentially, they were expected to facilitate the process:

> *We were expected to control* [the] *crowd that was expected so we were being asked to be crowd controllers, to be facilitators of the process, people would be coming in and with the limited number of health care providers and the overwhelming clientele, then you would have some bottle-necking and as a result we were expected to cause things to run smoothly.* (PHNFG3)

The practitioners' roles also included preparing resources and systems to meet the impending demands on the system. It was clear that practitioners had minimal time to prepare. The time from the announcement of the policy in September 2007 to its implementation on April 1, 2008 was only 6-7 months. Pharm1 explained, "*After we were notified that there was a set date for the project to be implemented, then we just had to prepare our resources and have our staff ready for the implementation of the free health care."*

For some practitioners, the policy change meant a philosophical shift, especially regarding the manner in which patients were managed:

> *We had little training on how to behave to the customers, customer is always right. We* [were] *made to understand that the patients would now become the customers or the clients and we were expected to give them good service by being courteous.* (PHNFG3)

7.3. Changes in the work of the practitioners since the policy change

Practitioners generally found their work was more stressful following the policy change. The impact of the policy resulted in an exponential increase in workload, which had implications for how services were delivered and the satisfactory outcome of the policy as a whole. These changes were reported during the interviews:

> *I think in the first month we went to 100.0% of more than what we are normally doing and it has settled off to about a 60.0%, 65.0% over what we would normally do on a daily basis and it continues on the weekends. Because what we are seeing on a Saturday is what we would have normally seen during the week. What we are seeing on Sunday is what we would see on Saturday as outpatients.* (PharmFG9)

Some practitioners alluded to the increased workload, increased waiting times and changes in how surgical cases were done on a given day:

> *Workload has increased, probably 40.0-50.0%. Initially, it probably went up to about 100.0-120.0% but it has dropped back because we can only do so much and no more. For instance if the surgeon put 20 cases on the list but the work day is just eight hours, we can do only eight or ten, that's it.* (DRFG8)

The increased patient load translated into longer waiting times for patients in all facilities.

The impact extended beyond the public system. Pharmacists working in a semi-private pharmacy (these pharmacies previously dispensed subsidised drugs to public patients but were now dispensing free pharmaceuticals to all public patients as part of the policy change) where the staff complement was significantly greater than in the public facilities, reported that:

> *Our opening hours have been extended. It's now a 12 hour work day...each person does an 8 hour shift...staggered shift. We do far more prescriptions...we are seeing a lot more clients...more strenuous...more stressful.* (Pharm3)

Practitioners generally agreed that, despite the increase in patient workload, the services offered remained the same. They were, however, concerned about the move from the private sector to the public sector by some patients, which some considered an abuse of the system: *"I think they are abusing the government funds"* (DRFG7).

Impact on the work of the professional nurses. Most nurses identified there had been changes to their work since the policy implementation, which they suggested involved many challenges. An observation, however, is that references to their work were often made in terms of the impact of the policy change on the patients. Nurses in PHC talked about their work since the abolition of user fees: *"The free health care system is really putting stress on the staff...all members of staff...all categories of staff because you have to think of maintaining order in the health centre when you have a big crowd"* (PHNFG3).

Some NPs did not experience any change in workload, but others reported seeing more people. The increased workload was attributed to (a) NPs' need to conduct school medicals, which are required by all students before entry into school; (b) more middle class people utilising the public facilities, (c) private doctors referring patients to public facilities, and (d) unnecessary utilisation of health facilities by some patients.

Another change experienced by some practitioners was overcrowding in the health facilities. This could partly be due to users' lack of knowledge regarding the use of the facilities and the types of conditions for which they should seek care at the various facilities. NPs commented,

> *The work is overwhelm*[ing]. *Because of the lack of knowledge and understanding of the people, they use the clinic as a first aid centre...They come and ask you "check and see if this baby has fever for me" or "I have a toothache; can I have two Panadols!"* (NPFG6)

The increased patient load meant nurses spent less time assessing patients. This negatively affected the nurses' ability to maintain the standards required to provide quality care. However, they were also active in developing new strategies to address concerns:

> *A client might come with...what one thinks is a medical condition but on interview realises that it is more than that...one would have wanted to spend more time extricating information...to help that patient you cannot totally do that* [now]

> *because of the number that you have to deal with. The quality has deteriorated a bit because of the quantity; it's not that you are giving bad service it's just that you cannot do what you are trained to do, to deal with the total person at the particular time.* (NPFG5)

NPs could not agree on the number of patients they usually saw on a daily basis. The number varied because of factors such as the type of clinic being held and the availability of a doctor at the health centre. Of note is that NPs and doctors performed similar roles in the health centres. Moreover, some health centres were managed solely by NPs:

> *In my health centre, the patients are registered, their checks are done and the dockets are disseminated around to the doctors and the NPs...No special case...the doctors go faster than the NPs, so they see more patients. There are some health centres that are manned by the NPs alone. Where they are manned by the NPs alone, she sees the patients.* (NPFG5)

NPs spent more time assessing their patients than doctors and, as such, sometimes saw fewer patients than the doctors. Furthermore, information provided by the NPs suggested that the number of patients seen at the health centre on a particular day may just have been a percentage of the total number of persons who visited the facility for care. It would not have been uncommon for over 200 patients to show up at the health centre. However, after triaging, NPs might see an average number of 25-30 patients daily.

Commenting on the changes in number of patients and time spent with each, NPs said:

> *Where time factor is concerned…It's like you are almost being forced to go through a ritual whereas you probably have a little time to sit and maybe counsel with a patient, you really are pressed. Assessment takes so much time, when you have to assess maybe 100 patients to ensure that you work it out to maybe to be 70, 60 odd and the doctors are coming in and they complain "how many numbers did you give out this morning?" It's every day, it's not like in the past you would look forward to an easier day…once or twice in the week…And people are inconsiderate because the patient* [fusses] *if you walk out of your office, it's as if they want you to announce if you're going to the bathroom or if you are just going to catch a bite…it's not like taking a lunch break.* (NPFG6)

PHNs talked about the increased numbers of patients using the health centres. Some clinics such as antenatal and child health were spoken of as particularly challenging for PHNs, who sometimes had to see between 60 and 100 patients in a day. In secondary care, RNs' response to the increase in workload and stressful nature of their work was to adjust things to deliver nursing care.

Other RNs noted that workload had increased because of social issues. In hospital, an increase in the number of persons with social problems or terminal illnesses contributed to the increased workload. This occurred because there were sometimes no relatives to accept discharged patients and many of those who were terminally ill preferred to return to hospital to die.

> *I work on the maternity ward and cases* [like] *hyperemesis that is triggered by social issues, for example, coming in* [at] *eight weeks gestation and within a day of coming into hospital her vomiting ceases; you send her home, two days after, within 48 hours,* [she's] *coming back with the vomiting uncontrollable and within minutes of being in the hospital it resolves.* (RNFG1)

Additionally, RNs reported minor changes to the type of health conditions seen in hospital A&Es, including more trauma cases such as stab wounds and chops.

Professional nurses' perspectives on staffing numbers and working arrangements. The increased patient load created by the policy change affected staffing in the health facilities, and created challenges in achieving continuity of care:

> *I find that covering the clinics is really a painstaking thing. I think that* [the impact of] *moving an officer from one area to the next has on the whole system is that there is no continuity of care. This week one nurse is here, she builds that relationship with a client and the next week you have to take her away and as a result, every time the clientele comes* [there] *is a new staff* [member] *or the person they had built this trust with is not there that week, so they really get frustrated. They don't bother to come back, some. And even when they come, that surety, that certainty that you'll get that high standard of nursing care is just not there. It's a real greater struggle to maintain that standard. It was not like that before. It was much easier because the system was much more facilitatory.* (PHNFG3)

The policy change also meant extended work hours or shift systems. These had been introduced with the aim of accommodating the increased patient load without creating extreme pressure on the limited number of staff. However, PHNs commented on the issue:

> *We have been working on Saturdays now and we are given limited time to work with...and the amount of clients, like Saturday...they were about 400 persons for medicals and some of them came from as early as 2am to get numbers...we could only see 200 and send away the rest to come back* [the following] *Saturday.* (PHNFG3)

In addition, shift work had been introduced in health centres. Shifts, however, sometimes resulted in people having to work into the next shift, which was not sustainable:

> *They had to do like a 7-3 and a 10-6 shift and after a while it caused a problem because the nurses were complaining that they were tired...we were having the whole burnout syndrome...We had to reverse back to our 8:30-4. (PHNFG3)*

Equally, RNs in hospitals noted their observations regarding staff trying to construct duty schedules: "*When you're writing your duties...for the 7-3 shift* [it] *is the same persons working on the 2-10 shift...you have to ask them to work on...so they are overworked"* (RNFG1).

There was also a shortage of some categories of staff, making it difficult for nurses to refer patients appropriately. NPs gave an account of the challenges they encountered when trying to refer certain patients to other members of the health team:

> *Another...problem that we face also is you'll find problem and you don't know where to refer them because you don't have like a social worker...those issues...especially in that area you find problems, patients don't have this, don't have that and you don't know where to refer them. If you refer, you come against a wall...so it's a big problem for us.* (NPFG6)

The availability of various categories of staff, on the other hand, resulted in greater levels of satisfaction. Some NPs expressed satisfaction with the services being provided by staff at their health centre, "*I appreciate the fact that we have a social worker, a special clinic for the HIV/AIDS cases* [and] *a very good nutritionist and much education go on around there"* (NPFG6).

Attrition of staff. One effect of the policy change was that staff were leaving the public health institutions. Importantly, this attrition was not necessarily associated with remuneration but with the lack of supplies to work with, especially in the hospitals. The attrition of staff had serious implications for nurses who took on extra responsibilities in the absence of sufficient doctors. This movement of staff was evident across the facilities in the RHA. They gave an account of their experience, "*We cannot retain the nurses and the doctors. They come in and they are leaving like in a couple months or a year after...we are not retaining anybody"* (PHNFG3).

In hospitals, the challenge was similar. RNs from across all the RHAs gave their accounts of the existing situation:

> *I find that nowadays…sometimes it's not even the monetary part of it, why you have people leaving…like out of nursing…like going abroad but it's because of the supplies. They cannot be bothered, they have to walk up and down, they've to be begging and sometimes they have to send even to other hospitals to beg, which is ridiculous so these are some of the things that are pushing some people out of the public system.* (RNFG2)

Overseas Nurses. Due to the shortage of nurses in the public health system, nurses from other countries such as Cuba, India, Nigeria, and the Philippines were often recruited to boost numbers. However, this solution to the nursing shortage did not sufficiently relieve the situation. This was because overseas nurses often required close supervision. Local nurses reported issues with language, accents, and patient care generally. Another issue with overseas nurses was that the local nurses were unhappy overseas nurses received better remuneration packages. Additionally, the nurses felt they needed to take extra responsibility for the overseas nurses. RNs recounted the challenges they experienced while working with some overseas nurses:

> *There was this issue where the* [overseas] *nurse was going with Augmentin to give to the wrong patient. On the ward, I'm the most senior nurse, I stopped her because I saw my certificate going down the drain...I called her back instantly and said it is not time, let us just wait awhile until after breakfast.* (RNFG1)

Other RNs also agreed that working with some overseas nurses was stressful:

> *I've worked with a few of them and it just put more stress on me because you have to be watching. Even if you assign* [them] *to, say, do this, as soon as you turn...they are going to do something else. They don't know about a sterile dressing...they don't know about passing a female U. Cath* [Urinary

> Catheter]*...they don't understand...they just take up gloves, put* [them] *on and ready to go. There was a situation where one just came, took a nurse's notes from the day before and just copied everything.* (RNFG1)

Teamwork. While comments differed regarding the current rapport among team members since the policy change, it is clear that changes had taken place. Some nurses were satisfied with the level of support received from administrative staff such as CEOs while others lamented the lack of support:

> *I've worked as a FNP in another parish and we had what was known as clinicians meeting. I am yet to see that since transfer into this parish that I am. There is absolutely no clinicians' meeting and I think it is so important that you meet as clinicians because you have commonalities, you have new things in the way you manage things. The doctor does not know everything. He can learn from a practitioner, as well as the practitioner learns from him*. (NPFG5)

7.4. Practitioners' perspectives on funding and resources in the public health system

While some practitioners were not *au fait* with the budgetary allocations to the public health sector, the general view was that the health sector was underfunded and required more resources. DR1 alluded to the funding situation and the assistance to the local facility from other sources:

> *Public health facilities are underfunded. We obtain aid from a number of persons and organisations such as Scotia Bank assisting with our dialysis unit and the care of patients with scoliosis; Jamaica National* [Bank]; *Supreme Ventures; Missionaries and Food for the Poor assisting with equipment and disposables. Sometimes we have private persons who were treated here or families of private persons or even the employers of some persons who have been here and see the need and they choose to donate something.*

Others sources of funding noted were CHASE, NHF and JSIF (Jamaica Social Investment Fund) (see Chapter 2 for more details).

In contrast, Pharm3 viewed the continuation of the policy as an indication that there were adequate funds in the public health system:

> *The drug bill is a massive bill. I think the government in their wisdom must have set aside some plan for the sustenance of this programme. The fact that the programme is continuing... it is being funded. I'm not sure if the funds are being*

> *exhausted or if they are near exhaustion. We've never had to worry that we are closing down because we can't access drugs.*

Some doctors in primary care also expressed satisfaction with the resources available in the public health facilities. However, in expressing this, they noted the pressure on resources due to some patients abusing the system.

Professional nurses' perspectives on the availability and quality of resources. Nurses expressed concerns regarding the lack of resources since the policy change, which, they claimed was adding more stress to their work. In some health centres, there was a lack of stationery and paper towels for some and of equipment for others. The lack of adequate funding also affected the way nurses executed their duties, and as such they were concerned that previously "*we could go and do home visits that might be 10 miles away* [but now] *you cannot do that home visit because your mileage is cut down because of funding, it affects everything"* (NPFG5).

The policy change and decentralisation generally, meant that there was no flexibility in terms of generating additional funds from fees or setting one's own charges. PHNs talked about the difference in resources in the public health system prior to and after the abolition of user fees:

> *Prior to decentralisation we were much better. When we were handling our own cash, collecting our own fees and purchasing, we never ran out of Depo* [Depo Provera]*, we never had a problem with OCP* [Oral Contraceptive Pills] *and any of these services…and since decentralisation especially now with the free* [health care] *it's terrible.* (PHNFG3)

The lack of adequate resources to carry out their work on a daily basis forced practitioners to change the ways in which they delivered care. Some hospital-based RNs reported resorting to personal funds to administer required services to patients. "*I know nurses who personally collected funds among themselves to give proper patient care to persons they care for. On the medical ward they help to buy nutritional liquid"* (RNFG2). The ambulance service in some hospitals was also a problem. RNs noted their experience: "*We don't have any working ambulances, sometimes we only have one. We have to get one from Red Cross which* [the hospital has] *to pay*" (RNFG1). Hospitals sometimes resorted to borrowing ambulances from other facilities. Due to the shortage of working ambulances, relatives sometimes assisted with transporting patients home or between facilities.

Lack of resources also included inadequate funding to pay salaries in a timely manner; provide training for some staff such as customer services personnel and obtain adequate materials to work with. PHNs commented on the changes encountered with payment of salaries:

> *Not to mention our salaries...sometimes they are late and I think if it wasn't for the* [abolition of] *user fees they would be able to pay us some of the things on time. Sometimes they don't even tell you that they can't pay...sometimes it's at the last minute*. (PHNFG3)

The attitude of the RHAs to the late payment of salaries had a de-motivating effect on some nurses. PHNs also talked about how they had to reduce travelling, especially for home visits, due to the cut in travelling allowances.

The view that there was inequity in the allocation of resources to the various institutions also resonated with hospital-based RNs:

> *There are many things that are allocated to specialty areas that are not given to general areas. There are some hospitals that are not functioning to capacity and* [yet] *they are getting equal amount of resources and staff. There needs to be proper allocation of human and material resources.* (RNFG2)

Professional nurses' perspectives on equipment. The policy change negatively affected the manner in which care was administered. This was due mainly to the lack of requisite supplies and equipment. This lack of equipment was stressful for staff and meant they needed to develop new systems and policies:

> *Sometimes when patients come for a particular medication, you can't find any syringe to give them the injections and they do not understand. They think that you are the one that doesn't want to give it to them and you are wasting time when you do not have what to use. That is very stressful.* (RNFG2)

Expanding on this sentiment, those in RNFG1 said:

> *It* [the situation] *has changed a lot in terms of more work.* *You are not able to give the type of quality care that you ought to give because of the amount of persons that you are seeing all at once. You have to be changing up...some of the hospital policies to try and accommodate...you have to be trying new things.*

PHNs noted the deplorable state of the equipment they had to work with. For some NPs, equipment was *"adequate to a point. We have to find our own instruments to work with,"* but for others it was a concern:

> *As NPs the roles we carry need the use of some little things and some big things. Little things,* [like] *a stethoscope, a sphyg* [sphygmomanometer]*, a thermometer. Big things like the diagnostic set that has otoscope and auroscope...these are things if we cannot buy, we cannot have to use.* (NPFG5)

Additionally, malfunctioning equipment was not repaired in a timely manner. RNs highlighted the challenge in hospitals:

> *The equipment are overused, they are overworked, sometimes you can't even trust the reading that you are getting....because each time you ask for someone to service it, the artisan might just come and patch it up and you get to use it for a couple of days and then it starts malfunctioning again.* (RNFG1)

RNs also pointed out a lack of supplies and equipment to work with and their dependence on gifts:

> *We have limited resources to work with...no bed, bed without rails. We did not have overhead trolleys at each bed, defibrillators are not working, crash carts, when you pull them they stick on you,* [the] *dynamap you have to borrow,* [there is] *shortage of staff...Without gifts we don't know where we would be.* (RNFG1)

RNs were sometimes also faced with the problem of using incompatible and older gadgets. For example, RNs talked about the experience when monitoring blood glucose levels:

> *The government provides some strips for* [one] *glucometer...they stopped getting those strips and they send another machine* [that] *the strips cannot work with. You* [then] *have to wait longer time for them to purchase those. They* [also] *tell you that money is not in the budget for that at this time.* (RNFG1)

Professional nurses' views on materials and supplies. Lack of resources also meant inadequate materials and supplies in health centres and hospitals to deliver care:

> *Resources, example: condoms, we don't have pills, Depo; we have to be sending away clients. Clients are on the pill for years and they come to the clinic, you have to send* [them] *to go and purchase pills...they don't want to switch to the injection;*

> *they want to stay on the pill. These are clients who are financially unstable, what guarantee do you have that they are going to purchase pills?* (PHNFG4)

There were also problems with getting some screening tests done and difficulty in getting results. This impacted on patients' treatment, as well as how they were cared for.

> *Another problem that we've been having, since couple months ago…the VDRL results have been coming back to us not done because they don't have the reagents to test. It has been proposed that we send the clients to private labs to have it done.* (PHNFG4)

In hospitals, the stress nurses experienced was sometimes due to lack of basic resources such as syringes to administer injections. While this was stressful in itself, it was compounded by the attitude of patients who interpreted this lack of resources as nurses' reluctance to administer care:

> *It is very stressful on us. Sometimes when patients come for a particular medication, you can't find any syringe to give them the injections and they do not understand…they think that you are the one that doesn't want to give it to them and you are wasting time when you do not have what* [you need] *to use.* (RNFG2)

RNs experienced frustration due to the lack of resources and had to develop strategies to address the issues. Addressing the issues also meant loss of patient care time: "*Lack of basic sundries* [syringes, needles etc.] *has frustrated myself and a lot of my co-workers. You have to be improvising, walking, begging, and it has affected optimal patient care* (RNFG2). However, administrative support from people like the CEO had improved the situation in some hospitals.

Shortage of resources in A&E resulted in having to care for patients on stretchers on some occasions. RNs gave an account of the challenges they encountered within A&E:

> *I have a gentleman* [on] *one of those* [beds] *they used to transfer patients from a stretcher to a chopper. I have a lady who is in respiratory distress sitting up in a wheelchair; I have a 96 year gentleman who fell in his bathroom this morning and has multiple lacerations to his head, I have him sitting in a wheelchair. I have patients who require a bed and have to be sitting up…There have been instances where we have to wake patients up out of their beds…stretchers…because an emergency came in that required the stretchers…wake them and put them on a chair to sit, then you take the stretcher.* (RNFG2)

The main response to such shortages was for the nurses to feel dissatisfied. In addition, they sometimes responded by buying the supplies themselves: "*I'm very dissatisfied because of what we don't have to use. The patient* [is] *in pain and* [we have] *no injection needles. It is terrible and I don't feel good about that"* (RNFG2). Other RNs noted similar concerns:

> *We need better working conditions, enough equipment,* [and] *proper equipment to work with. Simple things like hand soap...hand towels you have to buy it for yourself or your staff pool together and buy it...Conditions need to improve.* (RNFG1)

7.5. Quality and effectiveness of care

The study also ascertained practitioners' perceptions on the quality and effectiveness of the care provided. In describing the changes in quality, one pharmacist commented, "*I think the quality of service* [has] *deteriorated. It can't be just* [the increased] *numbers we are serving. I have seen more dispensing errors under this system and I have had more complaints coming to me"* (Pharm2). Doctors shared a similar view regarding the indirect effects of the policy change:

> *The quality of care would be affected because you don't have time to explore what you need to explore with each individual patient. Because in the back of your mind, you have 40 people waiting to come...my stomach is growling and I'll soon pass out from hunger so let me just hurry up, deal with the basic issue and move on.* (DRFG7)

Seeing 100 patients in a timely manner, in A&E, for example, without compromising the quality of care was reported as being difficult. In addition to issues with assessment, there were concerns about the review of patients:

> *You have a sick patient there, you have so many to deal with and you don't get around* [to] *reviewing him in a timely manner, the patient gets into trouble. The monitoring; in terms of individuals; in terms of equipment…If you have a pulse oximeter beeping, then you can look around, but you don't even have that.* (DRFG8)

The doctor based in administration endorsed the views expressed by others on the negative effects of the policy change on the quality of care. This comment also highlighted the impact of the policy on waiting times to obtain treatment for some medical conditions and the need for practitioners to respond with more invasive treatment in the first instance in order to manage these cases:

> *In waiting a long time* [patients'] *conditions can progress to emergencies or they may even die...let's consider a patient with breast cancer…a lady who has breast cancer…you don't have to do mastectomies for all breast cancers; you can do lumpectomy and treat them with radiation* [which] *is just as good as a mastectomy. Now if I do a lumpectomy on that patient, they need to get radiation in six weeks of their surgery…the date for radiation for that patient is nine months…so what I'm doing, I'm going to expose that patient to the risk of recurrence or the spread of the disease?…I would tell that patient that it's best to have a mastectomy all the time rather than save the breast although it can be saved…and it goes for other illnesses also.* (DR1)

Professional nurses' perceptions of quality and effectiveness of care. RNs also pointed out the effect of the policy change on both human resources and their ability to offer the necessary care to patients:

> *It's more quantity than quality. Human resources* [are] *falling short. Both doctors and nurses are looking to going out. You are always in need of more human resources and the number of patients you see is not getting any less. So, you have to spread yourself thin. It's like a touch and go. You have to pay attention to the most critical. That social and psychological support that you want to offer...you see that you're not giving it...You don't have enough time, not enough energy or the resources to offer it.* (RNFG1)

The quality of care in relation to waiting times, drug availability and resources was argued as being negatively affected. Patients were frustrated when services were not available and, as such vented, their feeling on the practitioners:

> W*e try to give quality but it's not always* [possible]. *With waiting hours and with the drugs they are given prescriptions, they cannot be filled. We have lack of resources. No blood pressure machine, no infant scale. So you have to be learning to juggle weighing mother and baby then minus so it's added stress on the staff.* (PHNFG3)

Conversely, some practitioners maintained that the quality of care had improved, as evidenced by positive health outcomes and patient satisfaction:

> *Even our chronic disease patients, they know now that they don't have to pay for the blood test…So you find that we have all the things that we need to do for them. So in fact the quality of care has been improved greatly. You have patient satisfaction. Some of them are so happy that they come too often because the care has been good. Those persons who have left the private doctor to come in they would say to you, "Nurse this was happening to me for so long and nobody could find it out and thank you for sending me down for x, y and z." Therefore, you can assess from that, that the quality of care is good. The time factor is as such that we would have spent a little more time but that does not necessarily compromise what you're delivering to them. What you do, is say it a different way, in a shorter time because…there is pressure of time. I have seen the pressures* [blood pressures] *that are staying down.* (NPFG6)

7.6. Contribution to improving access to health services

Practitioners identified several areas in which they had improved access to health services. These areas included extending the work hours:

> *Because of the long waiting list we have introduced a system where we can actually extend the day of each operating session because* [the] *operating session goes from 8-4pm and we will extend the day to 10 o'clock or even operate on Saturdays for non-emergency cases, and the doctors do it without pay.* (DR1)

Equally, hospital-based doctors were improving access by procuring technologically-advanced diagnostic equipment such as a CT scanners and introducing new services such as dialysis units in some hospitals. Doctors at one PHC facility had also introduced a screening book (which documented patients' data without requiring formal registration): "*it allows you to see more patients"* (DRFG7).

Professional nurses contributions to improving access to health services.

Nurses were very pragmatic in finding solutions to cope with the increased number of patients, as well as with the impacts of the policy change generally. One such solution was the introduction of a shift system in some PHC facilities, where previously there was none. While the aim of this solution was to improve access, it also sought to ensure staff did not suffer burnout. Some PHNs adjusted their clinic schedules to accommodate patients by making home visits on the way to and from work instead of during the day. They also encouraged patients to visit other clinics when resources were short. For example, when patients did not receive Depo Provera at a Family Planning clinic they were accommodated at another clinic day when supplies were available. Another area of contribution by nurses was an increase in patient education, especially for the elderly.

Additionally, nurses assisted at, as well as independently conducted, health fairs where patients could obtain services such as blood pressure and blood glucose checks. This also reduced the number of people visiting the health facilities. At-risk patients were often identified at these fairs and referred for more advanced services if necessary: "*Most of the nurses go to church when they do have their health fair; they come and they recruit doctors and nurses. The health fair cuts down on the* [number] *of persons that would come in*" (RNFG2).

Another measure adopted by some specialist practitioners included seeing clients in PHC facilities. This helped clients by minimising the hassle of travelling to the hospital and waiting for long periods of time. Engaging in other one-off activities aimed at improving access to health care was not uncommon for practitioners. NPs collaborated with pharmacists to make more informed choices when prescribing, as well as ensuring patients could receive the medications prescribed: *"we call to find out what drugs are available before prescribing it so the patient can obtain it"* (NPFG5). Furthermore, doctors in primary care alluded to the increased use of other categories of staff to improve access. Additionally, some practitioners in hospitals developed a new patient monitoring system for discharged patients: "*We...on the ward call them at a certain time at home to make sure that they keep their appointments, find out what amount of medication they have, remind them that they need to come* [in]" (RNFG1).

Nurses' perspectives of patient profile and behaviour. Nurses in PHC reported how the people using the system had changed. For example, people with uncommon conditions were now accessing services directly from the health centres instead of being referred by other health practitioners. In addition, more males and females with conditions of the reproductive system were utilising the centres. Procedures such as removal of sutures and dressings were also on the increase, especially for patients who had had surgeries in hospital. NPs commented:

> *Some of* [those, who] *possibly before free health care would not have come to you, they are now coming from the private practitioners so it increases our clientele and some of* [those, who] *are not so urgent would have to be given another*

> *appointment or* [be] *seen another day...so it means that they might come to the health centre and not necessarily get seen that day depending on the severity of the cases.* (NPFG5)

Although the NPs could not all agree on the types of health conditions seen, some reported that, despite the increased number of patients seeking care, the types of health conditions seen remained the same. Others, however, had observed increases in the number of patients seeking care for conditions such as hypertension, diabetes and rheumatic heart disease. Nurses were also seeing more persons with social problems, more referrals from private doctors and paying institutions and more users for some family planning methods.

According to RNs, people were also presenting to the A&E with health conditions that were always not consistent with those classified as emergencies.

> *We normally have true emergencies, persons with cardiac conditions, asthmatics, motor vehicle accidents, gunshot wounds, diabetics, the regular, you might have a one and two pop-ins but since the abolition of user fees we* [are] *having persons coming in with skin rashes, persons coming in with back pain for about two years, somebody...fell... "I hit my chest when I was a child and now I find that I'm having some pain"*...[a] *30 something year old person... just come to get an x-ray... persons coming in*: *"boy, I feel like I have the flu" "What have you taken?" "I don't really take anything but that's why I come to the doctor."* (RNFG1)

While improving users' health seeking behaviour was considered part of the policy change, some NPs did not find that to be true. For example, patients were found to be non-compliant in some instances. Some users were failing to attend their appointment then later showing up unexpectedly at the health centres expecting to receive the services:

> *I find that because they hear there* [are] *extended hours, they come in any time…they come in one o'clock, two o'clock* [in the afternoon] *and no matter how many patients you have there waiting…regardless of the health worker's state, they come in* [at] *three o'clock* [in the afternoon] *they must be seen…it might be a chronic case that missed their appointment or they say "I missed last month, rain was falling or because of the State of Emergency I didn't come."* (NPFG6)

Nurses viewed this type of behaviour by people as abuse of the system. According to NPs:

> [Users] *abuse the system in that we tend to give them longer appointments for the chronic cases. Once they come in we assess them they are stable, we might give them a three month appointment and you provide the means by which they can have their prescription repeated monthly until...*[the] *three months period elapses. By next month they are back there* [because] *they can't find it* [prescription] *or somebody had taken it or things like they didn't get it back from the pharmacist. They* [sometimes] *dispose of it* [prescription]*…and when you check some of them they have a pharmacy at home…they come with a whole bag…and you wonder what sometimes happens with these elderly, if they are not poisoning themselves…when the name of the drug changes they don't know, they get another supply, they carry it home and they put it down. (NPFG6)*

Users were also found to be roving across health centres, as well as hoarding medications. This perception by practitioners of some users abusing the system and roving from institution to institution resulted in NPs recommending greater educational programmes to achieve changes in users' health-seeking behaviour. According to PHNs, "*The number has increased and the fact that they were told that they can go anywhere now, I find people hopping from one clinic to another"* (PHNFG3). Using multiple facilities was problematic in terms of continuity of care: "*I have to call other health centres to get sometimes their immunisation status because they keep hopping...because that freedom was given to them to access the health care wherever"* (PHNFG3).

While NPs agreed that those who needed care were utilising the services, they also pointed to unnecessary use by some people, noting the measures adopted to manage the behaviour. Non-urgent cases were often assessed and given appointments to return for treatment. Patients were also expected to change the manner in which they used the facilities, as well as being more considerate towards the nurses. Nurses also believed patients' expectations of them had increased despite the increase in workload, further adding to their frustration. Not having to pay also meant some people returned more often: "*We have them coming frequently, they come today, they did not think what the doctor said to them was ok, they come back tomorrow again, another prescription is given. It's like they* [are] *collecting the prescriptions"* (PHNFG3).

Some hospital-based nurses highlighted their dissatisfaction, as well as the mood changes they experienced prior to commencing duty daily. RNs commented: *"Not satisfied...I am depressed sometimes...for example you know you are coming on duty...you have medical clinic Mondays, Wednesdays and Thursdays and you know that you're going to come on and see at least 50-something patients for the day"* (RNFG1).

Secondary care nurses also commented on how users utilised the hospitals, especially the A&E, and how this negatively impacted on the working relationships between nurses in A&E and the wards:

> *You do find cases coming in the wee hours of the morning that you considered can be seen* [during the] *daytime, you will see those in the nights. A child who has a fever who has not fitted…for a day or two but they just decide to take the child to A&E at this point in time…they have been having diarrhoea and vomiting but they decide to come 1 or 2 o'clock in the mornings because they assume that at that point in time you won't have to wait.* (RNFG2)

A significant impact for the nurses was the changed socioeconomic status of the users they saw. This meant more people from the middle class were now accessing care at the public health facilities compared to prior to the policy change. As a consequence of this change, nurses found that they had to spend more time, as these patients asked more questions about their health and were more aware of their health conditions: "*If you can by chance bypass anything with a client from the lower socioeconomic group, you couldn't do that with the middle class persons...because they would ask a lot of questions and they take up more of your time"* (NPFG5).

In addition, doctors in hospitals with private practice privileges also referred their patients to the hospitals offering free services, further increasing the patient load:

> *What you find happening now* [is] *a lot* [of] *people who could afford the care outside* [are] *coming in and a lot of the doctors who have their private practice their patients do come in…they refer them to come into stay, do their surgery….get their care here. They access the pharmacy, they access the lab, they access the CT* [Computer Tomography], *they access the echo, they do everything in the one hospital so they just come in as their private patients.* (RNFG2)

7.7. Practitioners' satisfaction with their work environment since the policy change

Practitioners were mostly dissatisfied and frustrated with the lack of resources, especially equipment, in the work environment. Patients' negative attitudes also affected practitioners' feelings about their work environment:

> *With the environment, there is much to be desired; we could do with some improvements...because some of these locations you don't have any computer to work with...Some of them even lack units, like even a fan and other equipment, which would make the work quite easy like the Public Announcement (PA) system so working conditions can be very uncomfortable...consider writing labels for...even 400 labels by hand to deal with that quantity of prescription.* (Pharm1)

Additionally, PharmFG9 commented, "*I've noticed between then* [the policy change] *and now...that the patients have become exceptionally abusive. And that's understandable because* [they're] *waiting so long for service."* These threats had moved from being verbal to physical.

A few practitioners expressed satisfaction with the work being done by NGOs such as the NHF and the JSIF to refurbish some health facilities and space. However, inadequate staff workspace continued to be a contributing factor to the dissatisfaction some practitioners experienced. Difficulties resulted from the facilities not being spacious enough to accommodate the large number of people now accessing the services:

> *We have the problem of overcrowding...the facility itself needs expansion, particularly the area where the assessment, dressing, general first aid like nebulisation is usually done. For a while, we've been lobbying for a proper dressing room and an area for assessment (NPFG6)*

Furthermore, many were critical of the lack of equipment maintenance in the facilities.

> *The other thing is that the frustration also exists in maintenance of equipment. All equipment has a finite period for* [its] *lifetime and maintenance is really at* [a] *low ebb. Any equipment from a blood pressure machine right up to a CT scan, maintenance has been very poor, so we have frequent break downs and we're unable to get it back up to working level in a reasonable time.* (DR1)

One doctor, in an administrative role at a hospital, also expressed frustration with the poor maintenance and inadequate equipment and supplies in the work environment:

> *It creates a lot of frustration on my part and, of course, I can speak for the others. The other doctors report to me; the other departments report to me and I hear their frustration and their frustration is their inability to deliver the service. Before, there was a limitation in delivering but we had the option to ask the patient to purchase some of the inputs into their care from private sources, for example, if you have a hernia operation, there's an appliance we used called the mesh and we could ask the patient…we can do your surgery if you go* [to] *the supplier and can buy the mesh and bring it to us [and] we will do your operation. But now we have limited ability to supply this mesh so the operation doesn't get done.* (DR1)

Conversely, some pharmacists and NPs were satisfied with their work environment, despite the challenges encountered, including abuse from clients.

Doctors shared their frustration regarding adhering to previous health policies amidst the increased patient load. Furthermore, they expressed views on how adherence to the new policy was impacting on their health:

> *Let us paint a picture. You have two doctors working at health centre, you have 60 people already registered,* [and] *you also have 20 people waiting to be screened. You cannot turn anybody back,* [because] *that's not our policy but there are two of you there. There is no lunch time; you feel pressured, you don't want to get up and use the bathroom because you just want to hurry up and finish, go through the lot and leave. So* [you] *end up with your ulcer stomach, bad digestive system, your UTI [*Urinary Tract Infection*] but the patients are happy because the patients have been seen.* (DRFG7)

Others were also dissatisfied with the work environment. As a result, some had opted to leave or resign from the public health system for more lucrative jobs in the private sector and overseas. This was often due to the workload. Doctors commented:

> *I think with the free health care and the increase in the load of patients coming into the hospital, the junior staff feel overworked, they are getting frustrated. They are not as excited as before. So pretty much, my staff have been cut by more than 50.0%* [due to resignations]. (DRFG8)

Impact of the policy on professional nurses' physical work environment. In talking about their physical work environment, NPs voiced their dissatisfaction with the conditions at their work places in PHC:

> *For the past 21 years, I've been using the same work desk...Sometimes you have rats in there, since the drawers are bad it allows space for rat to come in. I've been asking for that desk* [to]*...change. I remember falling off* [a] *chair...that is why I'm speaking.* (NPFG5)

Equally, PHNs were dissatisfied with their work environment: "*The building is in a terrible state; heavily infested with termites all over. The electrical wiring* [is] *not up to standard, the spacing...the place is terrible"* (PHNFG3). Another nurse also reported challenges in the work environment: "*Spacing is a problem. It is chaotic from Monday to Friday. Sometimes I have to forfeit my office to facilitate somebody coming in from outside like social workers"* (PHNFG3).

NPs pointed out their dissatisfaction with the physical environment at some outstations (rented properties utilised as health centres):

> *Some of the out-stations leave much to be desired. There is nowhere comfortable for you to work. Most of the time they are rented buildings so you just work. Not to mention the bathroom situation. I think if we are offering health care to people then we should work in an environment that is fairly comfortable for us to do our jobs.* (NPFG5)

Despite refurbishment of some facilities, there was still need for more space and suitable furniture: "*We are seeing refurbishing of the building itself but in terms of furniture and space, we still have that problem...the furniture really deplorable"* (NPFG5). A similar situation existed in other parishes:

> *Some amount of effort has been made by NHF and JSIF to refurbish a number of health centres and there are plans afoot to do some others…In terms of spacing, the original structure for many of these facilities was not built to facilitate the overwhelming crowd that we are getting now, so space is a problem."* (PHNFG3)

Nurses were not only concerned with space and furnishings, but also with the temperature in the buildings:

> *The place is hot...I have a back problem...I have to be shifting around chairs just to find a comfortable one. You don't have a proper fan system. The place is burning,* [it's] *summer now. They put in AC* [air conditioning unit] *but the place wasn't wired for it. You sit there looking at the AC and you're pouring wet.* (NPFG5)

The lack of adequate ventilation in the buildings was another matter raised by the nurses. NPs detailed their concerns:

> *When the facilities were made the persons who designed them did not think of ventilation. These little areas that we work* [in] *have one little window and it's not a window that can be thrown open. There is not much air coming in. There is no cross ventilation.* (NPFG5)

PHNs felt that the lack of adequate space was also affecting patient assessments. They talked about how administration was addressing the problem:

> *Where I am, we have two offices. We have to be using outstations like you have a desk on the outside, you have partitions, but it is not enclosed that you can have your one-to-one. I feel because people can hear sometimes you don't actually get what* [information] *you are supposed to get from the client. We have discussed that in meetings but for the upper level management to deal with it, we haven't seen anything as yet.* (PHNFG4)

Some health facilities were better equipped than others. When working in less-equipped facilities, nurses did not have the convenience of a lunchroom, therefore they took shortened lunch breaks at their workstations, which lacked comfort and privacy and where they were frequently disturbed by waiting patients.

General satisfaction among professional nurses. In talking about their general satisfaction, nurses highlighted the areas of concern below. Nurses considered that feeling a part of an organisation was as important to job satisfaction as the physical environment:

> *For me it's not only the physical environment because that's not all there is to a work. I love to know that I feel a part of the organisation with which I work. Some of us don't feel a part of the system because we are not involved in decision-making at all. A little thank you sometime…If our supervisors or those who are in authority visit us sometimes in our clinical areas,* [it] *makes a difference...come to see how we are doing in the environment...and ask "How are you doing?", "How* [are] *you getting on?"* (NPFG5)

In commenting generally on the negative effects of the policy change on the current situation in the work environment, PHNs were concerned about the decrease in quality care:

> *The training that you had...personally you feel like you are not doing the job that you are equipped to do...because you don't have the space and when clients come you're not able to look after them the way you'd like to; for example, if you had say 50 clients, the time you spend with one you're not able to because you're thinking that the other 49* [are] *thinking that I'm spending too much time with one person.* (PHNFG3)

Due to the shortages of staff, large numbers of patients, and need to be present for each patient, nurses found it difficult to take break periods and, as such, some had developed ill health. RNs noted,

> *Nurses are exposed to every possible illness, and most of them are stress related. I did not come into nursing with a peptic ulcer disease, I have it...UTIs are so frequent* [because] *you can't even get a bathroom break.* (RNFG1)

Additionally, nurses were very vocal about their welfare in the work place. They were dissatisfied with the resources available to them and argued that more systems and resources were required in the public health system to improve comfort on the job. RNs talked about their concerns, which resonated with all other groups, and included the need for training of more nurses; improved working conditions; provision of child-care support such as a crèche for nurses of childbearing age; provision of a lunch room or lounge for rest periods and lunch breaks; adequate medical supplies and equipment in all RHAs; and other support for nurses such as counselling services. An RN commented on the need for rest areas:

> *When I supervise at nights and I see the conditions under which the nurses work, it's a shame...staff in general, the doctors will go into the patient's bed and sleep, go on the cupboard tops, put their head on the desks. One chair on the female ward...and there's a hole in it...people sitting there so long and they take the IV* [intravenous] *fluid box and put in there... just for rest...we want better working conditions.* (RNFG1)

Generally, RNs felt that they were sought after by many overseas countries and, as such, believed more should be done to retain them in Jamaica. In addition to an increase in salary, nurses considered they could be given incentives such as *"recognition, houses, car and concessions"* (RNFG1) as a means of motivation. Despite the increased workload, however, nurses remained committed to the professional code of ethics for nursing practice.

Physical and emotional effect of professional nurses since the policy change. Nurses spoke about the physical and emotional effects of the policy change on them. All categories noted that their work was challenging and stressful. Besides increased workload, nurses considered the policy change had resulted in extreme additional pressure on them, tiredness, and stress. They felt service delivery could be negatively affected: "*I'm stressed to the limit right now with work…can't cope much longer. It's two clinics, it's almost the same staff so we are stressed, we are overworked"* (NPFG5). NPs also felt: *"If you don't mind, when you think you are delivering quality health care, you are compromising your health and also the patient's health."* (NPFG6)

In secondary care, nurses were also affected by the chronic workload and attitudes of people toward them: *"You find that you are tired, you are overworked...I think it has impacted on most of us in a negative light"* RNFG2. RNs further commented,

> *I'm normally cheerful...I worked in A&E for over a year as* [a] *Charge nurse. Because of the constant abuse, verbal and threats...I remember requesting from the matron that I be assigned somewhere else. I was becoming unhappy; I was becoming very defensive, tense. I just needed to get out there. It's not so much the workload, it's only because of the abuse* [from] *the patients.* (RNFG1)

Other RNs also considered resigning as a result of the work burden: "Y*ou are frustrated, you are depressed, you don't know what to do. Some of the days I feel like I'm ready to leave now and go to another profession and do something different*" (RNFG1). This feeling of being overwhelmed resonated with RNs:

> *The other day I felt as if I was at a cross road...I even started looking for a job, I was thinking to venture into something else apart from nursing. Just fed-up...I was surprised because I never knew that day would ever come when I would feel this way.* (RNFG1)

7.8. Practitioners' overall impression of the abolition of user fees policy

Practitioners expressed various views about the policy generally, ranging from the policy being good, to having required more work prior to implementation, to requiring revisiting to ensure sustainability and address the lack of resources. In comparing the current policy with other countries, one practitioner suggested that a basic minimum package was necessary. The negative impact of the policy on pharmaceuticals and the idea that some patients should pay were opinions also expressed by the practitioners, who considered these measures necessary if the government was to sustain the policy:

> *I think it's a learning process. Free health care is possible under certain guidelines....We should arrive at a basic minimum that we* [Jamaica] *can afford...There's a package, which means you won't die, you won't suffer severely but if you want to go further then you have to pay for it...sophisticated investigations or so. We can't have a blanket statement that all health care will be free because if I look at examples from other countries that have free health care...there are guidelines that are put in place and for one thing there is a basic minimum, which is guaranteed, and above that the patient will pay...One of the areas which suffers terribly from this free health care is the pharmaceuticals because that is the area where we see a 100.0% or 120.0% increase...I think the reason for this is that the patients are double or triple dipping into the pharmaceuticals. In my opinion, the patient should pay something and there should be an assessment process for patients who are indigent so they don't suffer unnecessarily from inability to pay*. (DR1)

Despite concerns about the implementation process, the benefits of the policy for persons in need were highlighted:

> *Definitely there are persons out there who need the medication, who need the health care and cannot really afford it. However, I think that it could have been better implemented and the necessary controls should have really been put in place to monitor patients and prevent abuse of the system. It is working but whether it's working effectively or efficiently that's a different thing...It needs to be tweaked some more...the efficiency part of it needs to be improved on... For the effectiveness, there's certainly some amount of effectiveness.* (Pharm1)

Systems to facilitate the smooth transition of the policy were apparently lacking. Pharm2 noted that patients' behaviour in accessing pharmaceuticals had changed and, as such, suggested necessary actions for the way forward:

> *Systems were not put in place to ensure that (1) patients did not abuse pharmacy services* [and] *(2) adequate staff was put in place. The patients were lining up from*

> *2 o'clock in the morning. Free health care had good intentions but for* [the] *pharmacy, the way forward, the major hospitals need a 24 hour service.*

Pharmacists expressed the view that improved access negatively affected staffing and quality of care, especially the ability to engage in their roles on hospital wards:

> *The access is now really greatly improved and they* [persons] *are now able to access medications for conditions in which the medications are very, very, very expensive. So in that sense there's a great benefit to the patient...We are not able to optimise on the quality that we output, for example, when you look at our staff shortage we are not able to extend ourselves even within the facility itself. So...going on the ward and being able to audit the drugs and interact with the health care team and the patients, then we are unable to deliver the type of quality health care that we really ought to.* (PharmFG9)

Similarly, doctors concluded that an evaluation of the policy was necessary, and should happen before any further changes were implemented. The doctors who argued that the policy had not been properly planned and should be revisited for more positive results stated:

> *Free health care is not necessarily a bad thing if it is well-planned. If it's poorly planned, poorly executed, it will be a bad thing. So we need to do away with what we have and come with a well thought out plan...I think we would have a better result.* (DRFG7)

Professional nurses' overall impression of the Abolition of User Fees policy. RNs felt that the policy had more negative than positive impacts:

> *The patients benefit in one way but they suffer in many other ways. They wait longer periods for investigations; some of them have to be done privately so the money they would have paid to access the system,* [they] *end up paying three times more* [for] *procedures privately or they end up suffering or dying without it because they can't afford it or if they have to wait on the appointment time they deteriorate even further. For the staff here, definitely no positives and the resources are being depleted.* (RNFG1)

This opinion resonated with other categories of nurses. For example, although NPs felt that patients who were lost in the system now had access to specialist treatment and surgeries, this came at a cost to nurses who sometimes were unable to take lunch breaks.

According to RNs, the policy was not working and required fundamental changes: *"It needs to be scrapped and other measures implemented"* (RNFG2). Measures suggested included returning to the previous arrangement for children under 18 years; reverting to the use of assessment officers to determine who could pay; and free services for children and the elderly. Nurses also maintained that some people were willing to pay for health services.

PHNs noted that the quality of the services was questionable and that holders of health insurance should utilise it. Furthermore, NPs felt that the policy should be revisited with the involvement of key stakeholders. Areas in which nurses considered the policy failed included:

> *In terms of funding, compromising nursing care and even medical care, in terms of provision of medication...in terms of the time that the patient has to wait for an urgent surgery...they have to get long appointment dates,* [in terms of] *equipment.* (RNFG1)

7.9. Conclusion

The policy change meant significant challenges for practitioners and nurses in hospitals and PHC settings. Themes extracted from the individual interviews and focus groups revealed practitioners' and nurses' perspectives of the user fees policy. Themes highlighted included changes in workload and work environments; the number of staff available to administer care; new working arrangements, which in some cases entailed extended working hours or shift systems; the types of patients, as well as the conditions seen; limited resources, which impacted on the treatment received and nurses' ability to deliver quality care; and levels of satisfaction with the system in general since the policy change. Practitioners and nurses were generally unhappy with the changes produced by the policy and the scant regard shown for their welfare. Some even contemplated resigning from the public health service. These findings have significant implications for future policy development and implementation, staff retention, nursing practice and quality service delivery generally. Despite these concerns, health workers adapted to their adverse working conditions and made the system work. The next chapter will discuss the findings of the study.

Chapter 8: Discussion

8.1. Introduction

This evaluation study used a multi-layered mixed methods approach to determine the impact of the abolition of user fees in the Jamaican public health system from three perspectives: policymakers, practitioners and users. The main objective of the policy change was to improve access to health services for all Jamaicans, with the expectation that people who had deferred care because of costs would now access the services. Evaluating the impact of the policy change one year after its implementation in 2009 may be viewed as too soon, since any change in the system might not yet have been appreciable. However, it is clear that changes to the public health system were apparent as soon as the policy was implemented and, as such, this study captured the early days following the introduction of the policy, including the implementation process and issues that required attention.

The previous two chapters demonstrated that, in the aftermath of the implementation of the user fees policy, widespread changes came about in the Jamaican public health system. This chapter will discuss the findings by drawing out parallels and differences in relation to international experiences, as well as new understandings that have emerged regarding the impact of the abolition of user fees on utilisation, access, and the work of main care practitioners. The changes included significant increases in utilisation, an indication of increased access to services, and far-reaching effects on the work of practitioners, including the professional nurse.

This chapter provides an overview of the key findings regarding the abolition of user fees and discusses (a) general impressions of the policy change, (b) impact on access, and (c) impact on the work of health practitioners with a focus on the professional nurse. Recommendations and implications are threaded throughout the chapter. Specific categories of nurses will be referred to where appropriate while any reference to nurses elsewhere in this chapter means all categories of nurses. The term ‘patients’ is used interchangeably with ‘users’ throughout the chapter.

8.2. Overview of findings

The study revealed the potential of the abolition of user fees to improve utilisation of the health services. For instance, visits to public hospitals and health centres had increased following the abolition of user fees when compared to 2006. Additionally, there was an immediate large increase in the use of pharmaceutical services at public health facilities. The study also revealed that people obtained, stored and filled prescriptions several times in order to take advantage of the free health care, which was widely publicised in the media and at health facilities. The increase in utilisation was so far-reaching it prompted policymakers and practitioners to describe it as a “run on the system.” In the absence of analysis that takes into account confounding variables, the change in utilisation patterns may be an indication of the policy’s success in regards to access. Consequences of the increased utilisation were overcrowding and increased workloads for practitioners. Users’ behaviours in this scenario challenges the interpretation of access by some proponents who argue that, access is the appropriate use of services by consumers according to their actual or perceived needs.

Stakeholders had different perceptions regarding the policy change. Policymakers were optimistic about the policy change and the subsequent increase in utilisation, although not all had been equally involved in the development of the policy. The decision to abolish user fees was made at the level of central government as a pre-election manifesto. Accordingly, many national and regional policymakers merely steered the implementation process and were not integrally involved in the entire policy process. To put it in context, a policy process comprises approximately four stages: problem identification or agenda-setting stage, policy formulation, policy implementation, and evaluation (Hercot, Messen, Ridde, & Gilson, 2011; McPake, Brikci, Cometto, Schmidt, & Araujo, 2011; Messen et al., 2011). Involvement in the entire process helps engender additional support and mobilise resources for the successful implementation of the policy. Conversely, lack of involvement often results in apathy on the part of stakeholders (Gilson & McIntyre, 2005; Hercot et al.; McPake et al.; Ridde & Morestin, 2011). This was not the case in Jamaica. There was no evidence of apathy; rather, it was apparent that national and regional policymakers were significant players in the implementation phase despite a lack of involvement in all stages of the policy. Policymakers were aware of their responsibility to identify inequities and improve access to health services.

Generally, the view of policymakers was that the policy was a good policy, one that was assisting them to (a) forge private and public partnerships, (b) invest in capital improvement, staff development, and quality assurance, and (c) monitor the health system.

Equally, policymakers believed access to health services had improved and services were now more equitable. The study also found that policymakers had novel ideas to further improve access for the vulnerable. One such idea was the strengthening of community health services in order to introduce a mechanism by which non-ambulatory users could be monitored without having to visit an acute care health facility. Such a strategy should improve access because services would be packaged in a manner that is responsive to users' needs.

In contrast to policymakers, health practitioners were more cynical about the policy's wide scale provision of free health care. While they thought the policy had good intentions, they argued it required some amendments and suggested better systems were required to make it effective and sustainable. They raised several concerns related to their increased workload, the pressure exerted by the increased demand on the resource-constrained health system, and government's ability to sustain the policy change. In addition, practitioners were critical of their lack of involvement in the development of the policy. Despite this criticism, policymakers claimed that meetings had been held with all interest groups in the health sector prior to the implementation of the policy, suggesting that practitioners had been involved with the policy prior to its implementation. One of these meetings was a press conference, held the day prior to the implementation of the policy. Practitioners' involvement, therefore, was largely at the implementation phase and encompassed roles such as guiding the implementation process and establishing the various arrangements in the policy at facility level. Practitioners' involvement in the other stages of the policy process could have averted some of the concerns associated with the policy change. This is because their work entailed daily interaction with the health system to ensure access and, as such, was positioned to identify areas requiring strengthening.

In addition, professional nurses in both urban and rural secondary and PHC facilities in Jamaica embraced the user fees policy and adopted measures to make it work to improve access. Generally, nurses reported that the policy change has improved access to care for those who could not afford to pay. They felt however, that the lack of consultation prior to the policy change contributed to problems such as overcrowding and inadequate drug supplies. The findings also showed that the policy change had negative consequences on the workload of nurses.

Users were receptive to the policy and generally satisfied. They viewed the policy change as a ‘good move’ by government; moreover, they felt empowered to utilise the health services without incurring any cost. Achieving a high level of satisfaction among users augurs well for the success of the policy, as this may translate into increased uptake of the services. It is, therefore, not unusual that each region revealed an immediate increase in demand for services subsequent to the removal of the user fees in the public health system. All stakeholders (policymakers, practitioners, users) agreed that more people were accessing health services since the policy change. Furthermore, the increased uptake of services was supported by data supplied by the MOH and extracted from the RHAs’ annual reports. This finding may be an indication that people had had unmet needs and were now more comfortable seeking care under the new policy. It could also suggest that removal of the direct cost for health care empowered people to access the required care.

The study found that monitoring of the policy was haphazard. Nonetheless, the CMO of Health and other staff in the MOH and RHAs were charged with responsibility to obtain regular feedback regarding the policy. To fulfil this mandate, some policymakers utilised statistics from regional reviews and various departments such as A&E to extrapolate about the effects within each given region and institution. It was found that policymakers were also using these data to modify the system and put necessary measures in place. This finding implies there had been inadequate planning prior to the policy implementation. It also suggests that important information about the changes caused by the impact of the policy might not have been comprehensively captured.

8.3. Overall impression of the policy change

Policymakers. The stakeholders had varied impressions of the policy. Policymakers were very positive and keen on setting up systems parallel to other countries with similar policy changes to ensure sustainability of the policy and improve access generally. A possible explanation for such optimism could be that there had been no official evaluation of the policy, despite some practitioners publicly expressing concerns about the negative effects of the policy. The optimism of policymakers, although not studied extensively, has also been reported in some African countries (Ridde & Diarra, 2009; Ridde & Morestin, 2011). This does not negate that policymakers need to address other issues that target individuals to limit disparity in access to health services.

Practitioners. Practitioners were desirous of having the policy revisited and possibly reversed. They were more interested in a targeted system rather than a universal system. Opinions voiced by practitioners included the following: (a) the policy should have been implemented on a phased basis; (b) free health services should only be available to children and the elderly; (c) a basic package should be created whereby persons would pay for more sophisticated tests; (d) a zoning system should be introduced to limit users to a particular geographic area, in order to control roving users who were sometimes triple dipping in terms of pharmaceuticals; (e) those who can afford to should pay out-of-pocket for services; and (f) those with health insurance should be required to use their insurance. The current arrangement did not allow the insured to use their health insurance to access health care in the public system. While above opinions were not all expressed in other studies in African countries, some studies revealed that practitioners considered only certain people should have access to free health care (Ridde & Diarra, 2009; Walker & Gilson, 2004).

There was no shortage of criticism of the policy change from practitioners, who felt the policy had been poorly executed and, as such, required revisiting. Some described it as a failure, making references to the lack of funding and increased risk of compromising the services being offered to the users. The reason behind practitioners being so critical of the policy change may be due to them being at the operational level and strategically positioned to evaluate the extent to which the policy was working. Furthermore, their work had been acutely affected by the policy change. Even though practitioners in African countries did not extensively voice these opinions, studies did reveal concerns about the manner in which similar policies were implemented (Ridde & Diarra, 2009; Walker & Gilson, 2004; Witter et al., 2009).

Professional nurses' general perceptions of the abolition of user fees in Jamaica. While nurses embraced the policy and were endeavouring to make it work under trying circumstances, they had several concerns. Generally, they were concerned about the physical working environment: poor infrastructure of buildings and furniture; lack of temperature control and adequate ventilation; limited space for assessment of users; and lack of restroom and lunchroom facilities. Despite these concerns, however, some facilities had been refurbished by governmental and non-governmental organisations. The study further found that, amidst the existing situation, some nurses were hopeful that the work environment would improve. Moreover, some nurses worked in environments with basic amenities, unconducive to the delivery of health care. The findings regarding the poor physical working environment may be the result of pre-existing maintenance problems rather than the removal of user fees. The increased demand created by user fees, however, might have exacerbated the conditions. This corroborates findings from a study in Africa, which reported poor working conditions for nurses, although it did not outline the details (Walker & Gilson, 2004). Addressing these working situations is vital to improving satisfaction among nurses.

Nurses frequently complained of being tired, stressed, depressed, ‘fed-up’, and overworked, and having altered mood and emotional states. Nurses felt demoralised by the lack of recognition for their contribution to the health system generally and by their non-involvement in the policy process as frontline workers. Furthermore, they sometimes contemplated resigning under the pressure, especially when their workload was exacerbated by verbal abuse from users. A possible explanation for the nurses’ experience is that the poor working conditions were a perennial problem worsened by the increased workload and other effects of the policy change. This supports findings from studies in South Africa where, despite some ambivalence, nurses felt the abolition of user fees contributed to their feelings of being exploited, overworked and de-motivated to the point of wanting to resign. South African nurses also felt left out of the decision-making process. Some nurses in Africa felt professionally accomplished by attending to more patients, despite having to care for patients who, they claimed, abused the free system (Burnham et al., 2004; Kajula et al., 2004; Ridde & Morestin, 2011; Walker & Gilson, 2004). Conversely, other nurses in South Africa reported the urge to spend less time with patients and found their work frustrating and tiring (Wilkinson et al., 2001).

In addition to the aforementioned concerns, nurses raised the following issues: lack of consultative meetings among team members since the policy change; lack of visits by supervisors; development of health conditions such as UTI and digestive disorders among nurses since the policy change; lack of facilities such as crèches for nurses’ children; and poor remuneration. These concerns on the part of nurses might have resulted from working in pre-existing disempowering environments. In contrast, some NPs reported enjoying good rapport with other members of the team, and some administrative staff, such as CEOs, were commended by hospital-based nurses for their support since the policy change. Of note also, is that some concerns such as poor remuneration and lack of facilities for nurses cannot be attributed to the user fees policy. The variation in views regarding health team relationships is in contrast with studies from South Africa, which reported that working relationships among team members remained unchanged (Walker & Gilson, 2004). The finding regarding administrative support is, however, consistent with results from some studies in African countries that reported nurses received support from staff in authority at the health facility, which helped them cope with the free health care experience (Walker & Gilson). While some of the issues above were not raised by nurses in the African studies, the findings reinforce reports about lack of support from supervisors, and nurses' feeling un-recognised and unrewarded for their contributions in some countries (Walker & Gilson). These findings have implications for the successful implementation of future policies and empowerment of nurses.

Users. Amidst policymakers' optimism and practitioners' and nurses' discontent, there was a high level of satisfaction among the users who were the greatest beneficiaries. The finding that the users surveyed were satisfied with the new system, despite voicing concerns about the challenges they encountered while trying to access health services have also been reported in African countries and is one of the factors contributing to increased utilisation (Burnham et al., 2004; Ridde & Diarra, 2009).

Monitoring. No specific system for monitoring the policy had been established. This resulted in reliance on existing systems, which may not have been an efficient mechanism to capture those changes associated with the new policy. Although not discussed extensively in the literature on abolition of user fees, monitoring mechanisms were often lacking, resulting in insufficient data being captured about the impact of the policy change in several countries (Messen et al., 2011; Ofori-Adjei, 2007; Ridde & Morestin, 2011; Steinhardt et al., 2011). This has implications for recognising the changes and addressing problems in a timely manner. Ineffective monitoring may also affect the success of the policy.

8.4. Impact of the abolition of user fees on access to health services

To fully understand the study's results in terms of access, the perspectives of policymakers, practitioners and the users on access and availability of resources since the policy change were taken into consideration. While the findings regarding increased utilisation of the health facilities are unequivocal, it is pertinent to discuss the findings regarding the other dimensions to access, because increased utilisation is dependent on people's ability to gain entry into the health system.

The literature presented in Chapter 3 highlighted multiple perspectives from which 'access' may be interpreted, so the variety of ways in which people interpreted access in this study was not surprising. Based on the findings, users' interpretation of this concept might not be clear cut, because there were reports that access to health services was easier since the policy change despite people having to wait in long queues at the pharmacy, in treatment rooms and for surgical procedures. For users, having to wait to be seen was less of an issue than receiving the medications and treatment. Reports by some users, practitioners and policymakers indicated that access to health services such as pharmaceuticals was particularly problematic. There were issues with buying drugs at private pharmacies, having to pay for the drugs that were not on the VEN list at government pharmacies, only being able to purchase a portion of the prescribed medications, foregoing prescribed drugs generally, and waiting until medication was available at the government pharmacy. Many users were not holders of health insurance and, while some had a National Health Fund card, access to medications and health care generally was still a challenge. Therefore, an increase in the number of people visiting the health facilities may not translate into improved access to health services. Additionally, availability of services may need to be considered in terms of difficulties encountered while obtaining and forgoing care (Mooney 1983).

These findings corroborate studies that showed various factors impacting on the supply of drugs in African countries following the abolition of user fees. For example, there were issues with funding in Ghana (Witter & Adejei, 2007) and, while drug shortage was initially prevalent in Uganda, it improved gradually (Burnham et al., 2004; Dieninger & Mpuga, 2004). It is apparent that the drug supply issues in Jamaica were two-fold. First, the supply of drugs was inadequate, and, second, expensive drugs were not on the VEN list. This has implications for the procurement of drugs and revision of the VEN list. Although a number of measures were taken by the Jamaican government including expanding the VEN drug list to provide access to more pharmaceuticals in government pharmacies; instituting a government card for easy access to drugs in private pharmacies; and procuring cheaper drugs in larger amounts from international agencies, more intervention is needed. For example, alleviating these problems in Jamaica might entail establishing a mechanism whereby only listed drugs are prescribed, expensive drugs are subsidised, or frequently prescribed expensive drugs are added to the list. Drug problems have been found to influence health-seeking behaviour (Chuma et al., 2009) and several studies in African countries also reported the unavailability of drugs (Burnham et al., 2004; Nabyonga-Orem et al., 2008; Walker & Gilson, 2004). This further reinforces the responsibility policymakers and providers have to ensure services are available, affordable and responsive to people's need.

Another important finding was that some users were roving between health facilities and would frequently hoard the drugs obtained at these facilities. The extent of this practice is not known. This finding was unexpected and suggests that users did not trust that the policy would be sustained and that more patient education is required regarding the purpose of the policy change, the use of pharmaceuticals, and the use of the health services in general. The lack of trust that the system would last may be attributed to the nation's historical background, one tainted with mistrust and oppression under Plantocracy. Double dipping in pharmaceutical supplies puts additional financial strain on an already resource-constrained health system and was concerning to practitioners, who were unable to track patient records for continuity of care. To manage the problem, practitioners proposed a mechanism whereby standardised, centralised, and computerised systems would be established in all health facilities to track people's utilisation patterns.

In some countries such as Australia tracking is managed by requiring people to present a unique identification card in order to access services. These cards, known as Low Income Earner or concession cards, enable holders to access subsidised services (Scott, 2001). The mechanism could also be used to prevent overuse of the system. A similar arrangement exists in Jamaica through registration with the NHF; however, it is available to all Jamaicans, not exclusively low-income earners, and has not been established or utilised as a tracking mechanism. Nevertheless, this arrangement entitles holders to subsidised drugs and could be adopted as a useful mechanism for tracking pharmaceutical uptake. The NHF could be reformed based on the Australian system as a mechanism to also improve access for the poor. The findings regarding users hoarding drugs and abusing the health system corroborate a study in Niger, which also noted that users hoarded or created a supply of medication following the removal of user fees (Ridde & Diarra, 2009). Additionally in South Africa, users were found to 'shop' around clinics in the aftermath of the policy change (Walker & Gilson, 2004). This level of mobility among people has implications for policymakers to establish suitable mechanisms to address these problems for successful policy outcome. This behaviour could be an indication of low health literacy (Sudore et al., 2006) among users. Addressing health literacy wouldrequire substantial work to understand its impact on the uptake and use of pharmaceuticals.

New information was revealed about access to helplines, telephones, out-of-hours services, and lack of resources in the facilities within the Jamaican context. Users were generally unsure about the availability of helpline or telephone facilities to assist them in obtaining assistance from a health professional. Although this lack of knowledge may be interpreted as a barrier to access, it is the researcher's belief that having access to helplines and telephones may not necessarily translate into better health-seeking behaviour. Other concerns raised by users included problems in accessing health services on weekends, public holidays and at night at some secondary care facilities, and the lack of resources (staff and equipment) generally. For these reasons, users adopted behaviours to cope with the issues, such as visiting private doctors for better and faster treatment. Access to helplines, telephones, and out-of-hours use of secondary care facilities are unreported. This finding, regarding some individuals reverting to the use of private facilities over public offerings, corroborates the JSLC 2009 report that investigated people's experiences since the abolition of user fees (PIOJ & STATIN, 2010). For some, the experience meant forgoing care when required, which was often linked to cost-related factors. Practitioners gave several accounts of users being sent away after initial assessment and asked to come back due to overcrowding and insufficient staff to address their health needs. Despite the increase in utilisation of services following the policy change, users were still confronted with other access issues.

Nevertheless, users continued to visit these facilities for health care. The overcrowding did not deter users, who often changed their behaviour and queued up at health facilities very early in order to be seen. A possible explanation for the attitude toward such obstacles while accessing care is that users were not fully aware of what access constituted; therefore, visiting a health facility and being told to return for treatment on another day did not distort their perception of access. The finding about users being sent home because of overcrowding has not been previously described in other research.

This is an important finding because it is unclear how assessments or the decision regarding whom to send home was made, which may also indicate that people are experiencing other barriers to accessing health services. Returning home without being treated could result in worsened health conditions for the users. There has been limited investigation into users' access to helplines and telephones in countries with removal of user fees, but reports regarding lack of resources and people reverting to private practitioners and other sources for treatment have been documented in countries such as Ethiopia (Asfaw et al., 2004), Ghana (Chuma et al., 2009) and Uganda (Nabyonga et al., 2005; Rutebemberwa et al., 2009; Xu et al., 2006). A significant phenomenon in the Jamacian experience is that users were reverting to private practitioners and other sources for care, suggesting that their health-seeking behaviours were not only linked with the cost of obtaining care.

The findings revealed users were pleased that their expectations of the health system were being met. They were satisfied with the services provided and rated the quality of care received as good. Despite these favourable ratings and services now being free, the study confirmed some users continued to use alternative means of treatment such as home remedies, often in the form of bush tea; self-treatment; and the services of herbalists, spiritual healers, and traditional healers, whilst simultaneously obtaining treatment from health facilities. There was no clear explanation for this finding; however, it is likely to be due to the cultural practices that embody the Jamaican society. Other factors possibly contributing to this behaviour were lack of confidence in the health system; belief that illness is the result of a curse (Seaga, 2005; Spence et al., 2010); or having had more positive health outcomes from alternative treatment in comparison to conventional treatments (Picking et al., 2011). While adopting self-care measures are positive health behaviours and consistent with international trends (WHO, 2002, 2008), the researcher, however, has concerns regarding the possible herb-drug interactions and efficacy of some treatments. This finding regarding simultaneously utilising health facilities and alternative treatment is supported by several studies in countries such as Uganda. A study in Uganda on utilisation of public or private health care practitioners by febrile children after removal of user fees showed that, despite free care being offered in government facilities, caregivers also visited a drug shop or private clinic for treatment (Rutebemberwa et al., 2009). In Ghana people also resorted to other sources for treatment rather than the arrangement provided by government (Ansah et al., 2009). Such treatments were considered cheaper, located nearer to users, or available on credit. The paradox here is that in the absence of financial resources to access health services, individuals opted for other forms of treatment (Hardeman et al., 2004; Jacobs & Price, 2006; Peters et al., 2008) however, when costs were removed for services such behaviours continued. Despite international endorsement, the use of alternative medicines may produce undesirable health outcomes if inappropriately used. Therefore, this has implications for patient education; research into alternative treatments and their effects; and dialogue among stakeholders on the concomitant use of herbs and prescribed medications. While the use of alternative treatment is topical and is utilised in the Americas, this study did not explore the literature on the topic further.

The need to travel long distances to access care may have contributed to the use of alternative or informal treatments, especially when transportation costs were a problem. Travelling across borders is often attributed to people's need to find facilities that offer all the services they need. Accordingly, policymakers should ensure all facilities are fully-equipped with the necessary resources to meet the needs of the population they serve. Travelling across borders contributed to overcrowding in some facilities and disrupted continuity of care; therefore, measures should be implemented to enforce the use of services within particular borders. This recommendation endorses the suggestions by some participants to (1) institute zoning, and (2) introduce mobile services to make services more accessible to people. These findings are not fully explored in other studies, although in Ghana a randomised control study found that use of informal care increased in relation to the distance from formal health facilities (Ansah et al., 2009). The impact of delaying or forgoing care by users when travel cost are astronomical needs further investigation as these impacts can increase mortality (Hardeman et al., 2004; McCaw-Binns et al., 2001).

While users were aware that user fees had been abolished, many were unable to identify all the services and drugs that were free. This suggests that some users were not knowledgeable about the package being offered to them and, therefore, may not have accessed some free services even if they had the need. This finding corroborates the report from the JSLC 2009, which found that some persons in the lower quintile were still not accessing care despite it being free. This could be attributed to people's lack of knowledge regarding the new service arrangements due to the precipitous nature of the policy change.

Otherwise, it might be due to people's reluctance to learn about the details of the services available to them. Messen et al. (2011) reported a similar situation in sub-Saharan African countries, in which the lack of planning affected the implementation of the policy, including dissemination of information to users. Dissemination of information about the policy in Jamaica was done via several channels, including print and electronic media, posters in health facilities, and health personnel. It is apparent that the dissemination of information process assumed some level of health literacy on the part of the users. Health literacy has been shown to influence how people access and use health services (Cooper, Hill, & Powe, 2002). It is also possible that those already engaged with the system had more exposure to the policy change than those who were not. The limited level of knowledge regarding free services is indicative of the need for further clarification of the policy for end-users. In Ghana, some communities did not sufficiently understand the abolition measures due to inadequate planning and consultation prior to the policy implementation, which ultimately affected how the services were utilised (Witter et al., 2007a). The findings from the Jamaican study have implications for a more targeted public education campaign regarding the terms and conditions of policies prior to implementation.

A large percentage of the users had been using the health facilities for protracted periods of time, which may explain the expressed levels of satisfaction with access to services, although there were concerns about lack of involvement in the planning of the services offered to them. Some users even travelled far distances to access the health facilities of their choice, which were not always the closest to their homes. Among the reasons given for their general choice of facilities were, good treatment, convenience, easy access both geographically and for appointments, and affordable services. Additional costs for transportation and meals were incurred when individuals travelled far distances and waited long periods for care at health facilities. This suggests that people's perceptions of the services a facility offers influence choice (Kiwanuka et al., 2008). Equally, people who waited a long time for appointments, which could be over one year, were at risk of deteriorating health conditions that might require more extensive treatment, further adding pressure to the health system. These were cited as problems users encountered while accessing care. People were also frustrated and vented their feelings on the practitioners when they waited a long time for care. These findings suggest a need for alacrity in addressing the demand for resources that may result in reduced waiting times.

While no standardised instrument was used to capture the quality of services data, concerns raised by practitioners related to the limited time available to assess users due to the large number of persons; increase in dispensing errors since the policy change; inability to care for users holistically; and increase in users' complaints. The lens through which practitioners viewed these concerns might be explained in part by (1) the type of heath facility to which the practitioner was assigned, (2) the health outcomes of users since the policy change, (3) the staff complement at the facility, (4) whether the facility was rural or urban, (5) the level of teamwork in the facility, and (6) the availability of resources such as drugs. The views, however, are invaluable since practitioners functioned at the operational level of the health facilities and had sufficient experience to judge the quality of services being offered. The inability to administer care according to expected standards not only jeopardised the lives of patients but also constituted additional stress for the practitioners and increased the likelihood of litigation. The threat of litigation was not explored in this study. Some practitioners were however, concerned about their inability to deliver care in a manner consistent with their training, as well as the risk of losing their registration status. These quality concerns reflect the need for additional resources to ensure safe, effective and efficient service delivery. Equally, the quality of services in South Africa was found to be reduced in the presence of increased patient loads, less time spent with users, and lack of privacy (Walker & Gilson, 2004). In Uganda there were reports of long waiting times, unfriendly staff and poor aesthetics in the work environment (Burnham et al., 2004; Kajula et al., 2004), although the lack of cleanliness and poor staff attitudes in Uganda were subsequently refuted by another study (Nabyonga et al., 2005). These findings are indicative of the need for policymakers to monitor quality indicators to ensure an efficient service delivery system.

This study found that there had been a reorienting of the Jamaican health system to accommodate the impact of the policy change. This included restructuring and strengthening the PHC system to reduce the pressure on secondary care services and promote preventive services. To accomplish this, health centres had been refurbished and new ones constructed, additional staff deployed to these areas, and people who utilised secondary services 'inappropriately' as suggested by practitioners, were frequently diverted to primary care facilities. Reorienting the public health system also meant training new categories of staff such as dialysis technicians, recruiting additional health practitioners locally and overseas, extending the opening hours, adjusting the shift system in some PHC facilities, and collaborating with private and semi-private organisations. These measures were adopted to ensure the efficiency of the public health system and success of the policy. Although there is no evidence from other studies to suggest health services had been redefined to address the effects of the policy change, researchers in Uganda (Nabyonga-Orem et al., 2008) and Madagascar (Fafchamps & Minten, 2007) described efforts made by governments to strengthen their health systems by procuring more pharmaceuticals, increasing budgetary allocations to the health system and training new staff. Of note is that practitioners in Jamaica, Uganda and Madagascar complied with the various changes and adjustments to their work situation in order to make the policy work.

Policymakers felt that, in order to ensure access, other health-related policies could be implemented, for example, encouraging more self-care and introducing mobile-type services to alleviate problems associated with transportation when care was required. They were interested in improving services for particular population groups such as the elderly, adolescents and persons affected by HIV and AIDS. By the same token, others were concerned with policies that would foster utilisation of PHC facilities for non-emergency problems rather than A&E, with a caveat that the infrastructural arrangements in the PHC facilities would need to be improved. Expanding the scope of practice for some health practitioners such as NPs, pharmacy technicians and patient care/ward assistants and clarifying the 40-hour work week were other means suggested by policymakers to make services more accessible to persons. While these proposals augur well for the policymakers, the impact of such interventions on health care delivery should be carefully assessed. These mechanisms, if addressed, would serve dual purposes. They could further improve users' access to health services, and avert any deleterious effects on staff. Health system modifications of this nature to improve access have not been mentioned in previous studies on the abolition of user fees.

Even though access to health services was a problem for some persons, self-referral was the main mode of entry to the health facilities by individuals requiring care. This suggests people were empowered to exhibit positive health-seeking behaviour. The mix of services also meant that people initiated and accessed care at various health facilities. This study found a slight increase in self-referral for 2009 in comparison to 2006 (Table 14). This increase may be attributed to the lack of gatekeeping in accessing health services, acceptance of self-referral as the main mode of entry into the health system, freedom to access care based on preference, and greater awareness of health needs under the new service arrangement. Gatekeeping by practitioners in primary care can reduce demand on hospital services (Forrest, 2003). This finding of high self-referral has not been described in other studies on the abolition of user fees. However, a decline in people being referred to hospital by practitioners after the removal of user fees was reported in Africa, possibly due to improvements in the services offered resulting in reductions in referral, or reluctance by lower level facilities to refer people to regional facilities for fear of losing reimbursement (Witter et al., 2007a).

Socioeconomic group and impact of abolition of user fees. While this study did not categorically identify the socioeconomic status of who was utilising the services, several conclusions can be drawn from the data. Very low monthly incomes were reported by the majority of the users who completed the patient survey. Policymakers and practitioners reported that they considered the poor were benefiting from the policy change and that persons who had not been able to afford the services prior to the abolition of user fees were now accessing these services. Additionally, reports of an emerging trend whereby discharged users remained on the wards as borders for longer than necessary because family members chose not to receive them or continue their care at home are also indicative of the low socioeconomic status of people using the services.

While these accounts offer a suitable explanation for the socioeconomic status of the persons utilising the system, caution must be exercised in interpreting them. This is because the observed increase could also be attributed to what some practitioners described as an increase in the number of users being referred from private institutions since the policy change, as well as inappropriate use of the health facilities by some users. Of note is that some doctors working in the public sector also worked in private health facilities and it appeared that, since the policy change, they were now frequently referring their private patients to the public facilities. In addition to increasing the patient load, this suggests diversity in the social status of the users. These findings regarding the social status of the people utilising the health system supports studies in Uganda, Ghana and South Africa, which found that more poor people utilised the health services following the removal of user fees (Burnham et al., 2004; Penfold et al., 2007; Walker & Gilson, 2004; Wilkinson et al., 2001). There were also reports that both poor and non-poor in Uganda contributed to the increase in utilisation (Xu et al., 2006). Some researchers were able to determine the socioeconomic status of the users through household surveys, while others expressed caution that their findings did not clearly identify the socioeconomic status of the persons contributing to the increase in utilisation. People remaining in some Jamaican hospitals because families did not take them home and reports of low income may be indicative of users' social status. It may be evidence that this group of users were experiencing disparity in accessing required services. Socioeconomic status has been shown to be a barrier to accessing health services (Goddard & Smith, 1998, 2001; Mooney, 2009; Schoen & Doty, 2004). Nevertheless, appropriate measures need to be established by policymakers to determine who is actually benefiting from the policy change, as this has implications for sustainability of the policy, future policy direction, and access.

Impact on utilisation of health services. Utilisation increased following the removal of user fees. Reports by policymakers, practitioners, and users corroborated data from the MOH and RHAs annual reports, showing increases in the following areas: hospital admissions, outpatient visits, A&E department visits, pharmacy utilisation, and health centre visits, as well as the total number of surgeries performed one year after the abolition of user fees. While hospital admissions increased in Jamaica, they remained stable in Uganda (Nabyonga et al., 2005; Yates, Cooper, & Holland, 2006). The explanations offered for this Ugandan finding were related to cost-related issues (people who could pay were charged a fee) and hospital capacity limits (Nabyonga et al.). The situation was different in the Jamaican context, since services offered in hospitals were free regardless of users' ability to pay.

These findings are similar to changes in PHC utilisation patterns following the removal of user fees observed in African countries such as Uganda, which had an increase 44.2% in 2001 and 77.1% in 2002 (Burnham et al., 2004, Nabyonga et al., 2005; Yates et al., 2006) and Madagascar (Fafchamps & Minten, 2007). Utilisation patterns varied for some countries, which may be a result of how wide-spread the policy change was. For example, Uganda implemented a nation-wide policy change, while exemption or abolition of user fees was limited to certain populations groups or geographic areas in other countries.

MOH data showed that, there was an increase in the total number of new cases in 2009 over 2006 (MOH, 2010). Analysis of this data however, indicates that those persons using the services were mostly repeat users, returning for treatment for the same or new illnesses. This was deduced from the number of years people had been using the system. As such, this may not be a true reflection of increased access. This raises a very important issue concerning people who might be ill yet still not accessing the required care, as well as others who may have reverted to the use of private facilities and other modes of treatment, a finding which is supported by the JSLC 2009 (PIOJ & STATIN, 2010). Conversely, reports from South Africa revealed a sustained number of new registrations for curative services following removal of user fees; however, attendance by children under the age of six declined. The explanation offered for the decline was that congestion in the facilities and reduced consultation time deterred women from seeking maternal and child health services (Wilkinson et al., 2001). In Uganda, new cases increased following cost-sharing, but a decline in attendance was observed seven months after the policy change. Similarly, utilisation in Jamaica declined six to nine months after the implementation of the policy, which suggests that the significant initial increase may have been due to gaps in the system, people who were ill having delayed seeking care prior to the policy change, or people possibly being disenchanted with overcrowding in the facilities.

Evidently, the aforementioned findings regarding utilisation in Uganda and South Africa (Burnham et al., 2004; Wilkinson et al., 2001) showed comparable impacts regarding utilisation following the removal of user fees in the public health systems. The findings, however, regarding the decline in utilisation after implementation of the policy occurred at varying time periods. Despite the reported decline, the study revealed sustained daily overcrowding at the health facilities. This has implications for health practitioners’ workloads and levels of satisfaction, as well as for the supply of resources.

Regional variation in utilisation of some services. Regional variations were evident in the manner in which people utilised the services. Most diabetics accessed hospital inpatient care in NERHA (the smallest region) whereas most of those accessing PHC facilities did so in the largest region, SERHA. People affected by hypertension accessed care in PHC settings in SERHA generally. Studies from other countries have revealed regional variations in the manner in which people utilised health services. For example, in Uganda, utilisation of health services was higher in the western side of the country in comparison to the northern side (Dieninger & Mpuga, 2005). It is not possible to explain the regional variation in Jamaica from this research however, this phenomenon may be due to several factors including users' preference of facility, the manner in which facilities offer services, people in an acute state seeking care from hospitals rather than PHC, PHC users possibly having better health-seeking behaviours and being more aware of the services available to them; or supportive follow up systems in the health institutions. Other studies have provided evidence of regional, demographic and geographic variations in surgical procedures such as tonsillectomies and appendectomies, and other treatment procedures (Boss, Marstellar, & Simon, 2012; Lopushinsky, Austin, Rabeneck, & Kulkarni, 2007; To & Langer, 2010). Such regional variations need to be investigated further to determine the factors that influence the service delivery mechanisms and health-seeking behaviours of users.

Data obtained from the MOH and RHAs' annual reports revealed there was an overall increase in the Maternal and Infant Mortality and Crude Death rates in 2009. Three regions (SRHA, WRHA, and SERHA) recorded a decreased Infant Mortality rate. The increase in the crude death rate, however, was across all four RHAs. Also found was an overall increase in Maternal Mortality rates generally, with marked increases in SRHA and SERHA. The changes in Maternal Mortality rates might not necessarily be associated with the policy change, as they might be influenced by demographic changes, as well as the recording mechanisms used by the MOH and RHAs. Nevertheless, the high maternal mortality rate recorded in SRHA is of concern and requires further examination to establish the contributing factors. As alluded to earlier, in the absence of analyses to take into account any confounding variables, there are no clear explanations for these unanticipated findings. These results should be interpreted judiciously as they have not been previously observed in other studies, in South Africa for example the uptake of maternal and child health services declined following the removal of user fees. This problem was attributed to the congestion in health facilities and reduced consultation time (Wilkinson et al. 2001). In Ghana delivery-related-deaths declined (Asante et al., 2007).

8.5. Impact on the work of main health practitioners and the professional nurse

The study revealed practitioners' workloads increased following the policy change. Practitioners embraced the policy change, although there were feelings of discontent about a number of issues such as their non-involvement in the policy development. This finding was endorsed by policymakers, who reported that the health workforce had embraced the policy and offered excellent service in some facilities even though they were pressured. Practitioners' concerns included feeling stressed and overburdened by the increased workload since the policy change. Such experiences, however, did not negatively affect their resolve to make the policy work. This supports the findings of studies on abolition of user fees in Ghana where health workers were shown to embrace the policy change, citing opportunities to improve professionally and serve people although workloads had increased (Witter et al., 2007a, 2007b, 2010). Staff morale was also negatively affected in Uganda (Burnham et al., 2004; Gilson & McIntyre, 2005). Although Jamaican health practitioners' job security was not threatened, it was not uncommon for staff in countries such as Zambia and Uganda to lose their jobs because revenue previously generated from user fees to pay salaries was no longer available (Masiye et al., 2008; Nabyonga-Orem et al., 2008).

Practitioners' increase in workload may be the consequence of a number of factors: (a) additional workload not only from people genuinely in need of health care but also the inappropriate and haphazard manner in which other persons used the facilities, (b) having to work and manage facilities with inadequate staff, and (c) having to improvise in the face of limited resources in order to offer quality service. Similarly, in Uganda, Ghana and South Africa (Bhayat & Cleaton-Jones, 2003; Burnham et al., 2004; Chuma et al., 2009; Witter et al., 2007a, 2007b), the increased workload for health workers in the aftermath of the policy change was sometimes attributed to unnecessary use of facilities by some persons (Ridde & Diarra, 2009; Walker & Gilson, 2004). To address this type of user behaviour, policymakers need to reinforce existing measures and establish new ones in order to sensitise people about the appropriate use of the different types of health services. Mechanisms to ensure adherence to the measures should also be introduced.

As well as increased patient loads, practitioners reported seeing existing health conditions in larger numbers. For example, they were seeing more users with chronic diseases such as hypertension, diabetes and lung disorders, rather than new conditions. This finding suggested that the case mix had remained the same for most facilities and existing users were utilising the services more often. While most of the results regarding changes in the manner in which practitioners offered services have not been fully described in the literature, similar findings on case mix have been reported. A study in Uganda also showed that the case mix attending health facilities remained unchanged after the removal of user fees (Burnham et al., 2004). Nevertheless, the profile of the users of the Jamaican health system since the policy change needs more targeted investigation.

Professional nurses' workload. Clinically, the work of professional nurses increased significantly following the implementation of the no user fees policy. The study found nurses perceived that the policy change created additional pressure and destabilised their working situation, and compromised their ability to maintain professional practice. Measures were, however, adopted for effective implementation of the policy. Nurses, who are integral to improving access, frequently had to prioritise patient care in relation to the resources available to them. This also required improvisation to ensure an acceptable standard of service delivery. It was not unusual for nurses to make critical decisions regarding patient care despite inadequate resources and increased demand for service. For this reason, some patient care was often deferred due to resource constraints, for example, inadequate numbers of staff. This finding corroborates reports from most of the work in this field in Africa, in which nurses and health workers generally were found to experience increased workloads following the abolition of user fees (Burnham et al., 2004; Kajula et al., 2004; Ridde & Diarra, 2009; Ridde & Morestin, 2011; Walker & Gilson, 2004; Wilkinson et al., 2001; Witter et al., 2007a, 2007b). Of note however, is that increased workload for health workers, including nurses, in some countries was commensurate with an increase in pay (Witter et al., 2007a, 2007b). As will be shown below, the impact of the policy change on the work of the nurse in the Jamaican context differed in several ways from the findings of other research.

When the nursing groups were disaggregated by the researcher, their views regarding the impact on work differed. Some PHNs engaged in 'crowd control' in PHC facilities in order to maintain a harmonious work environment. This task frequently created additional stress, which could contribute to burnout. This also meant time that should be spent administering nursing care was spent on non-nursing activities, which had implications for effective service delivery. Equally, NPs reported having to find strategies to manage the increased numbers of patients, which included brief assessment times and postponement of care. When care was postponed, patients were initially assessed and given appointments to return for care. Although deferring care to another day was a temporary solution to manage patient load, it contributed to a recurrent cycle of sending patients away, which might have negatively impacted on patients' wellbeing because their conditions could deteriorate while waiting to be seen. In addition, when patients returned, this contributed to the workload of another day and had implications for mobilising sufficient resources to manage the increased number of persons using the system.

The unnecessary use of the services by some people not only put strain on the limited resources in the health system but also contributed to the stress and workload of nurses. Nurses reported that users from the private health system and middle classes, were now sometimes presenting for non-urgent problems. Managing this issue requires fundamental changes in people's health-seeking behaviour and may be achieved through patient education. Furthermore, it was difficult for nurses to consistently practise within their training and regulatory standards. For example, nurses expressed concern about their inability to care for patients holistically due to the increased numbers. They often administered physical care in a hurried manner with limited time to counsel and educate patients. Nurses' ability to create a patient-friendly waiting environment was also negatively affected by overcrowding. These issues may impact negatively on health outcomes, because managing a patient holistically, coupled with patient education, not only improves health status but may also encourage compliance with therapy. In addition, hurried care negatively affects the nurse-patient relationship, reduces the quality of service offered to individuals and increases the risk of litigation.

The study further found that NPs and doctors performed similar roles in the health centres; however, as a key role, NPs single-handedly managed services such as school medical examinations. All children need a school medical; in the absence of this certification, children are denied entry into schools. While NPs working parallel to doctors is not an outcome of the policy change, their presence has increased the number of persons with the requisite skills to assess and diagnose, thereby alleviating the pressure on the few doctors in the system. By virtue of their training NPs have the knowledge and skills to perform many tasks that are similar to a doctor. Patients have been found to be more satisfied with services offered by NPs; they offer better quality care, had longer consultation time and ordered more diagnostic tests (Horrocks, Anderson, & Salisbury, 2002). This further contributed to the effective implementation of the policy in terms of the presence of skilled personnel to respond to the demand for care. There is little or no discussion on the above issues in the literature from other countries that have experienced removal of user fees. While a few studies have reported the impact of removal of user fees policy on the work of the nurse, there is seldom mention of the particular categories of nurse or details of how their work changed (Witter et al., 2007b; Walker & Gilson, 2004). Nevertheless, in South Africa, PHC nurses reported compromised professional standards as a result of being ‘stretched’ by a large number of patients (Walker & Gilson, 2004). Assessment of the effects of removal of user fees on the work of professional nurses is important because it has implications for adequate staffing and future policy implementation. This is because nurses such as NPs have been found to increase access to quality and effective health care in some geographic areas and are strategically positioned to manage culturally-related access barriers (Safriet, 1992).

Individual nurses care for different numbers of patients and they were sometimes unhappy with patients’ attitudes toward the health system generally. This current study showed that NPs could not agree on the number of patients they were now attending. According to data obtained from the NPs, the number of patients did not apparently vary significantly from the pre-reform figures of approximately 25-30 patients per day. In contrast, PHNs offering maternal and child health services had to manage larger numbers of users. Thus, overcrowding was a daily occurrence for most primary and secondary care facilities. The study further found that some patients were considered inappropriate by the nurses, whereby they were non-urgent cases or could pay for the services. While previous studies did not mention the number of patients seen or number of hours worked by all categories of professional nurses, Walker and Gilson (2004) reported that nurses in Africa were concerned about overcrowding and increased workload, which suggests there were large numbers of patients to care for. Additionally, studies mentioned extended or long working hours and high mean client numbers per week for doctors and midwives in Afghanistan, Ghana and Senegal, with midwives’ daily workloads dependent on whether they were in a regional or local facility (Steinhart et al., 2011; Witter et al., 2007b, 2009, 2010).

Nurses were also concerned that the quality of services offered to clients had deteriorated since the policy change, and the increased patient load had affected their ability to adequately assess patients. Increased numbers resulted in reduced assessment time for each patient. Nurses were unhappy with this practice, which could jeopardise the users' wellbeing and the nurses' professional status. As a result, information crucial to making an accurate diagnosis could be missed. In addition, attempting to meet the needs of all patients could result in burnout, forcing nurses to perform poorly on the job, stay away from work, or resign. All these factors potentially affect the sustainability of the policy.

In addition to the compromised quality of services, the nurses reported that there was sometimes a lack of privacy when attending to patients. This was a concern for PHC nurses because lack of privacy could prevent patients from sharing important information required for accurate treatment. The study revealed that these factors affected the nurses' ability to maintain minimum standards of quality care and might have serious implications for access and the success of the policy generally. This is consistent with studies in South Africa and Uganda, which also reported that practitioners, including nurses, considered that services provided since the introduction free health care were of lower quality, with reduced time available for each patient; and a lack of privacy when attending to patients (Burnham et al., 2004; Deininger & Mpuga, 2004; Kajula et al., 2004; Nabyonga et al., 2005; Nabyonga-Orem et al., 2008; Walker & Gilson, 2004). Generally, the workload of nurses increased in the aftermath of the policy change, resulting in unanticipated consequences such as nurses being pressured to made critical decisions about their work and the delivery of patient care. It is apparent that while some services were available to the users, they may not have met their needs. These findings are vital to the success of the policy and future policy direction.

Resources and the work of main health practitioners. Compounding the increased workload of practitioners were a number of other factors including under-equipped facilities, lack of computerised systems in some pharmacies, and poorly-functioning equipment. While the experience with equipment may be related to untimely maintenance, it may also be due to the additional strain from the increased demand and the low priority given to repair equipment by policymakers due to a shift in focus to other matters. The claim regarding resources resonated with both policymakers and practitioners. Supplies such as family planning methods and reagents for diagnostic tests were inadequate. Practitioners were often frustrated because of their inability to provide the services required; in some circumstances users were asked to purchase their own materials in order to access procedures such as hernia repair. This finding revealed that only some users could afford to purchase materials and, as such, inequities continued in the system. Equally, poor access to family planning methods predisposes a childbearing family to unplanned pregnancies, STIs and economic hardship.

Inadequate resources such as equipment have not been discussed extensively in the literature, however, countries such as Uganda experienced problems with equipment and supplies in the aftermath of the policy change (Burnham et al., 2004). Additional budgetary allocation was injected into the Ugandan health system for support prior to the policy change (Dieninger & Mpuga, 2004). Jamaica also received additional budgetary support, which was insufficient to meet the increased demand. Except for countries in which the policy was not fully understood and facilities reverted to charging for services (Chuma et al., 2009), there is limited discussion in the literature regarding patients having to purchase supplies after the removal of user fees. Patients having to pay out-of-pocket for supplies, indicates that the policy, which was meant to improve access, was now creating barriers and inequity.

Of significance is that this study found practitioners changed the manner in which they offered care in order to contribute to improving access to health services. Changes included extending health facilities' working days and working hours; adjusting some institutions' policies, especially those related to when and where staff would work; financially assisting users to obtain diagnostic procedures; patient education and additional pressure to complete duty schedules/rosters with the limited staff; collaboration with other units such as pharmacies; and new measures by which to monitor discharged users. Some amount of lobbying was also underway to obtain well-needed equipment such as CT scanners and MRI machines. It is apparent that practitioners were committed to making the policy work.

There was, however, a lack of appropriate casual space for some staff and, as such, staff often had to take their lunch breaks at their workstations in the presence of waiting users. These users were sometimes 'abusive' and 'insensitive' to the needs of the practitioners. One explanation for these attitudes is that sometimes users would arrive at the facilities at very early hours of the morning and by lunchtime had already waited for long periods of time prior to receiving care. Of note is that some institutions made efforts to provide rest areas for staff. The finding that practitioners had to take their lunch breaks in the presence of waiting patients due to lack of an appropriate staff facility has not been previously reported in studies on the abolition of user fees. A few studies have, however, documented the negative effects of the policy change on practitioner-patient relationships (Burnham et al., 2004; Ridde, Robert, & Messen, 2012; Ridde & Diarra, 2009; Walker & Gilson, 2004). This suggests that practitioners' working conditions require more in-depth investigation. Measures by policymakers to maintain practitioners' health in order to enhance effective performance on the job are important. Satisfaction is paramount to retaining practitioners in the system and, as such, should receive the required attention.

In regards to staffing, policymakers alluded to an increase in staff for some health facilities; however, practitioners were of a different view, since the perennial shortage of staff prior to the policy change had still not been sufficiently addressed. As a result, practitioners were now working longer hours sometimes without lunch or bathroom break periods. The increased working hours and lack of breaks resulted in staff experiencing health conditions such as digestive disorders and UTIs. While it may not have been effective, minimal work had initially been done to improve staffing in Jamaica. Efforts were made post implementation to recruit and train some categories of staff, for example, pharmacists and dialysis technicians, in order to boost the complement in the facilities (MOH, 2008b). These measures were intended to alleviate the pressure on the staff in the facilities, make the services available to users and maintain the quality of services provided, as well as minimise waiting times. This finding is consistent with studies in Uganda and Niger, which also reported that health workers were recruited to support the policy change (Nabyonga-Orem et al., 2008; Ridde & Diarra, 2009). Improving staff numbers was necessary to improve access, the main objective of the policy, and must remain an on-going priority.

Despite there being several possible explanations, the aforementioned issues could be attributed to the limited budgetary support injected into the system prior to the policy change and the hurried nature in which the policy was implemented. Regional policymakers and practitioners considered the public health system to be underfunded and felt this should have received serious attention prior to the implementation of the policy. The budgetary shortfall meant lack of basic supplies such as syringes and needles. National policymakers, on the other hand, reported that there had been additional budgetary support to offset the policy implementation. Evidently, this allocation was insufficient and policymakers need to mobilise more funds to address the demands resulting from the policy change. Budgetary support has been reported in other countries as vital to ensure implementation and sustainability of the policy change (Burnham et al., 2004; Nabyonga-Orem et al., 2008).

The policy had not allowed sufficient time for the key stakeholders to be engaged fully in the process, a concern that resonated with most practitioners. They reiterated the point that the policy change would have been more effectively managed if they were involved throughout all the stages of the policy process. An important lesson here is that all stakeholders must be integrally engaged in all phases of the policy process if it is to achieve widespread credibility and sustainability. Practitioners are also important in getting users to buy into new policies. Involvement of some key stakeholders in the policy process has also been described in other countries with similar policy changes, but there was a lack of consultation with practitioners in some countries such as Uganda and Ghana (Kajula et al., 2004; Witter & Adjei, 2007). Although practitioners in Jamaica embraced the policy generally, it is important to note that they were trying to make the policy work under stressful and difficult circumstances. Practitioners were often disenchanted with the increased workloads, overcrowding, limited resources, poor working conditions, and reduced time able to be spent with users in order to accommodate more persons. These opinions suggest that it is important for policymakers to address these issues in order to improve satisfaction among practitioners.

Resources and the work of professional nurses. The study found that nurses in both primary and secondary care were concerned about the resources available generally and their ability to deliver care in an acceptable manner. This corroborates studies in Africa in which nurses and health workers were frustrated by the lack of resources such as drugs (Gilson & McIntyre, 2005; Walker & Gilson, 2004). There was a shortage of basic materials and equipment to work with across both primary and secondary facilities in all four RHAs. Inadequate equipment ranged from basic necessary items such as blood pressure machines to more advanced technologies such as CT and MRI machines. Other unavailable items included needles, syringes, stethoscopes and diagnostic sets. There was also a shortage of stretchers, especially in A&E departments which had seen a large increase in patient presentation. Often this was because the stretchers were being used as additional beds. It was further found that whenever an emergency case arrived at the A&E Department and there was need for a stretcher, these patients were then moved to chairs.

This meant that the services required by persons could not be provided. This put people's lives at risk, resulting in possibly deteriorating health conditions, frustration for users, increased stress and frustration for the nurses who often felt powerless or had to find creative means to manage the problems, and tensions within the health workforce and among staff and patients. In addition, the policy resulted in situations that constituted a barrier to access where the reverse should have been achieved.

Drugs, contraceptives and other supplies were often quickly depleted due to the increased demand. This posed a challenge for nurses for two main reasons: the free care policy, which was intended to improve access, appeared to be a barrier in itself, and some patients were of the view that nurses were to blame for the problems they encountered while accessing care. This supports findings from research in African countries where nurses reported stock out of medical supplies and lack of resources generally, which impacted negatively on nurse-patient relationships. An acrimonious relationship between nurses and patients can occur when drugs are not available or nurses have to dispense in the absence of a pharmacist (Burnham et al., 2004; Deininger & Mpuga, 2005; Nabyonga et al., 2005; Nabyonga-Orem et al., 2008; Ridde & Diarra, 2009; Walker & Gilson, 2004).

Policymakers and providers

It was found that nurses were concerned about the effects of this shortage of resources. Areas of concern included the risk of asking people who were financially challenged to purchase materials and supplies, such as family planning methods, at private facilities if they were unavailable at government facilities. Patients who lacked the necessary financial resources not only added pressure to the system but their reluctance to buy contraceptives in the private sector also put them at risk of unplanned pregnancies. Additionally, nurses were frustrated and stressed when items such as glucometers for testing blood glucose were incompatible with the strips supplied. Shortages of, or overused and malfunctioning equipment, were equally frustrating for the nurses, since defective equipment produced inaccurate results. It was further found that when supplies were unavailable, nurses had to request support from other departments and hospitals or walk to other departments to obtain the required supplies. Nurses found this overwhelming and an impediment to administering quality care. Nevertheless, the study found there was support from some administrative staff to mobilise resources. Overall, however, the finding that nurses were stressed and frustrated by the lack of necessary resources has implications for nurses' and users' wellbeing, as well as nurses' contribution and commitment to the success of the policy. Having to travel between departments not only added stress to the nurses' work but would also reduce the amount of time available to administer nursing care in an effective manner.

Possible explanations for the aforementioned concerns are that shortage of resources was a perennial problem, which the abolition of user fees merely exacerbated and insufficient resources had been infused into the system to support the increased demand arising from the removal of user fees. Despite limited discussion in the literature on creative measures adopted by nurses to overcome the challenges of inadequate resources, the Jamaican findings are consistent with studies in South Africa where nurses found the shortages of equipment and other resources frustrating, a situation further compounded by the free health care policy. Even in countries where policymakers injected additional funding and other resources, similar problems were experienced (Burnham et al., 2004; Deininger & Mpuga, 2005; Nabyonga et al., 2005; Nabyonga-Orem et al., 2008; Walker & Gilson, 2004).

A shortage of suitable workspace and ambulances in hospitals was also found to be affecting the work of the nurse. Nurses sometimes arranged for the transfer of patients, as well as accompanying the patients. This further placed pressure on the nurses who often experienced stress when there was a shortage of ambulances. To alleviate such problems, private ambulances were brought in, at a cost to the facilities or relatives assisted in transporting their kin. These solutions were a concern for nurses who were sometimes required to accompany patients but experienced some level of discomfort when travelling in the vehicles of users' relatives. Equally, space to administer care was found to be inadequate in the PHC facilities. While other studies in Africa have mentioned the shortage of resources generally, no specific details exist about ambulance services. However, reports about congestion and overcrowding in facilities suggest there were also workspace problems (Walker & Gilson, 2004; Witter et al., 2007a, 2007b; Wilkinson et al., 2001).

Even though policymakers reported recruiting extra staff locally and overseas and training new categories of staff, the findings showed nurses were often concerned about the shortages of staff in addition to the archaic cadres (established number of trained professionals in the public health system) in the facilities generally. This was because of inadequate coverage with insufficient personnel to assign to particular areas. Nurses were frequently redeployed to other facilities to ensure minimal coverage. For this reason, continuity and accepted standards of care by nurses could not be guaranteed. Furthermore, nurses' work hours were extended or adjusted in some health centres to compensate for the shortfalls in staff. This included a shift system for some and assignments on Saturdays for others. Of note is that the new shift system in health centres created an additional burden for nurses who complained of being overworked, tired and suffering from burnout. This resonated with hospital-based nurses where the same nursing staff worked repeat shifts, for approximately 16 hours or more. This finding has implications for patient safety and the potential to influence nurses' decisions to leave the organisation. When nurses work for long hours, the risk of errors has been found to increase (Rogers, Hwang, Scott, Aiken, & Dinges, 2004; Scott, Rogers, Hwang, & Zhang, 2006). The effect of long working hours on the nurse was not explored further.

While the above findings regarding the shortage of staff have been mentioned in studies from other countries with free health care (Walker & Gilson, 2004; Witter et al., 2007b), the adjustment to working hours and shift schedules by professional nurses is yet to be documented. Community health nurses, midwives and doctors, however, reported working long hours after the abolition of user fees in Ghana (Bosu et al., 2007; Witter et al., 2009). Additionally, prior to the removal of user fees, policymakers in some African countries recruited additional staff (Dieninger & Mpuga, 2005). While the specific category of staff was not mentioned, the Zambian MOH recruited mainly nurses (Masiye et al., 2008). In Jamaica, policymakers also expressed interest in empowering and up-skilling some categories of staff such as the NPs for capacity building and strengthening of the policy.

Another contributing factor to the shortage of staff was the turnover rate. The study revealed that nurses were thinking about leaving due to the lack of necessary supplies. This is contrary to the popular belief among Jamaicans that remuneration is the main reason for nurses leaving the public health system, and may be explained by the finding that nurses were frustrated by the need to source supplies when out of stock. Nurses were equally disenchanted by the lack of recognition for their work and worth. Evidently, nurses felt disempowered, even while ensuring their users' rights were observed. This was an unexpected finding. While personnel migrated regionally and internationally, it was found that some nurses were also attracted to the incentives offered locally in the private sector. This supports findings from studies in Africa where a perceived deterioration in working conditions was one of the driving forces for nurses to resign in favour of more lucrative job offers in the private health sector or overseas (Walker & Gilson, 2004). In addition to staff turnover implications for continuity of care, there is also a significant amount of time required to orientate new staff, which might ultimately result in negative impacts on the effective and efficient performance of the Jamaican nursing workforce.

The solution of recruiting overseas nurses for capacity building in the health facilities created additional stress. The study found that nurses in hospitals were especially vocal about the added responsibility and additional stress experienced when supervising and interacting with these nurses on the wards. Language barriers and practices that might potentially jeopardise the lives of the patients were dominant opinions. Nurses also reported that overseas nurses were given more attractive remuneration and gratuity packages than locals. They perceived this practice as a disincentive to the Jamaican nurses. As a result, nurses suggested that policymakers revisit the terms and conditions for recruiting overseas nurses, as well the remuneration for local nurses. Clearly, nurses were dissatisfied with the strain placed on them by having to monitor and supervise overseas nurses. They also felt betrayed because of the discrepancy created by policymakers regarding remuneration packages offered to overseas nurses relative to theirs. These tensions may have existed prior to the introduction of free care. However, the impact of the policy had the potential to create anxiety among the groups, especially when combined with increased workload and shortage of staff. The interaction between the two groups of nurses might have been influenced by the history of having overseas workers enjoying better working situations than locals under Plantocracy. The impact of free care on the interaction between overseas nurses and locals has not been described as a problem in other countries with similar policies, and was not explored further in this study.

Additional problems encountered by nurses in PHC settings included the inability to refer some patients when there was a need. This was a result of a particular category of health personnel not being assigned to the facility or a shortage of that category, for example, social workers in the public health system generally. Some nurses were, however, satisfied with the categories of personnel at their disposal in the health centres.

The type of facility may have influenced the availability of certain categories of staff (see Chapter 2 for types of facilities). While shortage of resources, including staff, has been mentioned in the literature, no details were provided relating to the experiences of different categories of staff. To improve access, policymakers and providers have a responsibility to ensure that resources such as trained staff are available to deliver care. This also influences users' choice of facility (Kiwanuka et al., 2008).

Nurses were equally dissatisfied with other experiences in the workplace that were effects of or exacerbated by the policy change. For example, the late payment of salaries, about which they were seldom advised, had been a contentious issue for some PHNs. This was attributed to the inadequate funding of the health system and a possible result of the policy change. Late payments were compounded by the reduction in payments for travelling for home visits. In response to reduced travel funding, nurses reported a reduction in the number of home visits and the manner in which they were conducted. This finding meant some persons had limited access to services and were at risk of deteriorating health. The reduction in payment for travel may be a reflection of inadequate funding as part of the policy change, as well as a shift in focus, which saw funds being diverted to strengthen other areas of the health system. Undoubtedly, this constituted a de-motivating factor for nurses. Policies which significantly reduce the budgetary allocation to nursing services have serious implication for improved access, because nurses are integral to enhancing access to health services and such change can limit their creative and innovative efforts.

While studies have not extensively reported late payment of salaries to nurses, mention has been made about late reimbursement to some facilities, which may also include payment for nurses (Witter et al., 2007a, 2010). In contrast, some authors have reported increased salaries and other incentives for health workers including nurses, (Witter et al., 2007b), while others mentioned that loss of revenue from user fees contributed to job losses for some categories of workers, and reductions in the number of committee meetings and outreach programmes (Burnham et al., 2004; Gilson & McIntyre, 2005; Kajula et al., 2004; Masiye et al., 2008; Nabyonga-Orem et al., 2008). Nurses in hospitals were also concerned about the effects of inadequate budgetary support on the training of some categories of staff in some RHAs. The lack of budgetary support for training of staff is unreported in the studies on the abolition of user fees. Even though nurses attributed these problems to the removal of the user fees policy, other administrative factors may have contributed to the budgetary and payment issues, which require further investigations.

Change in patient profile on the work of the professional nurse. The study found that, despite the increased patient load, the types of health conditions patients presented with did not change with the removal of user fees. There was, however, an increase in the uptake of some services such as curatives and family planning services. Nurses in health centres also reported seeing more private patients for post-surgery services such as removal of sutures and dressings. Possible explanations for this finding are that the free system was more accommodating; patients no longer delayed seeking care when required; and gaps in the system may have prevented people from fully utilising the services prior to the policy change. While nurses were confident the health needs of Jamaicans who could not afford out-of-pocket payments were now being met, they were concerned about the increased number of private patients utilising the PHC services since the policy change. Studies in African countries have shown that, while there was increased utilisation of curative services, there was no change in the case mix. Nurses also felt that people who could not afford health care were benefiting from the free care (Burnham et al., 2004; Wilkinson et al., 2001). While studies in Africa did not extensively discuss the increase in private patients utilising public facilities, nurses felt that people who could afford to pay for health care should pay (Ridde & Diarra, 2009; Walker & Gilson, 2004). These findings have implications for future policy change; in terms of mobilising the required resources including human resources, to address anticipated and unanticipated changes associated with the policy.

Furthermore, the nurses, in describing the impact of the policy change on their work, usually made reference to the changed manner in which people were utilising the health system. Despite the extended work hours, nurses gave accounts of patients arriving as early as 2am, to obtain a number to be seen, as well as late at night for non-urgent conditions. This suggests that overcrowding in the facilities had inspired patients to develop new coping strategies when seeking treatment. A possible explanation for this behaviour is that people did not trust the longevity of the policy change. In addition, this created more stress on nurses and burdened the system generally. The study further found that nurses felt patients lacked good judgement in utilising the facilities, were not sensitive to the nurses' needs, for example, their need for lunch breaks, and were inclined to vent their frustration on the nurses whenever they did not receive the required services. Negative attitudes to nurses may be associated with people arriving at early hours and having to wait for long periods of time to be seen. This supports findings from a study in South Africa, in which nurses viewed some users' attitudes as uncouth (Walker & Gilson, 2004). While mention was made of people arriving late at night for care in Africa, the situation in Jamaica occurred both at night and early in the morning and for different reasons (Ridde & Diarra, 2009).

8.6. Conclusion

There were varied views among policymakers, practitioners and users about the impact of the policy change. Utilisation of services increased immediately following the policy change; however, there was an initial decline 6-9 months after with a sustained increase over the pre-policy period. Access was improved for all, which can be viewed positively, nonetheless, the policy also had some downsides, which may be additional barriers encountered by users in an attempt to access health services.

In support of the access theoretical framework the study has revealed that for people to gain access to health services a number of factors must synchronise for the desired effects to be achieved. User fees were abolished in Jamaica to remove the cost barrier however insufficient budgetary allocation and planning to sustain the policy accompanied the change. The increased utilisation; overcrowding; and lack of resources such as drugs, and working equipment resulted in an increased workload for nurses and other health practitioners which meant care provided was sometimes compromised. Policymakers need to address issues regarding all the main characteristics of access – availability, affordability, accessibility, accommodation and acceptability – in a realistic manner if they are to reap meaningful gains in addressing access issues and inequities in health service.

The practitioners and nurses interviewed embraced the user fees policy, despite concerns about several issues such as lack of involvement in the policy process prior to implementation. Although these practitioners including nurses perceived that people were benefiting from the change, they also had concerns, which included the following: the health system's capacity to sustain the policy, increased workloads and overcrowding, poor working conditions, inadequate resources such as drugs and equipment, inadequate workspaces, misuse of the system and low morale. The next chapter will provide a conclusion to the study.

Chapter 9: Conclusion

9.1. Introduction

This study used a multi-layered mixed method approach to evaluate and provide new insights into the impact of the abolition of user fees in the Jamaican public health system on access, care provided and the work of the professional nurse. This chapter commences with highlights of the major findings, and then outlines the strengths and limitations of the study, lessons learned, implications for future policy, practice and research, and finally makes recommendations for future programme and policy development. This study evaluated the impact of the user fees policy from three perspectives: the policymaker, the provider and the user. The objectives of the study were to examine the utilisation of services in public health facilities during the period 2006-2009 to establish whether barriers to access had remained a problem for consumers since the abolition of user fees; to analyse the effects of the abolition of user fees on the work of the professional nurse; and to identify the lessons learned for Jamaica and developing countries regarding the abolition of user fees. The findings provide additional evidence with respect to the impact of abolishing user fees in public health systems and make several contributions to the existing literature on the experience of free health care policies in developing countries and its impact on the work of the professional nurse.

For this study access theory was utilised to shed new light on access to health services while other scholars have opted to use theories such as policy implementation theory. In addition, access theory has frequently been discussed from the users' perspectives however, this study expanded on this by looking at the policymakers and providers' perspectives especially that of the professional nurse. The findings revealed that when health services were made available users changed their behaviours. For example there was inappropriate use of the facilities, they hoarded the medications and they queued up at the facilities at early hours in the mornings. These behaviours suggest that people did not trust the system to last. The study also showed that cost is only one barrier to access because users encountered a number of other challenges.

The decision to introduce the user fees policy in Jamaica was determined and ratified at the level of central government, in other words, was politically motivated. This meant little or no consultation regarding the policy process with key stakeholders, especially frontline workers such as nurses. Given the level at which the policy was determined, it was not unusual for the some stakeholders interviewed to consider that the implementation phase had been politicised. This view may be attributed to the policy's inclusion in the then government's Election Manifesto. Drawbacks to the process, moreover, were the hurried manner in which the policy was implemented and the lack of participation by key stakeholders in the process. This suggests that the planning and implementation processes lacked sufficient analysis of the likely effects of the policy and the support needed to ensure its effective implementation. For a policy change of such magnitude, specific arrangements should have been put in place for timely and accurate monitoring of the possible effects, yet this had not been the case in the Jamaican context. Planning and consultation with health practitioners is important as such policies have far-reaching effects on their work and has implications for how practitioners can help improve access. Monitoring of the policy was done through existing systems. While these systems captured some effects, the monitoring might not have been sufficiently targeted to capture all the changes associated with the policy. This had implications for prompt management of the impact of the policy and for future policy development.

The experiences of African countries with similar economic situations to Jamaica were utilised by the Jamaican government to guide the process of introducing the removal of user fees. A possible reason for utilising these experiences may have been the paucity of data on contexts and policy implementation processes for free health care within Jamaica and the Caribbean generally. This influenced the manner in which policymakers interpreted the feasibility of the project. For policymakers, the aim of the policy change was to remove the financial constraints that constituted a barrier to access to health care. For them, a window of opportunity presented itself and, to fulfil the mandate of the government, the policy had to be implemented at any cost. In contrast, practitioners, including nurses, thought the policy change was politicised and over-ambitious. Dominant practitioners' opinions regarding measures that might have improved the success of the policy included reverting to exemption policy; providing a basic minimum package; retaining the free care policy for children under 18 years; and provision of free services for children and the elderly. Practitioners considered these would be more realistic and practical solutions to addressing poor access to services in a resource-constrained public health system. Users' understanding of the policy varied. While they were aware of the availability of free care, most could not identify all the services that were free. This indicates that they did not fully grasp the arrangements in the policy, that more education of the public regarding the policy was required and that the users' experiences may reflect the lack of consultation with key stakeholders whose role included dissemination of information to end-users. The lack of knowledge regarding the available services can be interpreted as a barrier to access, which, of course, is counter-productive and incongruous with the policy objective of improving access to health services. It also has implication for health literacy and a better understanding of the multidimensional nature of the concept access.

Despite the political context within which the policy originated, experience shows that rapid changes took place as a direct result of the policy. One significant finding from this study was that utilisation of the public health facilities increased markedly immediately after the implementation of the policy. This was evident in the uptake of all services in the public secondary and primary care facilities. The use of A&E, curative, and pharmaceutical services were most pronounced. Although there were reports by the MOH that utilisation rates declined after the first nine months, there was, however, an overall increase between 2006 and 2009. This increased utilisation resulted in practitioners being concerned about the sustained daily overcrowding at the facilities. In addition, when patients were unable to obtain free care from their usual health facilities, many resorted to paying for services, a finding that was supported by the PIOJ, which reported that people from all quintiles were increasingly trending back to the private sector for health care. There were no clear explanations for this phenomenon. However, it suggests that they are other barriers to access or a growing disenchantment with the system and has implications for the success of a policy intended to improve access.

It is apparent that people who utilised the health services were from various social backgrounds; encountered problems in accessing the services; and were inclined to revert to using private services when care could not be obtained at the public facilities. The socioeconomic status of users generally could not be clearly established from this research, as those surveyed indicated that people from all social backgrounds utilised the services. Problems that users encountered included travel costs, having to purchase drugs at private facilities and long waiting times. These issues, however, did not dissuade people from seeking care at facilities, even amidst claims that the use of private facilities was increasing. Although only people who used the public health system were surveyed, the use of private services may translate into a barrier to access and requires the attention of policymakers.

Perspectives regarding the policy among policymakers, practitioners and users were dissimilar. Policymakers remained optimistic about the policy generally and were satisfied with its immediate impact on utilisation. In the absence of any specific formal evaluation of the policy, they were guided by data provided by the facilities, parishes and RHAs, to respond to the positive and negative impacts of the policy. Policymakers were conscious of the areas within the system that required strengthening. Practitioners were highly dissatisfied with their working conditions, increased workloads, and lack of involvement in the policy process. While they felt the policy had good intentions and was benefiting those who could not afford care, they also believed that people who could afford to pay should pay for the services. Equally, they cited the need for practitioners to be involved in the policymaking process. Ironically, users were generally satisfied with the services provided, even though they encountered long waiting times, drug unavailability, and decreased assessment times *inter alia*. However, a possible lack of understanding of the policy resulted in patients roving among health facilities and hoarding drugs. These practices implied that users did not trust the system would last.

The findings revealed that the policy resulted in changes to the work of health practitioners generally. It further demonstrated how nurses contributed to improved access to health services as well as how health policies impact their work and other health professionals. Despite the policy change being politically motivated, professional nurses made the policy work under trying circumstances. Dominant opinions expressed by research participants included a call for greater analysis, planning and consultation to have preceded the policy change; low morale; lack of recognition; poor remuneration; poor working conditions; overcrowding; and increased workload resulting in ill health among nurses, and reduced patient assessment times. Even though some additional staff had been employed, nurses gave accounts of inadequate resources forcing them to make harsh decisions regarding patient care; additional stress in monitoring overseas nurses; lack of facilities such as lounge and child care services; misuse of the services by some persons; and hostility from patients. Nurses adopted new roles, which included crowd control and worked under stressful and frustrating conditions, to make the policy work. Generally, the perception among nurses was that the pre-existing conditions of a resource-constrained health system had exacerbated their current work situation. In addition to working with limited resources, nurses reported having to change the manner in which they offered care. Those in PHC modified their work schedules in order to conduct home visits and provide family planning services. Given the above issues and lack of adequate administrative support, it was not uncommon for nurses to resign from the public service. These findings add substantially to the understanding of nurses as actors in the free health care environment, not only as implementers of the policy but they ensured the sustainability of the abolition of user fees policy.

Ultimately, the policy change was not just a political rhetoric because it addressed a need that existed. Increased utilisation of health services was achieved, despite inferences that user fees may just be one of the problems encountered by users of the health system. However, the policy change had serious implications for budgetary allocation, resource allocation, human resources, information transfer and monitoring mechanisms. Inadequate funding and perverse incentives, such as limited resources, lack of additional incentives for increased workload, and lack of adequate administrative support, were undermining the policy. These problems could have been averted or minimised if careful analysis had been undertaken prior to its implementation. Taken together, these results suggest that the concerns raised by nurses and other practitioners might have been influenced by the policy implementation processes.

9.2. Strengths and limitations of the study

Strengths. There are seven major strengths of the study. First, methodologically, the study took the evaluation of policy change further by adopting a multi-layered mixed methods approach to provide three tiers of data, across regions, across primary and secondary care facilities, among policymakers, across professions and among users. This provided competing perspectives that add to the robustness of the findings on the impact of the policy change. Second, most researchers have studied the impact of free health care on health workers in rural and urban PHC settings. However, this study examined the perspectives of main practitioners, including the professional nurse, in rural and urban primary and secondary care public facilities in four RHAs. The RHAs differed geographically, demographically and epidemiologically, so gathering data from each added to the depth of the study. Obtaining data from secondary care facilities added substantially to the study and the existing literature on the abolition of user fees. Third, transcription was completed by the researcher, which aided familiarity with the data, an advantage that was used to enhance the analysis and interpretation phase of the study. In addition, all data were collected by the researcher except for some user surveys and national statistical data.

Fourth, the study employed member checking, whereby participants were asked to provide comments and feedback on interview notes. Fifth, the process of triangulation was used to further interpret the findings within and across groups, and between the document review, interviews and focus groups. Sixth, the study provided evidence of key perspectives through the use of quotations, numerical data and statistical inferences. Additionally, where figures were inconsistent, clarification was sought from the MOH in order to achieve accuracy. Seventh, the researcher was neither involved with the policy change nor worked in the health system at the time of the policy change or during the study. Moreover, data were analysed outside of the country, making them free from any interference. As a result, bias was reduced and the researcher was open to possibilities within the findings.

Limitations. There are five main limitations of the study. First, the use of non-probability sampling techniques to recruit policymakers and practitioners potentially reduces the generalisability of the findings. Eight eligible policymakers (national and regional) were selected based on their roles and positions in the public health system. This provided no possibility of assessing the typicalness of the participants and, by virtue of their roles and positions, confidentiality could not be assured. Despite using a systematic sampling technique to recruit users, persons utilising the health facilities on the days of data collection may not have been representative of the general population.

Second, data collection had to be done within specific time frames and, as such, only persons using the main service areas on those specified dates and times were included. Additionally, the decision to survey 200 users was a pragmatic one. Once the quota was reached, other users were automatically eliminated. Similarly, the study excluded non-users of the public health system. This was because the study aimed to capture the perspectives of users of facilities where services were free. Private facilities still charge a fee for the services provided. Additionally, no strong inference can be provided about the social status of the group who utilised the services at the time of the survey, although it was apparent people from varying social backgrounds utilised the facilities.

Third, due to unforeseen circumstances, the researcher had to administer some surveys in the absence of student researchers. This could be viewed as an advantage from the perspective that the researcher was able to clarify any concerns for the respondent regarding the study. However, controlling for bias was also important. Nurses in the facilities were, therefore, asked to assist with the selection of participants by choosing every fifth person from the registration book. Fourth, despite checking for completeness of the surveys, there were some missing responses to the variable “quality of service” in one survey, due to the pages sticking together. This, however, did not affect the analysis generally, since the survey was sufficiently completed to be included in the data analysis.

Finally, as part of the document review, official statistics were obtained from the MOH and the RHAs. Annual reports and additional documents provided by the MOH statistician and other MOH personnel were also utilised to determine trends in utilisation patterns since the abolition of user fees. The data from the MOH should essentially reflect the national figures, but this was not so for some statistics. Some inconsistencies were detected on examination of the data provided by the MOH and the RHAs. The decision was, therefore, taken to focus conclusions on the data provided by the MOH for most variables.

9.3. Lessons learned

While many lessons can be deduced from the findings of this study, only those judged to be the most important for Jamaican and international audiences will be mentioned here. The study revealed that decisions for the policy change in Jamaica were made at the central government level, resulting in a top-down administration of the arrangements. This also implies that the process was not participative and, as such, some stakeholders were not involved in the initial stages. In addition to highlighting the political nature of the policy, the study revealed the impact policies influenced by political agendas can have on health system and the work of professional nurses. The policy was unplanned and implemented in a precipitous manner. Nevertheless, the abolition of user fees increased utilisation and, as such, preparation for this far-reaching change was paramount. Engaging stakeholders at all stages of the policy process to engender consensus and success of the implementation process was lacking. Policymakers should also have mobilised the necessary resources in anticipation of the increase in demand. Furthermore, for a policy change of this magnitude to achieve success and sustainability political will and commitment are required. Commitment to the programme can be only achieved through the provision of the necessary resources and funding to sustain the changes. While some resources were provided, the 'run on the system' indicates those were insufficient.

Additionally, nurses and other practitioners were integral players in the policy change and should have been involved at all stages of the policy process; this however, was lacking, resulting in nurses feeling demoralised, frustrated and powerless to anticipate all the possible effects of the policy change. Even though they expressed concerns about poor working conditions, increased workload, inadequate resources and lack of recognition, nurses made a significant contribution to the implementation of the policy. It may be necessary for policymakers to provide incentives for nurses as recompense for the increased workload. This is necessary because nurses and all practitioners worked hard to make the system work under trying and difficult working conditions. Furthermore, policymakers need to implement strategies to train and retain Jamaican nurses in order to effectively manage the contentious situation regarding overseas nurses. In other words, strategies should be adopted to reduce the need to recruit or employ overseas nurses.

Implications for policy and practice. The findings bring into focus implications for policy and practice in an environment free of health service charges. For any policy change to be successful it requires all stakeholders to take ownership of its provisions. It, therefore, means engaging participants at each stage of the policy process (agenda setting, formulation, implementation and evaluation). Although the debate on user fees was progressively on-going, no consensus on how to reform the system had been determined in Jamaica. The context within which the policy was implemented, the 'big bang' approach adopted for its implementation, and the response of stakeholders, such as nurses and other practitioners, suggest a level of uncertainty regarding adherence to the policy process stages leading up to the implementation. Despite embracing and actively implementing the changes, nurses and other practitioners had serious concerns about the impact of the policy on their work. It is, therefore, important that policymakers engage with and amass the views of all stakeholders such as nurses for future policy development and implementation. Nurses ensure the sustainability of the policy change.

Communication is essential for the success of any policy change, especially between implementers and end-users. This fosters clear interpretations of the tenets of the policy. A policy may be interpreted by different stakeholders in different ways, so, for uniformity in implementation, clear, targeted communication is required. While there was some level of uniformity across the RHAs in Jamaica, not all users could identify the services available to them under the new policy. This lack of awareness has implications for the increased use of the services, which, by extension, was the aim of the policy. Users' lack of knowledge regarding the available services undermines the main objective of the policy. Despite publicity via avenues such as print and electronic media, a level of misunderstanding prevailed. This may be a reflection of users' health literacy and educational levels. For future policy, therefore, it is important to employ simplified, unambiguous guidelines and effective communication strategies for disseminating information to stakeholders and users.

The study revealed that no formal, specific monitoring or evaluation mechanisms had been instituted prior to the implementation of the policy. Such mechanisms are necessary to capture early and on-going changes, as well as to provide feedback to further enhance policymakers' ability to improve outcomes and expeditiously address problems within the system. Additionally, a monitoring system would enhance the policy by identifying workforce issues and increased areas of utilisation, as well as misuse: both sources of further strain on the health system. It was apparent that facilities, parishes and RHAs had obtained data regarding changes in the system in a haphazard manner, which suggests weaknesses in the policy processes and has implications for future monitoring.

While some policymakers agreed that the public health system had received additional budgetary support for the policy change, others were of the view that the system lacked sufficient recurrent and capital budgetary support. This meant some RHAs had to adopt creative means, such as private-public partnerships, to generate additional funding. The lack of insight into the extent to which increased utilisation would affect the already resource-constrained health facilities was apparent. There was widespread shortage of resources, which negatively affected the morale and work of practitioners, especially the professional nurse. Furthermore, some stakeholders favoured the previous exemption system and were averse to the new system, which they felt could not be sustained within the current resource-constrained health system and existing economic climate. Arguably, there should have been extensive planning to identify a reliable and sustainable source of funding to meet the demands of the new system. Moreover, cost-benefit analysis and needs assessment would have been instrumental in determining gaps in the system, as well as the resources required to address the needs. Careful attention in these areas may be appropriate for future policy development. Examination of the long term effect of the policy is critical to achieving access to health services.

Implications for future research. While the mixed methods study presents useful information on the impact of the user fees policy in the Jamaican public health system, further research using other designs such as quantitative and/or qualitative longitudinal studies is required. This would enhance comparability, as well as strengthen the credibility of these findings. Additionally, the study confirmed that abolition of user fees in Jamaica had resulted in increased utilisation. The implementation process, however, lacked sufficient planning and may require research to determine the best practices for implementing such policies, as well as to determine the real costs of abolishing user fees.

Nurses in this study expressed concerns about working with overseas nurses, an area of research that remains untapped within the Jamaican context. It might, therefore, be necessary to undertake an examination of the efficiency of migrant nurses. Equally, staff turnover should be investigated to determine its impact on a cost-constrained environment, such as the public health system.

Even though health care was now free, people were returning to the private sector. This behaviour could be indicative of people returning to their usual providers following attempts to use the public system or a result of the demands on the system. Practitioners also reported non-compliance of some users and daily overcrowding in the facilities, which suggests there may be additional factors affecting the health-seeking behaviours of users. It would be instructive, therefore, to examine reasons for the shift from utilising the free services to paid health care, to investigate why people were non-compliant and who and what factors were contributing to the daily overcrowding at the facilities. This research might help detect impacts that require immediate attention.

The study also found that there were variations in health indicators such as Infant and Maternal Mortality rates, and Crude Death rates across the RHAs, but that more people were utilising the facilities and were generally comfortable with their current health status. However, people continued to use home remedies and other forms of treatment. Further research into the impact of the abolition of user fees on health outcomes and health indicators, such as mortality rates, as well as the concomitant use of alternative treatments and health services, should be undertaken.

The study demonstrated that the utilisation of health services had increased in the aftermath of the policy change. There was, however, no clear indication as to the socioeconomic groups utilising the services. While this study used the income provided by users to predict their socioeconomic status, more research is required to clarify the issues regarding the social status of people benefiting from the policy. Additionally, research is required into other known barriers to access, such as geographic location of health facilities and transportation issues, as well as the costs for users to overcome these challenges.

Materials and supplies were often inadequate to meet the demands of the increased uptake of services, and were further compounded by malfunctioning or lack of equipment. This was a source of frustration for nurses and other health practitioners. Evaluation of the policy to examine the effects on resourcing and maintenance issues is, therefore, also necessary in order to determine the adequacy of supplies, such as family planning resources and other preventive measures.

9.4. Recommendations

This section provides key recommendations may be instrumental for future policy and programme development and implementation. While the study was conducted in Jamaica, the findings have international merit and, as such, these recommendations may be applied to other countries contemplating or undergoing a similar change.

It is recommended that a review of the user fees policy be conducted in the current Jamaican public health system to determine if the findings of this study remain valid. This is necessary because stakeholder data for this study were gathered in 2010 and, with a dynamic political and social system operating in Jamaica, matters identified in the early period of the policy change may have settled or new issues emerged. No significant changes to the policy should be implemented until such a review happens.

It is important to conduct a needs assessment to determine the gaps in a health system prior to any further policy change. Preparation and planning contribute significantly to the policy's successful outcome, and as such, are mandatory. For consensus, consultation should be undertaken through effective communication with main stakeholders, such as nurses and other health practitioners, to engender their support.

Resources, including human resources, funding, equipment, material and pharmaceuticals, should be mobilised and regularly maintained in order to strengthen service delivery. Institutions should be reimbursed for funds no longer generated from user fees, in order to purchase supplies locally, for example, contributions toward contraceptive supplies in health centres. Sufficient funds should also be made available at parish and facility levels for small-scale local expenses.

Formal, systematic monitoring and evaluation mechanisms should be established for the existing policy and for future ones. Such systems are necessary to provide prompt and accurate feedback on the facilities' experiences in order for early intervention. Standardised and computerised systems should be set up to track the use of services, especially pharmaceuticals, and could also prove a viable solution to the problem of patients roving between facilities or hoarding drugs.

Policymakers must actively manage the effects of the policy change on the work situation of nurses and other health practitioners. This requires addressing working conditions and remuneration, and providing adequate resources including supplies and staff in order to counter issues such as staff shortages and burnout. Policymakers should also recognise nurses' contributions in sustaining policy change such as the user fees policy and provide opportunities for discussions regarding impending policy changes. Ideas articulated by nurses could positively influence the policy process, build consensus and improve morale. One strategy to reduce the workload of nurses and other health practitioners would be fast tracking of licensure for NPs in order to expand their role into the area of prescribing. This is already happening internationally and urgently needs to be addressed within the Jamaican context.

In conclusion, this study found that the removal of user fees in the Jamaican public health system generally had positive effects on access, as indicated by the increased utilisation of health services. However, the study reinforced the need for policymakers to adhere to policy processes, mobilise resources to meet the anticipated increases in demand, and hold consultation with key stakeholders such as nurses. Equally, it highlighted the need for policymakers to implement strategies to buffer the effects of the policy change on the work of nurses, who were sometimes forced to change the manner in which they offered care in order to make the policy work. Nurses operated under difficult working conditions, including a lack of clinical resources and suitable facilities; some suffered burnout symptoms and were demoralised by the lack of recognition for their contribution. Urgent attention to the aforementioned would result in more successful policy implementation that will benefit practitioners and users in the Jamaican public health system.

Appendices

Appendix 1. Ten leading causes of death among males and females in Jamaica: 2006-2008

Cause of death - males	**2008**	**2007**	**2006**
External Causes*	1, 984	2, 065	1,464
Cerebrovascular Diseases	873	878	772
Diabetes Mellitus	630	671	633
Malignant Neoplasm of Prostate	544	589	522
Ischaemic Heart Diseases	476	543	511
Hypertensive Diseases	449	436	393
Chronic Lower Respiratory Diseases	337	336	310
Other Heart Diseases	332	352	335
Malignant Neoplasm of the Larynx, Trachea, Bronchus and Lung	321	284	305
Human Immunodeficiency Virus (HIV) Disease	247	233	235
Total	**6,193**	**6,387**	**5,480**
Cause of death - females	**2008**	**2007**	**2006**
Cerebrovascular Diseases	**1,135**	**1,131**	**969**
Diabetes Mellitus	**1,079**	**1,017**	**1,063**
Hypertensive Diseases	**588**	**631**	**514**
Ischaemic Heart Diseases	**500**	**549**	**521**
External Causes*	**349**	**342**	**216**
Other Heart Diseases	**347**	**363**	**309**
Other Malignant Neoplasm	**294**	**329**	**263**
Malignant Neoplasm of the Breast	**257**	**252**	**228**
Human Immunodeficiency Virus (HIV) Disease	**180**	**164**	**156**
Malignant Neoplasm of the Cervix Uteri	**142**	**164**	**133**
Septicaemia	**142**	**72**	**62**
Total	**5,013**	**5,014**	**4,434**

Note. Adapted: STATIN. (2010). *Demographic Statistics 2009*. Kingston, Jamaica: Author
*External causes include sudden and violent cases reported by the police but not yet registered by the Registrar General's Department

Appendix 2. Policymakers' letter of invitation

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui

Letter of invitation to policymakers

Dear ____
____
____
____

You are invited to participate in an interview as part of a study on the **"The abolition of user fees in the Jamaican public health system: Impact on access, care provided and the work of the professional nurse."**

I am a Lecturer at the University of Technology, Jamaica, who is currently pursuing doctoral work as a Commonwealth Scholar at the Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington, New Zealand.

If you decide to participate, the researcher will engage you in a semi-structured interview at a time and venue that is convenient to you. It will take approximately 20 minutes. I do not expect the interview to cause you any discomfort. I am also seeking your permission to audio-record the session. Please see the attached information sheet for more information.

Your participation in the study is entirely voluntary and you can withdraw at any time within two weeks of participation. If you choose not to participate, your interaction with the researcher will not be affected. All information supplied by you will be kept in confidence. While you may be identified by virtue of your position, your name will not be published in the report. You will sign a consent form.

I will be pleased to answer any questions you may have. Contact persons are listed below:

Contacts
Principal Investigator – Miss Adella Campbell PhD Candidate
Address: Graduate School of Nursing, Midwifery and Health
Victoria University of Wellington, New Zealand
E-mail: campbeadel@myvuw.ac.nz
Telephone #: +64 4 463 6662 (New Zealand); 1876 983 7949 (Jamaica)

Jamaican contact details
23 Lejune Avenue
Keystone
Spanish Town
St Catherine
Jamaica
Phone – 1876 983 7949
Email: campbeadel@myvuw.ac.nz

Primary Supervisor – Dr. Katherine Nelson
Address: Graduate School of Nursing, Midwifery and Health
Victoria University of Wellington, New Zealand
E-mail: kathy.nelson@vuw.ac.nz
Telephone #: +64 4 463 6138

Second Supervisor – Associate Professor Jackie Cumming
Director, Health Services Research Centre
Victoria University of Wellington, New Zealand
E-mail: Jackie.cumming@vuw.ac.nz
Telephone #: +64 4 463 6567

Independent Advisor – Dr. Philip Onuoha
Head of School,
School of Allied Health and Nursing
University of Technology, Jamaica
237 Old Hope Road
Kingston 6
Jamaica
Email: ponuoha@utech.edu.jm
Telephone #: 1876 927 1680

Appendix 3. Information sheet

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui

The abolition of user fees in the Jamaican health system: impact on access, care provided and the work of the professional nurse

Information sheet

You are invited to take part in a research project on the “Impact of the Abolition of User Fees in the Jamaican Health System on Access, Care Provided and the Work of the Professional Nurse.” This Research project is being undertaken by Adella Campbell of the Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington, New Zealand. Adella is a Lecturer at the University of Technology, Jamaica, who is currently pursuing doctoral work as a Commonwealth Scholar in New Zealand. The information gained from this evaluation will add new knowledge that may result in improved access to health services and inform the policy process regarding access to health services and the work of the professional nurse

Aims of the evaluation

The evaluation aims to:

1. To examine the utilisation of services in the public health facilities during the period 2006 – 2010.
2. To analyse the effects of the abolition of user fees on the work of the professional nurse.
3. To establish whether access to health care services by the consumers of health care remains a barrier since the abolition of user fees.
4. To identify the lessons learnt for Jamaica and developing countries regarding the abolition of user fees.

Evaluation design

A multi-layered mixed-method design involving document reviews, semi-structured interviews and focus group with key stakeholders (policy-makers, providers and users) in the public health system will be used. The approach involves a mutual understanding between participants and researchers and will focus on process and outcomes. Findings from the three data sets will be merged to create an overall picture of the impact of the policy change and to establish the lessons learned for developing countries.

Participant selection

Potential participants include policymakers for semi-structured interviews, providers’ for focus group and users for questionnaire surveys. Participants will be:

- Key policymakers in the Ministry of Health and Regional Health Authorities, Jamaica,
- Main care providers (doctors, nurses and pharmacists) in the public health system, and

- Users of the public health system.

What is required?

The semi-structured interview for policy-makers will focus on issues concerning the country's implementation plan prior to the removal of user fees; utilisation pattern; availability of services such as the location of health facilities and adequate drugs; affordability of services; resources including manpower, materials such as medical equipment and funding of the health service; social policies to address access and the inequity in the health system – policies such as those regarding education, housing and road infrastructure. The interviews will be for a minimum of 25 minutes and with consent will be recorded. Tapes will be transcribed by researcher.

Focus group discussion for providers will be focussed on participants' work, types and number of cases seen daily, morale, satisfaction, funding of services, quality of care, health outcomes, waiting time, referral process and innovations to improve access to health care. The focus group discussion will last approximately 60 minutes and with consent will be recorded. There will be a moderator and an assistant working with each focus group – one to facilitate the questions and discussion, and the other to take notes, manage the tape recorder and monitor the group process. Tapes will be transcribed by researcher.

Questionnaire surveys for users will focus on issues concerning health condition, access to health care, availability of drugs, perception regarding health personnel, waiting time, the referral system, use of alternative methods of treatment, distance from health facility, aesthetics of the health facilities, satisfaction with the services, knowledge of the health services, expectations of the health system, social status and involvement in the decision-making process. Nursing students will assist with the questionnaire survey. They will sign a confidentiality agreement.

Consent

You are not obligated in any way to participate in this study and should you decide not to participate, this information will remain confidential to the researchers. If you agree to take part, you will be asked to sign a consent form. You are free to withdraw from the study at any time. If you withdraw, your interview or questionnaire data will be destroyed but if you are part of a focus group the data will still be used.

Confidentiality

Every effort will be made to ensure all participants are not identified in the thesis and in any presentations, but by virtue of positions held by some key stakeholders who are interviewed, it is possible that some people may be recognised.

Data Storage

Once the study is completed, all tape recordings will be electronically erased, and transcriptions and interview notes will be stored for five years in sealed envelopes and then destroyed. Surveys will be securely stored and destroyed after five years.

Study Findings

This study will be written up as a report and submitted to the university as my thesis. The study findings may also be submitted for publication to health-related journals and presented at conferences. A summary of the findings will be made available to all study participants who request it.

Approval

This study has received ethical approval from the Victoria University of Wellington Human Ethics Committee and from the Ministry of Health and Regional Health Authorities, Jamaica.

Further Information

For further information or questions regarding this study, please contact the researchers.

Contacts

As per previous letter

Appendix 4. Policymakers’ and providers’ consent form

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui

The abolition of user fees in the Jamaican health system: impact on access, care provided and the work of the professional nurse

Consent form – policymakers and providers

- I have read and understood the information sheet for participants in this research project to evaluate the impact of the abolition of user fees in the Jamaican public health system.

- I have had the opportunity to discuss the study and am satisfied with the information I have been given.

- I understand that participation in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my continuing involvement with the researcher.

- I understand that my participation in this study is confidential and that every effort will be made not to identify me in any reports on this study.

- I know who to contact if I have any questions or concerns about the study or during the study.

- I agree to have the interview /focus group audiotaped.

- I understand that the findings of this report will be presented to the Victoria University of Wellington and that I will be sent a summary of this if I request it. I also understand that journal articles and conference presentations may be extracted from the research.

I ____
hereby consent to taking part in this study

Signature _____________________________ Date_____________________________

Researcher____

Address if you would like to receive a copy of the summary of the research.

____

Appendix 5. Policymakers' interview schedule

The abolition of user fees in the Jamaican public health system: Impact on access, care provided and the work of the professional nurse

Interview schedule – policy-makers

Background

1. Tell me about your role in the development and implementation of the free health care policy.

2. Tell me about your understanding of the free health care policy objectives.

Implementation

3. Tell me about the implementation plan for this policy change

4. What was your involvement in this?

Outcome

5. To what extent do you think the policy objectives have been achieved?

6. What monitoring of the policy change is occurring?

7. Tell me about the current challenges to accessing the free health care by other consumers?

8. What other policies do you consider could be implemented to ease the problem with access to health care by the vulnerable?

9. What is your general impression of the policy change to date?

Appendix 6. Checklist – document review

The abolition of user fees in the Jamaican public health system: Impact on access, care provided and the work of the professional nurse

Checklist – document review

Name of Facility ____________________ Type of document:________________
Year:________________________ Month:_________________________
Hospital Admissions _______________
Length of Hospital Stay _______________
Health Centre Visits ________________
Outpatient Visits ___________________
Accident and Emergency visits ________________
Total number of operations/surgeries ____________________
Total number on waiting list for operations/surgeries ___________
Pharmacy utilisation ________________________
Other Comments ____

Types of cases seen
Diabetes: Hospital _____________ Health Centre ____________
Hypertension: Hospital __________ Health Centre ___________
Asthma: Hospital_____________ Health Centre ___________
Malignant Neoplasm: Hospital _____________ Health Centre ____________
Other: Hospital _________________ Health Centre ____________
Other Comments ____
Mortality rates 2006 & 2009
Infant Mortality Rate 2006: _____________
Infant Mortality Rate 2009: ______________
Maternal Mortality 2006: ________________
Maternal Mortality Rate 2009: ____________
Crude Death Rate 2006: __________________
Crude Death Rate: 2009 __________________
Other Comments ____

Mode of referral
Self: ______________
Hospital: ___________
Health Centre: _____________
Private Doctor: _____________
Other: ____

Other Comments ____

Appendix 7. Providers’ letter of invitation

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui

Letter of invitation to providers

Dear ___________________________________

You are invited to participate in a Focus Group Discussion as part of a study on the “**The abolition of user fees in the Jamaican public health system: Impact on access, care provided and the work of the professional nurse.”**

I am a Lecturer at the University of Technology, Jamaica, who is currently pursuing doctoral work as a Commonwealth Scholar at the Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington, New Zealand.

If you decide to participate, the researcher will engage you in a discussion with other participants at a time and venue that is convenient to you. It will take approximately 30 minutes – one hour. I do not expect the discussion to cause you any discomfort. I am also seeking your permission to audio-record the session. Please see the attached information sheet for more details.

Your participation in the study is entirely voluntary and you can withdraw at any time within two weeks of participation. If you choose not to participate, your interaction with the researcher will not be affected. All information supplied by you will be kept in confidence. While you may be identified by virtue of you position, your name will not be published in the report. You will sign a consent form.

I will be pleased to answer any questions you may have. Contact persons are listed below:

Contacts
As per previous letter

Appendix 8. Providers' interview schedule

The abolition of user fees in the Jamaican public health system: impact on access, care provided and the work of the professional nurse

Focus group discussion schedule – providers

Background

1. Tell me about your role in the free health care policy process.

Outcome

2. How has your work changed since the introduction of free health care?

3. How satisfied are you with your current work environment?

4. How do measure the quality and effectiveness of the care provided?

5. Tell me about (*nurses, doctors, pharmacists*) contribution to improving access

6. What is your experience with funding and resources in the public health system?

7. What is your general impression of the free health care policy?

Appendix 9. Patients’ consent form

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui

The abolition of user fees in the Jamaican public health system: impact on access, care provided and the work of the professional nurse
Consent form - patients

You are invited to participate in a study on the “The abolition of user fees in the Jamaican public health system: Impact on access, care provided and the work of the professional nurse.”

If you decide to participate, the researcher will ask you 68 questions. The questionnaire will take approximately 55 minutes. I do not expect the questions to cause you any discomfort.

Your participation in the study is entirely voluntary and you can withdraw at any time. If you choose not to participate, your contact with the health facility will not be affected. All information supplied by you will be kept in confidence. Your name will not be published in the report. Journal articles and conference presentation may be extracted from the report. No potential risk or harm to participants during the study is anticipated.

I will be pleased to answer any questions you may have. Contact persons are listed below:

Contacts
As per previous letters

I have read the above or it has been explained to me and I had time to consider participation. I understand that I do not have to answer any question that I do not wish to. I agree to take part in the study.

Name of Respondent:____________________Signature of Respondent:___________
Date:________________________________ Witness: __________________________
Name of Researcher:________________________

For independent advice about your rights as study participants please contact:
Dr. Sheila Campbell Forrester
CMO
MOH, Jamaica
Telephone #: 967-1100-6
Email: foresters@moh.gov.jm

Appendix 10. Patients' questionnaire

The abolition of user fees in the Jamaican public health system: Impact on access, care provided and the work of the professional nurse

Patient Questionnaire

This is a questionnaire to find out about your perception of free health care and your experience with the Jamaican health system since the abolition of user fees. Please provide the answers to the questions below. Please fill in the blank space or check (√) the appropriate box after the signing of the consent form.

SECTION 1 – SOCIO-DEMOGRAPHIC DATA

BIOGRAPHIC DATA

1. What is your gender?
    1. Male ( )
    2. Female ( )
2. How old were you on your last birthday? ___________
3. What is your union status?
    1. Married ( )
    2. Common-Law ( )
    3. Single ( )
    4. Visiting ( )
    5. Divorced ( )
    6. Separated ( )
    7. Widowed ( )
    8. Other ____
4. In which district is your home located? ______________________________________
5. What is the highest education level you have fully completed?
    1. None ( )
    2. Primary ( )
    3. Secondary ( )
    4. Tertiary ( )
6. Are you currently studying?
    1. Yes ( ) Please specify level ____
    2. No ( )

HOUSEHOLD COMPOSITION & STANDARD OF LIVING

7. How many persons live in your household? ____Adult ____ Children
8. Who is the 'breadwinner' in the household? _________________________________
9. The house you are living in is:
    1. Owned
    2. Rented
    3. Leased
    4. Family owned
    5. Other ____
10. How many bedrooms are there in the house? _________________________________

11. Generally, how do you rate your standard of living?
    1. Very high ( )
    2. High ( )
    3. Fairly high ( )
    4. Average ( )
    5. Low ( )
    6. Very low ( )
    7. Unsure ( )

NATIONALITY

12. What is your nationality?
    1. Jamaican ( )
    2. Other ____
13. What was your country of birth?
    1. Jamaica ( )
    2. England ( )
    3. United States of America ( )
    4. Canada ( )
    5. Trinidad ( )
    6. Bahamas ( )
    7. Barbados ( )
    8. Cuba ( )
    9. Other ____

INCOME & EMPLOYMENT

14. What are your main sources of income in the past 12 months? (Tick as many as apply to you).
    1. Employment ( )
    2. Private Savings ( )
    3. Government benefits ( )
    4. Pension ( )
    5. Student Allowance/Scholarship ( )
    6. Other, please explain ________________________________
15. What is your income before tax for the last 12 months?
    1. Under $200,000 ( )
    2. $200,001 - $300,000 ( )
    3. $300,001 - $400,000 ( )
    4. $400,001 - $500,000 ( )
    5. $500,001 - $600,000 ( )
    6. $600,001 - $700,000 ( )
    7. $700,001 - $800,000 ( )
    8. $800,001 - $900,000 ( )
    9. $900,000 - $1000,000 ( )
    10. $1000,001 and more ( )
16. Is your income meeting your daily needs?
    1. Yes ( )
    2. No ( )
    3. Unsure ( )

17. What is your main employment status?
    1. Employed Full Time ( ) Part Time ( ) No. of hours worked ______
    2. Self-Employed Full Time ( ) Part Time ( ) No. of hours worked ______
    3. Unemployed and looking for a job ( )
    4. Unemployed and not looking for a job ( )
    5. Full time home duties ( )
    6. Retired ( )
    7. Full time student ( )

18. What kind of jobs do you do when you are working? ________________________
    ____

19. If you are not in employment, what work did you last do? ____________________

SECTION 2 - ACCESS TO HEALTH SERVICES

UTILISATION

20. What health services do you know that you can access freely under the public health services? ____
    ____

21. In the past, what was your usual place to seek health care when you were sick?
    1. Private doctor ( )
    2. Public Health Centre ( )
    3. Public Hospital ( )
    4. Private Hospital ( )
    5. Pharmacy ( )
    6. Other ____

22. Why did you usually choose this place for health care? ______________________
    ____

23. What are the general reasons why you visit this health facility? ________________
    ____

24. Which health care providers attend to you when you visit this health facility?
    1. Doctor ( )
    2. Nurse ( )
    3. Midwife ( )
    4. Medical specialist ( )
    5. Other health care workers ( )
    6. Other ____

25. How long have you been receiving health care from this health facility? ________
    ____

26. Is it possible to contact this health facility by telephone during opening hours?
    1. Yes ( )
    2. No ( )
    3. Unsure ( )

27. Does this health facility have access to a help-line you can call to get advice?
    1. Yes ( )
    2. No ( )
    3. Unsure ( )

28. In the past 12 months, have you ever had any of the following?
    1. Medical specialist appointment **Yes** ( ) **How long did you wait for appointment?** __________
    No ( )

2. Hospital medical appointment **Yes** ( ) **How long did you wait for appointment?__________**
No ( )

3. Hospital surgical appointment **Yes** ( ) **How long did you wait for appointment ? _________**
No ( )

4. Health centre appointment **Yes** ( ) **How long did you wait for appointment? _________**
No ( )

5. Blood tests **Yes** ( ) **How long did you wait for appointment? ________**
No ( )

6. X-ray **Yes** ( ) **How long did you wait for appointment? _________**
No ( )

7. Other medical procedures **Yes** ( ) **How long did you wait for appointment? ________**
No ( )

8 . How long do you generally stay in the waiting room before you are being seen by a health provider? _______________________

29. In the last 2 years, did you find it easy to get health care when you needed it?
    1. Yes ( )
    2. No ( ) **Please state why ________________________________**
    3. Unsure ( )

AFFORDABILITY

30. How much did you personally pay out-of-pocket to get health care at the last visit? ___
31. What did you pay for? ____
32. Which of these related to cost do you usually encounter when trying to access care from the public health facility? (Tick as many as apply to you).
    1. No problems ( )
    2. Unable to seek health care when needed ( )
    3. Inability to buy prescribed drugs ( )
    4. Did not take all the doses of prescribed drugs ( )
    5. Unable to obtain prescribed diagnostic test and treatment ( )
    6. Did not go for follow-up care ( )
    7. Could not afford transportation ( )
    8. Other ____
33. Have you received a prescription for medication in the last 12 months?
    1. Yes ( )
    2. No ( )
34. The last time you tried to fill a prescription at the public pharmacy, what was your experience? ____
35. Where do you get your medication if it is not available at the government pharmacy? _

QUALITY OF SERVICE

36. In general, how would rate access to health care services?
    1. Excellent ( )
    2. Good ( )

3. Fair ( )
4. Poor ( )
5. Very poor ( )

37. How would you rate the quality of care you personally received in the public health facilities?
    1. Excellent ( )
    2. Good ( )
    3. Fair ( )
    4. Poor ( )
    5. Very poor ( )
38. Please comment on any problems you have had with the health care services ____

    ____

    ____
39. How satisfied are you with the services provided at the public health facilities?
    1. Very satisfied ( )
    2. Satisfied ( )
    3. Neither satisfied nor dissatisfied ( )
    4. Dissatisfied ( )
    5. Very dissatisfied ( )

40. Are you aware that health care is free?
    1. Yes ( )
    2. No ( ) **Please state why** _______________________________________

    ____

AVAILABILITY

41. In the past 12 months, how difficult was it to get care on weekends, public holidays and at nights from this health facility?
    1. Very easy ( )
    2. Easy ( )
    3. Somewhat easy ( )
    4. Somewhat difficult ( )
    5. Difficult ( )
    5. Very difficult ( )
    6. Not applicable ( )
42. Where do you go for health care when you are unable to go to this health facility?

    State place ____

    State reason ____

    ____

    Approximately when was this date? _____________________________________
43. How long do you usually wait to be seen by a doctor or nurse at this health facility?

    ____
44. The last time you did not obtain health care from a health professional when you needed it, what did you do instead?
    1. Used home remedies ( )
    2. Used self-treatment ( )
    3. Went to the herbalist ( )
    4. Went to the traditional healer ( )
    5. Other ____

45. How far do you have to travel to get to the nearest health facility? _____________

46. At your last visit to a health facility did the doctor or nurse refer you to see someone else?
   1. Yes ( )
   2. No ( )

47. If yes, who were you referred to?
   1. Doctors ( )
   2. Nurses ( )
   3. Pharmacists ( )
   4. Other ____

48. How long did it take to get an appointment to see the health provider you were referred to? ____

PATIENT'S EXPECTATIONS AND PARTICIPATION IN PLANNING HEALTH SERVICES

49. What are your expectations of the health system? _________________________

____

____

50. How satisfied are you that your expectations are being met?
   1. Very satisfied ( )
   2. Satisfied ( )
   3. Neither satisfied nor dissatisfied ( )
   4. Dissatisfied ( )
   5. Very dissatisfied ( )

51. To what extent do you think patients should be involved in planning the health services offered to them? ____

   How do you think this is happening? ____________________________________

52. Were you involved at any time in the planning of any health services provided to you?
   1. Yes ( )
   2. No ( )
   3. Unsure ( )

53. What changes have you noticed since the introduction of free health care? ______

54. How has your use of the health services changed since free health care? _______

SECTION 3 - HEALTH HISTORY

CURRENT HEALTH STATUS

55. How would you rate your health in general?
   1. Excellent ( )
   2. Very good ( )
   3. Good ( )
   4. Poor ( )
   5. Very poor ( )

56. Compared to two years ago, how would you rate your current health status?
   1. Much better ( )
   2. Somewhat better ( )
   3. No change ( )
   4. Somewhat worse ( )

5. Much worse ( )

57. In the last 3 years did you have any of the following tests done? (Tick as many as apply to you).

1. Mammogram	Yes ( )	No ( )	Not Applicable ( )
2. Pap smear (cervical smear)	Yes ( )	No ( )	Not Applicable ( )
3. Blood test for prostate cancer (PSA)	Yes ( )	No ( )	Not Applicable ( )

58. Have you ever been told by a health care provider that you have?

1. High blood pressure	Yes ( )	No ( )
2. Diabetes Mellitus (Sugar)	Yes ( )	No ( )
3. Lung Disease e.g. asthma	Yes ( )	No ( )
4. Cancer (Malignant Neoplasm)	Yes ( )	No ( )
5. Heart Disease	Yes ( )	No ( )
6. Stroke	Yes ( )	No ( )
7. High Cholesterol	Yes ( )	No ( )
8. Arthritis	Yes ( )	No ( )
9. Depression	Yes ( )	No ( )

10. Other ____

59. In the past 2 years, have you been hospitalised?
1. Yes ( )
2. No ( )

60. What was the reason for your hospitalisation?
1. Surgery ( )
2. Stroke ( )
3. Diabetes ( )
4. Asthma ( )
5. Heart attack ( )
6. High blood pressure ( )
7. Cancer treatment ( )
8. Child birth ( )
9. Trauma/accident ( )
10. Diagnostic tests ( )
11. Other ____

ALTERNATIVE MEDICINE

61. In the last 2 years, have you used remedies from any of the following for your health condition? (Tick as many as apply to you).
1. Home ( )
2. Herbalist ( )
3. Spiritual healers ( )
4. Traditional healers ( )
5. Other ______________________________

62. How often do you use these remedies for your health condition? __________

63. Do you also see a doctor and nurse while you are taking these remedies?
1. Yes ( ) **Please specify why** ________________________
2. No ( )

HEALTH INSURANCE

64. Do you use health insurance?

1. Yes ( )
2. No ( )

65. What type of health insurance is it?
    1. Government ( )
    2. Private company ( )
66. Who pays the premium for your health insurance?
    1. Self ( )
    2. Family members ( )
    3. Employer ( )
    4. Other ____
67. Do you have a National Health Fund card?
    1. Yes ( )
    2. No ( ) If **no,** why? ____

Appendix 11. Victoria University of Wellington ethical approval

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

Phone 0-4-463 5676
Fax 0-4-463 5209
Email Allison.kirkman@vuw.ac.nz

MEMORANDUM

TO	Adella Campbell
COPY TO	Katherine Nelson, Jackie Cumming
FROM	Dr Allison Kirkman, Convener, Human Ethics Committee

DATE	December 18 2009
PAGES	1

SUBJECT	**Ethics Approval: No 17157, The Abolition of User Fees in the Jamaican Public Health System: Impact on Access, Care Provided and the Work of the Professional Nurse**

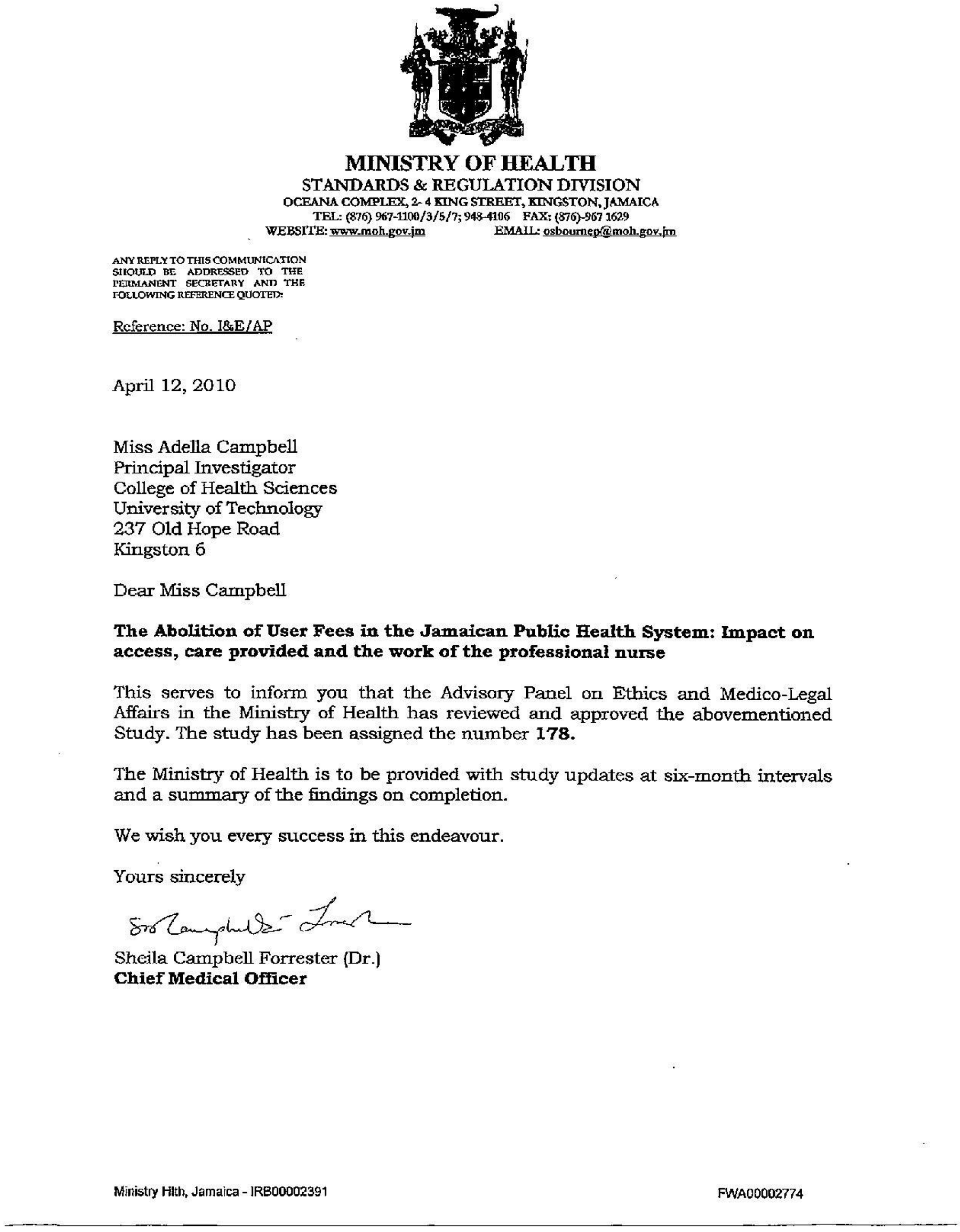
Thank you for your application for ethical approval, which has now been considered by the Standing Committee of the Human Ethics Committee.

Your application has been approved from the above date and this approval continues until 30 March 2012. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Allison Kirkman
Convener

Appendix 12. Ministry of Health, Jamaica ethical approval



MINISTRY OF HEALTH
STANDARDS & REGULATION DIVISION
OCEANA COMPLEX, 2- 4 KING STREET, KINGSTON, JAMAICA
TEL: (876) 967-1100/3/5/7; 948-4106 FAX: (876)-967 1629
WEBSITE: www.moh.gov.jm EMAIL: osbournep@moh.gov.jm

ANY REPLY TO THIS COMMUNICATION SHOULD BE ADDRESSED TO THE PERMANENT SECRETARY AND THE FOLLOWING REFERENCE QUOTED:

Reference: No. I&E/AP

April 12, 2010

Miss Adella Campbell
Principal Investigator
College of Health Sciences
University of Technology
237 Old Hope Road
Kingston 6

Dear Miss Campbell

The Abolition of User Fees in the Jamaican Public Health System: Impact on access, care provided and the work of the professional nurse

This serves to inform you that the Advisory Panel on Ethics and Medico-Legal Affairs in the Ministry of Health has reviewed and approved the abovementioned Study. The study has been assigned the number **178.**

The Ministry of Health is to be provided with study updates at six-month intervals and a summary of the findings on completion.

We wish you every success in this endeavour.

Yours sincerely

Sheila Campbell Forrester (Dr.)
Chief Medical Officer

Ministry Hlth, Jamaica - IRB00002391 FWA00002774

Appendix 13. Confidentiality agreement for nursing students

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui

Confidentiality agreement for nursing students of a research study

"The abolition of user fees in the Jamaican public health system: Impact on access, care provided and the work of the professional nurse"

Researcher: Adella Campbell

I have read the information sheet outlining this study. I have discussed with the researcher the nature of the research and have had any questions that I had, answered to my satisfaction. My role as the patient interviewer has been outlined to me by the researcher.

At all times the research information surveys will be inaccessible to other persons. The researcher has assured me that she will debrief me following data collection to address any issues that may arise.

Most importantly, I understand and agree to keep the information I hear in the course of data collection confidential to the researcher and myself.

Full Name:____
Signature:____
Date:____

Researcher's Signature:____

Date:____

Appendix 14. Supplementary data for user survey

Table A1.

Responses regarding current health status, access, satisfaction, quality care

Characteristics	Current health status					Total
Ratings	Much better	Somewhat better	No change	Somewhat worse	Much worse	Missing
Hospital (n=100)	37*(37.0%)*	27*(27.0%)*	25*(25.0%)*	10*(10.0%)*	1*(1.0%)*	
Health Centre (n=100)	52*(52.0%)*	30*(30.0%)*	15*(15.0%)*	2*(2.0%)*	1*(1.0%)*	
Access						
	Excellent	Good	Fair	Poor	Very Poor	
Hospital	18*(18.2%)*	34*(34.3%)*	31*(31.3%)*	12*(12.1%)*	5*(5.1%)*	1*(1.0%)*
Health Centre	10*(10.0%)*	43*(43.0%)*	33*(33.0%)*	13*(13.0%)*	0	
Satisfaction						
	Very Satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very Dissatisfied	
Hospital	14*(14.0%)*	59*(59.0%)*	12*(12.0%)*	3*(3.0%)*	12*(12.0%)*	
Health Centre	6*(6.0%)*	74*(74.7%)*	14*(14.1%)*	1*(1.0%)*	4*(4.0%)*	1*(1.0%)*
Quality care						
	Excellent	Good	Fair	Poor	Very Poor	
Hospital	23*(23.0%)*	37*(37.0%)*	31*(31.0%)*	5*(5.0%)*	4(4.0%)	
Health Centre	23*(23.2%)*	52*(52.5%)*	19*(19.1%)*	5*(5.1%)*	0(0.0)	1*(1.0%)*
Waiting time at facility						
Hours	≤ 3 hours	4-6 hours	7-9 hours	10+		
Hospital	62*(31.0%)*	29*(14.5%)*	6*(3.0%)*	3*(1.5%)*		
Health Centre	64*(32.0%)*	33*(16.5%)*	3*(1.5%)*	0(0.0)		

Table A2.

Respondents' usual reasons for choosing place for health care

	Health Centre				
No. of reasons identified	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
1	17*(85.0)*	23*(76.7)*	13*(65.0)*	25*(83.3)*	78*(78.0)*
2	3*(15.0)*	7*(23.3)*	6*(30.0)*	5*(16.7)*	21*(21.0)*
3	0*(0.0)*	0*(0.0)*	0*(0.0)*	3*(10.0)*	3*(3.0)*
Reasons					
Affordable/convenient	13*(65.0)*	19*(63.3)*	9*(45.0)*	12*(40.0)*	53*(53.0)*
Easy access/fast	1*(5.0)*	11*(36.7)*	9*(45.0)*	3*(10.0)*	24*(24.0)*
Near home	5*(25.0)*	1*(3.3)*	3*(15.0)*	8*(26.7)*	17*(17.0)*
Better treatment	5*(25.0)*	3*(10.0)*	5*(25.0)*	1*(3.3)*	14*(14.0)*
Minor illness	0*(0.0)*	0*(0.0)*	1*(5.0)*	4*(13.3)*	5*(5.0)*
Medical care	1*(5.0)*	0*(0.0)*	0*(0.0)*	1*(3.3)*	2*(2.0)*
Other	0*(0.0)*	3*(16.7)*	0*(0.0)*	3*(10.0)*	6*(6.0)*
	Hospital				
No. of reasons identified	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
1	14*(70.0)*	10*(33.3)*	13*(65.0)*	14*(46.7)*	51*(51.0)*
2	6*(30.0)*	8*(26.7)*	6*(30.0)*	15*(50.0)*	35*(35.0)*
3	2*(10.0)*	0*(0.0)*	0*(0.0)*	1*(3.3)*	3*(3.0)*
4	0*(0.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*
5	0*(0.0)*	0*(0.0)*	1*(5.0)*	0*(0.0)*	1*(1.0)*
Reasons					
Affordable	7*(35.0)*	11*(36.7)*	12*(60.0)*	10*(33.3)*	40*(40.0)*
Easy access	7*(35.0)*	13*(43.3)*	7*(35.0)*	10*(33.3)*	37*(37.0)*
Better treatment	1*(5.0)*	7*(23.3)*	3*(15.0)*	7*(23.3)*	18*(18.0)*
Near home	5*(25.0)*	3*(10.0)*	3*(15.0)*	7*(23.3)*	18*(18.0)*
Medical care	1*(5.0)*	1*(3.3)*	0*(0.0)*	3*(10.0)*	5*(5.0)*
Minor illness	0*(0.0)*	1*(3.3)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
Other	1*(5.0)*	1*(3.3)*	0*(0.0)*	0*(0.0)*	2*(2.0)*

Table A3.

General reasons why respondent visit health facilities of choice

	Health Centre				
No. of services identified	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
1	10*(50.0)*	10*(33.3)*	5*(15.0)*	7*(23.3)*	32*(32.0)*
2	8*(40.0)*	19*(63.3)*	12*(60.0)*	20*(66.7)*	59*(59.0)*
3	1*(5.0)*	0*(0.0)*	2*(10.0)*	3*(10.0)*	6*(6.0)*
4	1*(5.0)*	1*(3.3)*	1*(10.0)*	0*(0.0)*	3*(3.0)*
Reasons identified*					
Affordable	8*(40.0)*	23*(76.7)*	9*(45.0)*	22*(73.3)*	62*(62.0)*
Check-up	15*(75.0)*	12*(40.0)*	13*(65.0)*	19*(63.3)*	59*(59.0)*
Maternal & Child Health	3*(15.0)*	3*(10.0)*	11*(55.0)*	1*(3.3)*	18*(18.0)*
Accessible	2*(10.0)*	3*(10.0)*	5*(25.0)*	7*(23.3)*	17*(17.0)*
Referred	0*(0.0)*	6*(20.0)*	2*(10.0)*	3*(10.0)*	11*(11.0)*
Medication	1*(5.0)*	0*(0.0)*	1*(5.0)*	2*(6.7)*	4*(4.0)*
Dental	1*(5.0)*	2*(6.7)*	0*(0.0)*	0*(0.0)*	3*(3.0)*
Screening/Test	0*(0.0)*	1*(3.3)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
Other	2*(10.0)*	1*(3.3)*	1*(5.0)*	1*(3.3)*	5*(5.0)*

	Hospital				
No. of services identified	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
1	18*(90.0)*	13*(43.3)*	9*(45.0)*	5*(16.7)*	45*(45.0)*
2	0*(0.0)*	14*(46.7)*	9*(45.0)*	19*(63.3)*	42*(42.0)*
3	3*(15.0)*	5*(16.7)*	4*(20.0)*	8*(26.7)*	20*(20.0)*
Reasons identified					
Check-up	12*(60.0)*	17*(56.7)*	14*(70.0)*	23*(76.7)*	66*(66.0)*
Affordable	1*(5.0)*	23*(76.7)*	15*(75.0)*	24*(80.0)*	63*(63.0)*
Accessible	2*(10.0)*	9*(30.0)*	7*(35.0)*	8*(26.7)*	26*(26.0)*
Medication	3*(15.0)*	2*(6.7)*	2*(10.0)*	5*(16.7)*	12*(12.0)*
Maternal & Child Health	0*(0.0)*	1*(3.3)*	2*(10.0)*	2*(6.7)*	5*(5.0)*
Screening/Test	1*(5.0)*	1*(3.3)*	0*(0.0)*	1*(3.3)*	3*(3.0)*
Referred	1*(5.0)*	1*(3.3)*	0*(0.0)*	1*(3.3)*	3*(3.0)*
Other	1*(5.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
Not applicable	1*(5.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(1.0)*

*Responses to this question were problematic in that they were sometimes based on ease of access to services or in terms of the services accessed.

Table A4.

Facilities used by respondents for health care when they were unable to go to their usual health facility

	Health Centre				
Facilities	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Public Hospital	15*(75.0)*	19*(63.5)*	14*(70.0)*	22*(73.3)*	70*(70.7)*
Private Doctor	3*(15.0)*	8*(27.6)*	5*(25.0)*	7*(23.3)*	23*(23.2)*
Public H/Centre	2*(10.0)*	2*(6.9)*	1*(5.0)*	1*(3.3)*	6*(6.1)*
Private H/Centre	0*(0.0)*	0*(0.0)*	1*(5.0)*	0*(0.0)*	1*(1.0)*
Private Hospital	0*(0.0)*	1*(3.4)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
Not applicable	1*(5.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
Missing		1			1
Reasons					
Affordable	2*(10.0)*	6*(20.7)*	5*(25.0)*	10*(33.3)*	23*(23.2)*
Short wait	3*(15.0)*	5*(17.2)*	5*(25.0)*	6*(20.0)*	19*(19.2)*
Medical attention	1*(5.0)*	5*(17.2)*	4*(20.0)*	8*(26.7)*	18*(18.2)*
Near/convenient	4*(20.0)*	7*(24.1)*	2*(10.0)*	3*(10.0)*	15*(15.1)*
Health centre closed	2*(10.0)*	2*(6.9)*	3*(15.0)*	4*(13.3)*	14*(14.1)*
Have services	7*(35.0)*	3*(10.3)*	2*(10.0)*	1*(3.3)*	13*(13.1)*
Better treatment	3*(15.0)*	2*(6.9)*	5*(25.0)*	3*(10.0)*	11*(11.1)*
Medication	2*(10.0)*	1*(3.4)*	1*(10.0)*	0*(0.0)*	4*(4.0)*
Referral	2*(10.0)*	0*(0.0)*	0*(0.0)*	1*(3.3)*	3*(3.0)*
Not applicable	2*(10.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	2*(2.0)*
Missing		1			1
Dates – months – last use					
≤ 12	16*(84.2)*	22*(73.3)*	14*(70.0)*	19*(63.3)*	71*(71.7)*
13-24	0*(0.0)*	6*(20.0)*	4*(20.0)*	5*(16.7)*	15*(15.2)*
25+	1*(5.3)*	2*(6.7)*	2*(10.0)*	5*(16.7)*	10*(10.1)*
Not sure	1*(5.3)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
Not applicable	1*(5.3)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
Missing	1				1

Table A4. cont'd

	Hospital				
Facilities	NERHA = 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Public H/Centre	10*(50.0)*	10*(33.3)*	5*(25.0)*	17*(56.7)*	42*(42.0)*
Private Doctor	7*(35.0)*	13*(43.3)*	10*(50.0)*	11*(36.7)*	41*(41.0)*
Public Hospital	3*(15.0)*	5*(16.7)*	4*(20.0)*	1*(3.3)*	13*(13.0)*
Private Hospital	0*(0.0)*	1*(3.3)*	0*(0.0)*	1*(3.3)*	2*(2.0)*
Pharmacy	0*(0.0)*	1*(3.3)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
Private H/Centre	0*(0.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*
Reasons					
Near/convenient	5*(25.0)*	5*(16.7)*	9*(45.0)*	12*(40.0)*	31*(31.0)*
Short wait	7*(35.0)*	8*(26.7)*	9*(45.0)*	6*(20.0)*	30*(30.0)*
Medical attention	2*(10.0)*	6*(20.0)*	3*(15.0)*	9*(30.0)*	20*(20.0)*
Affordable	1*(5.0)*	6*(20.0)*	3*(15.0)*	2*(6.7)*	12*(12.0)*
Better treatment	1*(5.0)*	3*(10.0)*	0*(0.0)*	3*(10.0)*	7*(7.0)*
Referral	1*(5.0)*	3*(10.0)*	0*(0.0)*	2*(6.7)*	6*(6.0)*
Not applicable	4*(20.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	4*(4.0)*
Dates – months – last use					
≤ 12	12*(63.2)*	26*(89.7)*	9*(45.0)*	20*(66.7)*	67*(68.4)*
13-24	1*(5.3)*	2*(6.9)*	2*(10.0)*	3*(10.0)*	8*(8.2)*
25+	0*(0.0)*	1*(3.4)*	3*(15.0)*	3*(10.0)*	7*(7.1)*
Not sure	2*(10.5)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	2*(2.0)*
Not applicable	4*(21.1)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	4*(4.1)*
Missing	1	1			2

Table A5.

Respondents' expectations of the health system

	Health Centre				
Expectations	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Quality/good service	17*(85.0)*	27*(90.0)*	19*(95.0)*	28*(93.3)*	91*(91.0)*
Adequate resources	5*(25.0)*	1*(3.3)*	9*(45.0)*	0*(0.0)*	15*(15.0)*
Friendly staff	2*(10.0)*	5*(16.7)*	2*(10.0)*	5*(16.7)*	14*(14.0)*
Aesthetic environment	1*(5.0)*	3*(10.0)*	0*(0.0)*	0*(0.0)*	4*(4.0)*
No expectations	1*(5.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
	Hospital				
Expectations	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Quality/good service	15*(75.0)*	27*(90.0)*	20*(100.0)*	30*(100.0)*	92*(92.0)*
Friendly staff	3*(15.0)*	13*(43.3)*	4*(20.0)*	1*(3.3)*	21*(21.0)*
Adequate resources	4*(20.0)*	2*(6.7)*	4*(20.0)*	3*(10.0)*	13*(13.0)*
Aesthetic environment	0*(0.0)*	4*(13.3)*	0*(0.0)*	0*(0.0)*	4*(4.0)*
No expectations	1*(5.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(1.0)*

Table A6.

Respondents' opinion of ways in which patients can be involved in planning health services

	Health Centre				
	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Talk to health personnel	12*(60.0)*	20*(66.7)*	13*(65.0)*	24*(80.0)*	69*(69.0)*
Meetings/seminars	3*(15.0)*	8*(26.7)*	6*(30.0)*	2*(6.7)*	19*(19.0)*
Believed patients should be involved but gave no examples	5*(25.0)*	2*(6.7)*	1*(5.0)*	1*(3.3)*	9*(9.0)*
Suggestion box	0*(0.0)*	2*(6.7)*	1*(5.0)*	2*(6.7)*	5*(5.0)*
Survey	0*(0.0)*	1*(3.3)*	1*(5.0)*	0*(0.0)*	2*(2.0)*
Do not believe patients should be involved	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(3.3)*	1*(1.0)*
	Hospital				
	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Talk to health personnel	7*(35.0)*	18*(60.0)*	9*(45.0)*	23*(76.7)*	57*(57.0)*
Meetings/seminars	2*(10.0)*	9*(30.0)*	8*(40.0)*	1*(3.3)*	20*(20.0)*
Suggestion box	0*(0.0)*	2*(6.7)*	1*(5.0)*	4*(13.3)*	7*(7.0)*
Believed patients should be involved but gave no examples	6*(30.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	6*(6.0)*
Do not believe patients should be involved	5*(25.0)*	0*(0.0)*	0*(0.0)*	1*(3.3)*	6*(6.0)*
Survey	0*(0.0)*	1*(3.3)*	2*(10.0)*	1*(3.3)*	4*(4.0)*

Table A7.

Respondents views of patients' involvement in planning health services

	Health Centre				
Involvement	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Unsure	5*(25.0)*	18*(62.1)*	1*(5.0)*	17*(56.7)*	41*(41.4)*
Not happening	3*(15.0)*	2*(6.9)*	13*(65.0)*	6*(20.0)*	24*(24.2)*
Talk to health personnel	11*(55.0)*	0*(0.0)*	6*(30.0)*	2*(6.7)*	19*(19.2)*
Happening – but gave no examples	1*(5.0)*	9*(31.0)*	0*(0.0)*	4*(13.3)*	14*(14.1)*
Not applicable	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(3.3)*	1*(1.0)*
Missing		1			1

	Hospital				
Involvement	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Unsure	6*(30.3)*	9*(30.0)*	4*(20.0)*	17*(56.7)*	36*(36.7)*
Not happening	1*(5.6)*	12*(40.0)*	10*(50.0)*	8*(26.7)*	31*(31.6)*
Happening – but gave no examples	6*(30.3)*	8*(26.7)*	5*(25.0)*	4*(13.3)*	23*(23.5)*
Talk to health personnel	5*(27.8)*	1*(3.3)*	1*(5.0)*	1*(3.3)*	8*(8.2)*
Missing	2				2

Table A8.

Problems respondents encountered with the health care services

	Health Centre				
Problems	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n = 30(%)	TOTAL N(%)
No problem	10*(50.0)*	18*(64.3)*	8*(40.0)*	11*(39.3)*	47*(48.9)*
Long wait	7*(35.0)*	6*(21.4)*	7*(35.0)*	11*(39.3)*	31*(32.3)*
Drug unavailable	2*(10.0)*	5*(17.9)*	2*(10.0)*	7*(25.0)*	16*(16.3)*
Limited resources	0*(0.0)*	1*(3.6)*	1*(5.0)*	2*(7.1)*	4*(4.2)*
Slow response	0*(0.0)*	1*(3.6)*	3*(5.0)*	0*(0.0)*	4*(4.2)*
Overcrowding	0*(0.0)*	1*(3.6)*	1*(5.0)*	1*(3.6)*	3*(3.1)*
Minimal attention	0*(0.0)*	0*(0.0)*	1*(5.0)*	1*(3.6)*	2*(2.1)*
Attitude of health personnel	0*(0.0)*	1*(3.6)*	1*(5.0)*	0*(0.0)*	2*(2.1)*
Problem retrieving docket	0*(0.0)*	0*(0.0)*	1*(5.0)*	0*(0.0)*	1*(1.0)*
Missing		2		2	4*(4.0)*

	Hospital				
Problems	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
No problem	9*(45.0)*	13*(46.4)*	6*(30.0)*	16*(55.2)*	44*(45.4)*
Long wait	6*(30.0)*	2*(7.1)*	12*(60.0)*	10*(34.5)*	30*(30.9)*
Drug unavailable	2*(10.0)*	5*(17.9)*	1*(5.0)*	6*(20.6)*	14*(14.4)*
Neg. attitude of health personnel	4*(20.0)*	0*(0.0)*	2*(10.0)*	1*(3.4)*	14*(14.4)*
Slow response	0*(0.0)*	2*(7.1)*	0*(0.0)*	1*(3.4)*	3*(3.1)*
Overcrowding	1*(5.0)*	0*(0.0)*	1*(5.0)*	0*(0.0)*	2*(2.1)*
Problem retrieving docket	0*(0.0)*	2*(7.1)*	1*(5.0)*	1*(3.4)*	2*(2.1)*
Environment	0*(0.0)*	2*(7.1)*	0*(0.0)*	0*(0.0)*	2*(2.1)*
Inability to purchase drugs	0*(0.0)*	1*(3.6)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
Minimal attention	0*(0.0)*	0*(0.0)*	1*(5.0)*	0*(0.0)*	1*(1.0)*
Limited resources	0*(0.0)*	7*(25.0)*	1*(5.0)*	0*(0.0)*	1*(1.0)*
Missing		2		1	3*(3.0)*

Table A9.

Changes in the health system since the policy change

	Health Centre				
CHANGES	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
More people	11*(55.0)*	28*(93.3)*	12*(60.0)*	29*(96.7)*	80*(80.0)*
Fast worker	3*(15.0)*	7*(23.3)*	6*(30.0)*	5*(16.7)*	21*(21.0)*
Long wait	3*(15.0)*	7*(23.3)*	8*(40.0)*	2*(6.7)*	20*(20.0)*
Good service	2*(10.0)*	4*(13.3)*	3*(15.0)*	5*(16.7)*	14*(14.0)*
Poor service	3*(15.0)*	1*(3.3)*	3*(15.0)*	3*(10.0)*	10*(10.0)*
Negative attitude of health personnel	1*(5.0)*	2*(6.7)*	3*(15.0)*	2*(6.7)*	8*(8.0)*
More resources	3*(15.0)*	1*(3.3)*	2*(10.0)*	0*(0.0)*	6*(6.0)*
Help those who couldn’t afford it	2*(10.0)*	1*(3.3)*	0*(0.0)*	3*(10.0)*	6*(6.0)*
Shortage of resources	0*(0.0)*	2*(6.7)*	2*(10.0)*	0*(0.0)*	4*(4.0)*
Abuse of system	0*(0.0)*	1*(3.3)*	1*(5.0)*	1*(3.3)*	3*(3.0)*
Unsure	1*(5.0)*	0*(0.0)*	1*(5.0)*	0*(0.0)*	2*(2.0)*
Hospital					
CHANGES	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
More people	8*(40.0)*	29*(96.7)*	18*(90.0)*	29*(96.7)*	84*(84.0)*
Long wait	4*(20.0)*	6*(20.0)*	7*(35.0)*	6*(20.0)*	23*(23.0)*
Help those who couldn’t afford it	3*(15.0)*	6*(20.0)*	6*(30.0)*	4*(13.3)*	19*(19.0)*
Poor service	3*(15.0)*	5*(16.7)*	1*(5.0)*	3*(10.0)*	12*(12.0)*
Good service	6*(30.0)*	2*(6.7)*	1*(5.0)*	2*(6.7)*	11*(11.0)*
Negative attitude of health personnel	0*(0.0)*	4*(13.3)*	1*(5.0)*	2*(6.7)*	7*(7.0)*
Shortage of resources	1*(5.0)*	1*(3.3)*	2*(10.0)*	1*(3.3)*	5*(5.0)*
Fast worker	0*(0.0)*	0*(0.0)*	0*(0.0)*	2*(6.7)*	2*(2.0)*
Positive attitude of health personnel	0*(0.0)*	0*(0.0)*	1*(5.0)*	1*(3.3)*	2*(2.0)*
Abuse of system	1*(5.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
No change	2*(10.0)*	2*(6.7)*	2*(5.0)*	0*(0.0)*	6*(6.0)*

Table A10.

Changes in the respondents' use of the health system since free health care

	Health Centre				
Use of system	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Unchanged	6*(30.0)*	20*(66.7)*	11*(55.0)*	23*(76.7)*	60*(60.0)*
Use more	12*(60.0)*	10*(33.3)*	6*(30.0)*	6*(20.0)*	34*(34.0)*
Use less	2*(10.0)*	0*(0.0)*	2*(10.0)*	1*(3.3)*	5*(5.0)*
First time user	0*(0.0)*	0*(0.0)*	1*(5.0)*	0*(0.0)*	1*(1.0)*
	Hospital				
Use of system	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Use more	11*(55.0)*	11*(36.7)*	13*(65.0)*	11*(36.7)*	46*(46.0)*
Unchanged	4*(20.0)*	15*(50.0)*	4*(20.0)*	14*(46.7)*	37*(37.0)*
Use less	5*(25.0)*	4*(13.3)*	3*(15.0)*	5*(16.7)*	17*(17.0)*
First time user	-	-	-	-	-

Table A11.

Users' experience the last time they used a pharmacy

	Health Centre				
Experience	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
No problem	6*(30.0)*	10*(34.5)*	7*(35.0)*	6*(20.0)*	29*(29.2)*
Long wait	5*(25.0)*	13*(44.8)*	9*(45.0)*	20*(66.7)*	47*(47.5)*
Medication unavailable	5*(25.0)*	8*(27.6)*	4*(20.0)*	12*(40.0)*	29*(29.2)*
Paid for some drugs	0*(0.0)*	3*(10.3)*	1*(3.3)*	3*(10.0)*	7*(7.1)*
Overcrowded	2*(10.0)*	2*(6.9)*	1*(3.3)*	2*(6.7)*	7*(7.1)*
Attitude of pharmacists	0*(0.0)*	1*(3.4)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
Not applicable	2*(10.0)*	1*(3.4)*	1*(3.3)*	0*(0.0)*	4*(4.0)*
Missing		1			1
	Hospital				
Experience	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
No problem	6*(30.0)*	10*(33.3)*	5*(25.0)*	11*(36.7)*	32*(32.0)*
Long wait	7*(35.0)*	16*(53.3)*	11*(36.7)*	11*(36.7)*	45*(45.0)*
Medication unavailable	4*(20.0)*	5*(16.7)*	5*(25.0)*	7*(23.3)*	21*(21.0)*
Did not get some meds	4*(20.0)*	3*(10.0)*	0*(0.0)*	5*(16.7)*	12*(12.0)*
Paid for some drugs	1*(5.0)*	4*(13.3)*	1*(5.0)*	5*(16.7)*	11*(11.0)*
Attitude of pharmacists	1*(5.0)*	0*(0.0)*	1*(5.0)*	0*(0.0)*	2*(2.0)*
Overcrowded	1*(5.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
Not applicable	3*(15.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	3*(3.0)*

Table A12.

Coping strategies adopted by respondents when drugs were unavailable in public pharmacy

	Health Centre				
Alternatives	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Private pharmacy	18*(90.0)*	26*(89.7)*	18*(90.0)*	28*(93.3)*	90*(90.9)*
Do without	1*(5.0)*	2*(6.9)*	0*(0.0)*	7*(23.3)*	10*(10.1)*
Do without until available	0*(0.0)*	1*(3.4)*	0*(0.0)*	1*(3.3)*	2*(2.0)*
Not applicable	1*(5.0)*	1*(3.4)*	2*(10.0)*	0*(0.0)*	4*(4.0)*
Missing		1			1
	Hospital				
Alternatives	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Private pharmacy	16*(40.0)*	25*(41.7)*	*19(47.5)*	26*(89.7)*	86*(86.9)*
Do without	0*(0.0)*	2*(3.3)*	*1(2.5)*	3*(10.3)*	6*(6.1)*
Other health facilities	0*(0.0)*	2*(3.3)*	*0(0.0)*	1*(3.4)*	3*(3.0)*
Do without until available	0*(0.0)*	1*(1.7)*	*0(0.0)*	1*(3.4)*	2*(2.0)*
Not applicable	4*(20.0)*	1*(1.7)*	*1(2.5)*	0*(0.0)*	6*(6.0)*
Missing				1	1

Table A13.

Appointments respondents had 12 months preceding the survey

	Health Centre				
Appointment Type	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Health centre	11*(55.0)*	20*(68.9)*	15*(75.0)*	26*(86.7)*	72*(72.7)*
Blood tests	3*(15.0)*	8*(27.6)*	10*(50.0)*	4*(13.3)*	25*(25.3)*
Hospital medical	2*(10.0)*	2*(6.9)*	0*(0.0)*	2*(6.7)*	6*(6.1)*
X-ray	0*(0.0)*	3*(10.3)*	1*(5.0)*	1*(3.3)*	5*(5.1)*
Medical specialist	0*(0.0)*	0*(0.0)*	1*(5.0)*	1*(3.3)*	3*(3.0)*
Hospital surgical	0*(0.0)*	1*(3.4)*	1*(5.0)*	0*(0.0)*	2*(2.0)*
Other medical procedures	1*(5.0)*	4*(13.8)*	0*(0.0)*	0*(0.0)*	5*(5.1)*
No appointment	6*(30.0)*	5*(17.2)*	2*(10.0)*	3*(10.0)*	16*(16.2)*
Missing		1			1
Appointment period - days					
0-20	4*(20.0)*	15*(51.7)*	12*(60.0)*	6*(20.0)*	37*(37.4)*
21-40	5*(20.5)*	3*(10.3)*	2*(10.0)*	2*(6.7)*	12*(12.1)*
41-60	3*(15.0)*	3*(10.3)*	2*(10.0)*	1*(3.3)*	9*(9.1)*
61+	2*(10.0)*	17*(56.6)*	11*(55.0)*	24*(80.0)*	54*(54.5)*
Missing		1			1
Stayed in waiting room - hours					
0-2	8*(40.0)*	16*(55.2)*	8*(40.0)*	5*(16.7)*	37*(37.8)*
3-5	5*(25.0)*	7*(24.1)*	9*(45.0)*	19*(63.3)*	40*(40.8)*
6+	1*(5.0)*	1*(3.4)*	1*(5.0)*	3*(10.0)*	6*(6.1)*
Missing		1	1		2
	Hospital				
Appointment Type	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
Blood test	7*(35.0)*	7*(23.3)*	9*(45.0)*	9*(30.0)*	32*(32.0)*
Hospital medical	8*(40.0)*	5*(16.7)*	5*(25.0)*	7*(23.3)*	25*(25.0)*
Hospital surgical	6*(30.0)*	2*(6.7)*	4*(20.0)*	9*(30.0)*	21*(21.0)*
Medical specialist	6*(30.0)*	6*(20.0)*	3*(15.0)*	3*(10.0)*	18*(18.0)*
X-ray	4*(20.0)*	7*(23.3)*	4*(20.0)*	2*(6.7)*	17*(17.0)*
Health centre	6*(30.0)*	0*(0.0)*	5*(25.0)*	4*(13.3)*	15*(15.0)*
Other medical procedures	1*(5.0)*	3*(10.0)*	0*(0.0)*	0*(0.0)*	4*(4.0)*
No appointment	5*(25.0)*	10*(33.3)*	3*(15.0)*	7*(23.3)*	25*(25.0)*
Appointment period - days					
0-20	22*(110.0)*	14*(46.7)*	20*(100.0)*	11*(36.7)*	67*(67.0)*
21-40	7*(35.0)*	2*(6.7)*	4*(20.0)*	6*(20.0)*	19*(19.0)*
41-60	2*(10.0)*	3*(10.0)*	0*(0.0)*	4*(13.3)*	9*(9.0)*
61+	5*(25.0)*	8*(26.7)*	4*(20.0)*	12*(40.0)*	29*(29.0)*
Stayed in waiting room - hours					
0-2	6*(30.0)*	9*(30.0)*	11*(55.0)*	9*(30.0)*	35*(35.0)*
3-5	5*(25.0)*	8*(26.7)*	4*(20.0)*	9*(30.0)*	26*(26.0)*
6+	3*(15.0)*	3*(10.0)*	1*(5.0)*	3*(10.0)*	10*(10.0)*

Table A14.

Out-of-pocket payment by respondents at their last visit to a health facility

	Health Centre				
Amount paid out-of-pocket ($)	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
100–900	2*(10.0)*	1*(3.4)*	1*(5.0)*	0*(0.0)*	4*(4.0)*
901+	4*(20.0)*	1*(3.4)*	1*(5.0)*	2*(6.7)*	8*(8.1)*
None	14*(70.0)*	27*(93.1)*	18*(60.0)*	28*(93.3)*	87*(87.9)*
Missing		1			1
QUESTION. What did you pay for?					
Medication	2*(10.0)*	2*(6.9)*	1*(5.0)*	2*(6.7)*	7*(7.1)*
Registration	2*(10.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	2*(2.0)*
Doctor	2*(10.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	2*(2.0)*
Transport & lunch	0*(0.0)*	0*(0.0)*	1*(5.0)*	0*(0.0)*	1*(1.0)*
Not applicable	14*(70.0)*	27*(93.1)*	18*(90.0)*	28*(93.3)*	87*(87.9)*
Missing		1			1
	Hospital				
Amount paid out-of-pocket ($)	NERHA n= 20(%)	SRHA n= 30(%)	WRHA n= 20(%)	SERHA n= 30(%)	TOTAL N(%)
100–900	4*(20.0)*	2*(6.7)*	0*(0.0)*	3*(10.0)*	9*(9.0)*
901+	6*(30.0)*	5*(16.7)*	1*(5.0)*	3*(10.0)*	15*(15.0)*
None	10*(50.0)*	22*(73.3)*	18*(90.0)*	23*(76.7)*	73*(73.0)*
Health insurance	0*(0.0)*	0*(0.0)*	1*(5.0)*	1*(3.3)*	2*(2.0)*
Not applicable	0*(0.0)*	1*(3.3)*	0*(0.0)*	0*(0.0)*	1*(1.0)*
QUESTION. What did you pay for?					
Medication	1*(5.0)*	5*(16.7)*	0*(0.0)*	3*(10.0)*	9*(9.0)*
Doctor	4*(20.0)*	0*(0.0)*	0*(0.0)*	1*(3.3)*	5*(5.0)*
Transport & lunch	2*(10.0)*	1*(3.3)*	0*(0.0)*	1*(3.3)*	4*(4.0)*
Diagnostic	1*(5.0)*	1*(6.7)*	1*(5.0)*	1*(3.3)*	4*(4.0)*
Registration	3*(15.0)*	0*(0.0)*	0*(0.0)*	0*(0.0)*	3*(3.0)*
Surgery	0*(0.0)*	0*(0.0)*	1*(5.0)*	0*(0.0)*	1*(1.0)*
Not applicable	10*(50.0)*	23*(76.7)*	18*(90.0)*	24*(80.0)*	75*(75.0)*

References

Abdu, Z., Mohammed, Z., Bashier, I., & Eriksson, B. (2004). The impact of user fee exemption on service utilisation and treatment seeking behaviour: The case of malaria in Sudan. *International Journal of Health Planning and Management, 19*(S1), S95-S106. doi:10.1002/hpm.777

Akashi, H., Yamada, T., Huot, E., Kanal, K., & Sugimoto, T. (2004). User fees at a public hospital in Cambodia: Effects on hospital performance and provider attitudes. *Social Science & Medicine, 58*(3), 553-564. doi: 10.1016/S0277-9536(03)00240-5

Alleyne, D. (2010). The impact of user fees on health costs and health burdens in Jamaica: The cases of diabetes and hypertension. *Social and Economic Studies, 59*(1), 91-121,315-316,326. Retrieved from http://search.proquest.com/docview/749698043?accountid=14782

Andersen, R.M. (1995). Revisiting the behavioural model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1-10. Retrieved from http://search.proquest.com/docview/201658072

Ansah, E.K., Narh-Bana, S., Asiamah, S., Dzordzordzi, V., Biantey, K., Dickson, K., ... Whitty, C.J.M. (2009). Effect of removing direct payment for health care on utilisation and health outcomes in Ghanaian children: A randomised controlled trial. *PLoS Med, 6*(1), 48-58. Retrieved from http://search.proquest.com/docview/66861174

Asante, F.A., Chikwama, C., Daniel, A., & Armar-Klemesu, M. (2007). Evaluating the economic outcomes of the policy of fee exemption for maternal delivery care in Ghana. *Ghana Medical Journal, 41*(3), 110-117. Retrieved from http://www.ajol.info/index.php/gmj/article/viewFile/55277/43743

Asfaw, A., Braun, J.V., & Klasen, S. (2004). How big is the crowding-out effect of user fees in the rural areas of Ethiopia? Implications for equity and resources mobilisation. *World Development, 32*(12), 2065-2081. doi: 10.1016/j.worlddev.2004.07.004

Audibert, M., & Mathonnat, J. (2000). Cost recovery in Mauritania: Initial lessons. *Health Policy and Planning, 15*(1), 66-75. doi: 10.1093/heapol/15.1.66

Auditor General's Department, Jamaica. (2011). Performance Audit Report of the Ministry of Health's management of the supply of prescription drugs to meet the needs of the population. Retrieved from http://www.auditorgeneral.gov.jm/files/u5/PRESCRIPTION_DRUGS_PERFORMANCE_AUDIT_REPORT.pdf

Bailey, W., Wynter, H.H., Lee, A., Oliver, P., & Jackson, J. (1994). The effect of user fees on the utilisation of family planning services. A clinical study [Abstract]. *West Indian Medical Journal, 43*(2), 43-5. http://www.ncbi.nlm.nih.gov/pubmed/7941495

Barber, S., Bonnet, F., & Bekedam, H. (2004). Formalising under-the-table payments to control out-of-pocket hospital expenditures in Cambodia. *Health Policy and Planning, 19*(4), 199-208. doi: 10.1093/heapol/czh025

Barnett, J., Lalta, S., & Bailey, W. (2010). Towards alternative financing proposals for health care for the elderly with chronic conditions - Jamaica. *Social and Economic Studies, 59*(1), 153-180,318-319,326-327. Retrieved from http://search.proquest.com/docview/749698273

Barrett, R.D., & Lalta, S. (2004). *Health financing innovations in the Caribbean: EHPO and the National Health Fund.* (Technical Papers Series). Washington, D.C: Inter-American Development Bank, Sustainable Development Department. Retrieved from http://www.eldis.org/vfile/upload/1/document/0708/DOC19862

Bednarski, D. (2009). The value of nursing. *Nephrology Nursing Journal, 36*(2), 115-7. Retrieved from http://search.proquest.com/docview/216533789?accountid=14782

Bhayat, A., & Cleaton-Jones, P. (2003). Dental clinic attendance in Soweto, South Africa, before and after the introduction of free primary dental health services. *Community Dentistry and Oral Epidemiology, 31*(2), 105-110. doi: 10.1034/j.1600-0528.2003.00006.x

Biesta, G. (2010). Pragmatism and the philosophical foundations of mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *Sage handbook of mixed methods in social and behavioural research* (pp. 95-118). Los Angeles, CA: SAGE Publications Ltd.

Birbeck, G.L., & Munsat, T. (2002). Neurologic services in Sub-Saharan Africa: A case study among Zambian primary healthcare workers. *Journal of the Neurological Sciences, 200*(1–2), 75-78. doi: 10.1016/S0022-510X(02)00132-6

Biritwum, R.B. (1994). The cost of sustaining the Ghana's “cash and carry” system of health care financing at a rural health centre [Abstract]. *West African Journal of Medicine, 13*(2), 124-7. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/7803327

Bitran, R., & Giedion, U. (2002). *Waivers and exemptions for health services in developing countries*. Washington, DC: World Bank. Retrieved from www.ihf-fih.org

Black, C. (2011). *History of Jamaica*. United Kingdom: Longman Group Publishing.

Blas, E., & Limbambala, M. (2001). User-payment, decentralisation and health service utilisation in Zambia. *Health Policy and Planning, 16*(suppl 2), 19-28. doi: 10.1093/heapol/16.suppl_2.19

Boss, E.F., Marsteller, J.A., & Simon, A.E. (2012). Outpatient tonsillectomy in children: Demographic and geographic variation in the United States, 2006. *The Journal of Pediatrics, 160*(5), 814-819. doi: 10.1016/j.jpeds.2011.11.041

Bosu, W.K., Bell, J.S., Armar-Klemesu, M., & Tornui, J.A. (2007). Effect of delivery care user fee exemption policy on institutional maternal deaths in the Central and Volta regions of Ghana. *Ghana Medical Journal, 41*(3). Retrieved from http://www.ajol.info/index.php/gmj/article/viewFile/55278/43744

Bourne, P.A. (2009). Health insurance coverage in Jamaica: Multivariate analyses using two cross-sectional survey data for 2002 and 2007. *International Journal of Collaborative Research on Internal Medicine & Public Health, 1*(8), 195-213.

Braveman, P. (2006). Health disparities and health equity: Concepts and measurement. *Annual Review of Public Health, 27*(1), 167-194. doi:10.1146/annurev.publhealth.27.021405.10

Brophy, S., Snooks, H., & Griffiths, L. (2008). *Small-scale evaluation in health: A practical guide*. Los Angeles, CA: SAGE Publications Ltd.

Burnham, G.M., Pariyo, G., Galiwango, E., & Wabwire-Mangen, F. (2004). Discontinuation of cost sharing in Uganda. *Bulletin of the World Health Organisation, 82*(3), 187-195. Retrieved from http://dx.doi.org/10.1590/S0042-96862004000300008

Bush, M., Moss, L., & Wallis, S. (2006). Hustling to health - a nurse led outreach service. *Australian Nursing Journal, 14*(4), 35-35. Retrieved from http://search.proquest.com/docview/236650765?accountid=14782

Campbell, C. (2002). Early emancipation Jamaica: The historiography of plantation culture, 1834-1865. In K.E.A. Monteith & G. Richards (Eds.), *Jamaica in Slavery and freedom: Heritage, history and culture* (pp. 52-69). Kingston, Jamaica: The University of the West Indies Press.

Campbell, J., Oulton, J.A., McPake, B., & Buchan, J. (2009). Removing user fees? Engage the health workforce. *The Lancet, 374*(9706), 1966. doi:10.1016/S0140-6736(09)62118-8

Carley, K. (1993). Coding choices for textual analysis: A comparison of content analysis and map analysis. *Sociological Methodology, 23*, 75-126. Retrieved from http://www.jstor.org.helicon.vuw.ac.nz/stable/pdfplus/271007.pdf?

Chapman, J.L., Zechel, A., Carter, Y.H., & Abbott, S. (2004) Systematic review of recent innovations in service provision to improve access to primary care. *British Journal of General Practice*, *54*(502), 374-381. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1266174/

Chapple, A., Rogers, A., Macdonald, W., & Sergison, M. (2000). Patients' perceptions of changing professional boundaries and the future of 'nurse-led' services. *Primary Health Care Research & Development, 1*(01), 51-59. doi:10.1191/146342300674617169

CHASE Foundation, Jamaica. (2008). Retrieved from http://www.chase.org.jm/

Chawla, M., & Ellis, R.P. (2000). The impact of financing and quality changes on health care demand in Niger. *Health Policy and Planning, 15*(1), 76-84. doi: 10.1093/heapol/15.1.76

Chuma, J., Musimbi, J., Okungu, V., Goodman, C., & Molyneux, C. (2009). Reducing user fees for primary health care in Kenya: Policy on paper or policy in practice? *International Journal for Equity in Health*, *8*(1), 15. http://www.equityhealthj.com/content/pdf/1475-9276-8-15.pdf

Cochrane, R., & Sashidharan, S.P. (1996). *Ethnicity and health: Reviews of literature and guidance for purchasers in the areas of cardiovascular disease, mental health and haemoglobinopathies*. NHS Centre for reviews and dissemination. York, UK: University of York.

Cooper, L.A., Hill, M.N., & Powe, N.R. (2002). Designing and evaluating interventions to eliminate racial and ethnic disparities in health care. *Journal of General Internal Medicine, 17*(6), 477-486. doi: 10.1046/j.1525-1497.2002.10633.x

Cover, W.A. (1995). *Handbook of Jamaica 1955* (65th ed.). Ministry of Communications and Works. Kingston, Jamaica: Government Printing Office.

Creswell, J.W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications Inc.

Creswell, J.W. (2009). *Research design: Qualitative, quantitative and mixed methods approaches* (3^{rd} ed.). Thousand Oaks, CA: Sage Publications Inc.

Creswell, J.W., & Plano Clark, V.L. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage Publication Inc.

Culyer, A.J. (2001). Equity: Some theory and its policy implications. *Journal of Medical Ethics, 27*(4), 275-283. doi:10.1136/jme.27.4.275

Culyer, A.J., & Wagstaff, A. (1993). Equity and equality in health and health care. *Journal of Health Economics, 12*(4), 431-457. doi: 10.1016/0167-6296(93)90004-X

Davies, M.B. (2007). *Doing a successful research project using qualitative and quantitative methods*. New York, NY: Palgrave Macmillan.

Deininger, K., & Mpuga, P. (2005). Economic and welfare impact of the abolition of health user fees: Evidence from Uganda. *Journal of African Economies, 14*(1), 55-91. Retrieved from http://web.ebscohost.com.helicon.vuw.ac.nz/ehost/pdfviewer/pdfviewer

Dellagiacoma, T. (2007). Eight essential factors for successful nurse-led services. *Australian Nursing Journal, 14*(10), 28-31. Retrieved from http://search.proquest.com/docview/236620896?accountid=14782

Department of health and human services (USA). (2010). *Healthy People 2020: Health disparity*. Washington, DC. Retrieved from http://healthypeople.gov/2020/about/DisparitiesAbout.aspx

DeVoe, J.E., Baez, A., Angier, H., Krois, L., Edlund, C., & Carney, P.A. (2007). Insurance + access ? Health care: Typology of barriers to health care access for low-income families. *Annals of Family Medicine, 5*(6), 511-518. doi: 10.1370/afm.748

Dick, J., Clarke, M., Van Zyl, H., & Daniels, K. (2007). Primary health care nurses implement and evaluate a community outreach approach to health care in the South African agricultural sector. *International Nursing Review, 54*(4), 383-390. doi: 10.1111/j.1466-7657.2007.00566.x

Diop, F., Yazbeck, A., & Bitran, R. (1995). The impact of alternative cost recovery schemes on access and equity in Niger. *Health Policy and Planning, 10*(3), 223-240. doi: 10.1093/heapol/10.3.223

ECOSOC. (2009). ECOSOC High-level segment. *Annual ministerial review: National voluntary presentations of Bolivia, China, Jamaica, Japan, Mali, Sri Lanka, Sudan*. Informal Summary. Retrieved from http://www.un.org/en/ecosoc/julyhls/pdf/09%20nvp%20summary%209%20july%20final.pdf

Fabricant, S.J., Kamara, C.W., & Mills, A. (1999). Why the poor pay more: Household curative expenditures in rural Sierra Leone. *International Journal of Health Planning and Management, 14*(3), 179-199. doi: 10.1002/(sici)1099-1751(199907/09)14:3<179::aid-hpm548>3.0.co;2-n

Fafchamps, M., & Minten, B. (2007). Public service provision, user fees and political turmoil. *Journal of African Economies, 16*(3), 485-518. doi: 10.1093/jae/ejl040

Figueroa, J.P. (2001). Health trends in Jamaica: Significant progress and a vision for the 21st century. *West Indian Medical Journal, 50*(Supplement 4), 15-22.

Fink, A. (2003). *The survey handbook* (2nd ed.). Thousand Oaks, CA: SAGE Publications. Retrieved from http://books.google.co.nz/books?id=s_7GVySNWVgC&pg=PA75&source=gbs_selected_pages&cad=3#v=onepage&q&f=false

Flores, G., Abreu, M., Olivar, M.A., & Kastner, B. (1998). Access barriers to health care for Latino children. *Archives of Pediatrics and Adolescent Medicine, 152,* 1119 - 1125. Retrieved from https://mywebspace.wisc.edu/anoguera/web/med/Reading.for.class_11-02.pdf

Forrest, C. B. (2003). Primary care gatekeeping and referrals: Effective filter or failed experiment? *BMJ, 326*(7391), 692-695. doi: 10.1136/bmj.326.7391.692

Gertler, P., & Sturm, R. (1997). Private health insurance and public expenditures in Jamaica. *Journal of Econometrics, 77*(1), 237-257. doi: 10.1016/s0304-4076(96)01814-3

Gilson, L. (1997). The lessons of user fee experience in Africa. *Health Policy and Planning, 12*(3), 273-285. Retrieved from http://heapol.oxfordjournals.org/content/12/3/273.full.pdf+html

Gilson, L., & McIntyre, D. (2005). Removing user fees for primary care in Africa: The need for careful action. *British Medical Journal, 331*(7519), 762-765. doi: 10.1136/bmj.331.7519.762

Gilson, L., Russell, S., & Buse, K. (1995). The political economy of user fees with targeting: Developing equitable health financing policy. *Journal of International Development, 7*(3), 369-401. doi: 10.1002/jid.3380070305

Goddard, M., Smith, P. (1998). *Equity of access to health care*. Centre for Health Economics Occasional Paper, UK: University of York. Author. Retrieved from https://www.york.ac.uk/media/che/documents/papers/occasionalpapers/CHE%20Ooccasional%20Paper%2032.pdf

Goddard, M., & Smith, P. (2001). Equity of access to health care services: Theory and evidence from the UK. *Social Science & Medicine, 53*(9), 1149-1162. doi: 10.1016/S0277-9536(00)00415-9

Gordon-Strachan, G., Bailey, W., Henry-Lee, A., Barnett, J., Lalta, S., & Alleyne, D. (2010). The impact of user fees for preventive health care - Jamaica. *Social and Economic Studies, 59*(1& 2), 123-152. Retrieved from http://go.galegroup.com.helicon.vuw.ac.nz/ps/retrieve.do?retrieveFormat=PDF

Graham, S. (2009, August 15). The IMF and the no user fees policy in health. *Jamaica Observer*. Retrieved from http://www.jamaicaobserver.com/columns/html/20090814T200000-0500_157495

Gregory, P.M., Malka, E.S., Kostis, J.B., Wilson, A.C., Arora, J.K., & Rhoads, G.G. (2000). Impact of geographic proximity to cardiac revascularisation services on service utilisation. *Medical Care, 38*(1), 45-57. Retrieved from http://www.jstor.org/stable/3767101

Gulliford, M. (2009). Modernising concepts of access and equity. *Health Economics, Policy and Law, 4*(2), 223-230. doi: 10.1017/s1744133109004940

Gulliford, M., Morgan, M., Hughes, D., Beech, R., Figeroa-Munoz, J., Gibson, B., ... Sedgwick, J. (2001). *Access to health care*. Report of a scoping exercise for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO). London, UK. Author.

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does ‘access to health care’ mean? *Journal of Health Services Research & Policy, 7*(3), 186-188.

Gulliford, M., Figueroa-Munoz, J., & Morgan, M. (2003). Meaning of ‘access’ in health care. In M. Gulliford & M. Morgan (Eds.), *Access to health care* (pp. 1-12). Retrieved from http://books.google.co.nz/books?hl=en&lr=&id=mOXP05u5alAC&oi=fnd&pg=PR

Haddad, S., & Fournier, P. (1995). Quality, cost and utilisation of health services in developing countries. A longitudinal study in Zaïre. *Social Science & Medicine, 40*(6), 743-753. doi: 10.1016/0277-9536(94)00134-f

Hardeman, W., Van Damme, W., Van Pelt, M., Por, I., Kimvan, H., & Meessen, B. (2004). Access to health care for all? User fees plus a Health Equity Fund in Sotnikum, Cambodia. *Health Policy and Planning, 19*(1), 22-32. doi: 10.1093/heapol/czh003

Hastings, S. (2010). Triangulation. In N. Salkind (Ed.), *Encyclopaedia of research design.* (pp. 1538-1541). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412961288.n469

Hay Ho Sang, E.P. (1985). *The development of nursing education in Jamaica, West Indies: 1900-1975*. Retrieved from ProQuest Dissertations & Theses. (Ann Arbor 48106).

Health Sector Task Force. (2007). *A healthy Jamaica in a healthy world.* Kingston, Jamaica: Ministry of Health & Environment.

Health Sector Task Force. (2009). *Vision 2030 Jamaica national development plan:* (Draft Health sector plan). Kingston, Jamaica: Ministry of Health & Environment.

Hercot, D., Meessen, B., Ridde, V., & Gilson, L. (2011). Removing user fees for health services in low-income countries: A multi-country review framework for assessing the process of policy change. *Health Policy and Planning, 26*, ii5-ii15. doi: 10.1093/heapol/czr063

Higman, B.W. (2005). *Plantation Jamaica 1750-1850: Capital and control in a colonial economy*. Kingston, Jamaica: The University of the West Indies Press.

Hjertqvist, J. (2002, May). User fees for health care in Sweden: A two-tier threat or a tool for solidarity? *Health Care Commentary* #6. Atlantic Institute for Market Studies. Retrieved from http://www.aims.ca/site/media/aims/newsletter6

Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *BMJ, 324*(7341), 819-823. doi: 10.1136/bmj.324.7341.819

Howden-Chapman, P. & Cram, F. (1998). *Social, economic and cultural determinants of health* (National Health Committee: Health determinants programme. Background paper 1). Wellington, New Zealand: Ministry of Health.

Huber, D. & Blanchfield, K. (1999). Telephone nursing in ambulatory care. *Journal of Nursing Administration, 29*(3), 38-44. http://ovidsp.tx.ovid.com.helicon.vuw.ac.nz/sp-3.6.0b/ovidweb.cgi?

Hussein, A.K., & Mujinja, P.G. (1997). Impact of user charges on government health facilities in Tanzania [Abstract]. *East African Medical Journal, 74*(12), 751-757. Retrieved from http://ukpmc.ac.uk/abstract/MED/9557416

Hussey, P., Anderson, G., Berthelot, J.M., Feek, C., Kelley, E., Osborn, R., ... Epstein, A. (2007). Trends in socioeconomic disparities in health care quality in four countries. *International Journal for Quality in Health Care, 20*(1), 53-61. doi: 10.1093/intqhc/mzm055

Institute of Medicine. (1993). In M. L. Millman (Ed.), *Access to health care in America* National Academies Press. Retrieved from http://search.proquest.com/docview/868142123?accountid=14782

ICN. (2009). *Delivering quality, serving communities: Nurses leading care innovations*. International Nurses Day 2011 Toolkit. Retrieved from http://www.icn.ch/images/stories/documents/publications/ind/indkit2009.pdf

Israel, M., & Hay, I. (2006). *Research ethics for social scientists: Between ethical conduct and regulatory compliance*. London, UK: SAGE Publications Ltd. Retrieved from http://books.google.co.nz/books?id=EfNLH99zlcEC&pg=PR5&source=gbs_selected_pages&cad=3#v=onepage&q&f=false

Jacobs, B., & Price, N. (2006). Improving access for the poorest to public sector health services: Insights from Kirivong Operational Health District in Cambodia. *Health Policy Planning, 21*, 27-39. doi: 10.1093/heapol/czj001

Jacobs, M., & McCoy, D. (1997). Free care for pregnant women and children under six. *The Lancet, 349*(9064), 1541-1542. Retrieved from http://search.proquest.com/docview/199061669?accountid=14782

Jamaica Constitution 1962. Retrieved from http://www.jis.gov.jm/special_sections/Bills

Jamaica Ethnic Groups. (2009). *In The encyclopaedia of the nations*. Retrieved from http://www.nationsencyclopaedia.com/Americas/Jamaica-ETHNIC-GROUPS.html

JIS. (2007). *National symbols*. Retrieved from http://www.jis.gov.jm/special_sections/Independence/symbols.html

JIS. (2008, March 11). *Special attention being paid to primary health care system*. Retrieved from http://www.jis.gov.jm/news/archive/14479

JIS. (2009, March 25). *Poorest Jamaicans accessing health care*. Retrieved from http://www.jis.gov.jm/news/106-health/18977-health-poorest-jamaicans-accessing-health-care

JIS. (2010, April 15). *Government renewing primary health care system this year*. Retrieved from http://www.jis.gov.jm/news/archive/23599

James, C.D., Hanson, K., McPake, B., Balabanova, D., Gwatkin, D., Hopwood, I., ... Kirunga, C. (2006). To retain or remove user fees? Reflections on the current debate in low- and middle-income countries. *Applied Health Economics and Health Policy, 5*(3), 137-153. Retrieved from http://go.galegroup.com.helicon.vuw.ac.nz/ps/retrieve.do?retrieveFormat=PDF

James, C., Morris, S.S., Keith, R., & Taylor, A. (2005). Impact on child mortality of removing user fees: Simulation model. *British Medical Journal, 331*(7519), 747-749. doi: 10.1136/bmj.331.7519.747

JAMPRO. (2010). *Jamaica at a glance*. Retrieved from http://www.jamaicatradeandinvest.org/index.php?action=content&id=at_glance

Johnston, J. & Montecino, J.A. (2011). *Jamaica: Macroeconomic policy, debt and the IMF*. Washington D.C, USA: Centre for Economic and Policy Research. Retrieved from http://www.cepr.net/documents/publications/jamaica-qr-2011-04.pdf

Kajula, P.W., Kintu, F., Barugahare, J., & Neema, S. (2004). Political analysis of rapid change in Uganda's health financing policy and consequences on service delivery for malaria control. *International Journal of Health Planning and Management, 19*(S1), S133-S153. doi: 10.1002/hpm.772

Kato, K., & Bart, W. (2008). Descriptive statistics. In N. Salkind (Ed.), *Encyclopaedia of educational psychology*. (pp. 237-239). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412963848.n65

Kenealy, T., Arroll, B., Kenealy, H., Docherty, B., Scott, D., Scragg, R., & Simmons, D. (2004). Diabetes care: Practice nurse roles, attitudes and concerns. *Journal of Advanced Nursing, 48*(1), 68-75. doi: 10.1111/j.1365-2648.2004.03173.x

Khandker, S.R., Koolwal, G.B., & Samad, H.A. (2010). *Handbook on impact evaluation: Quantitative methods and practices*. The International Bank for Reconstruction and Development/World Bank. Washington, DC: World Bank.

Kipp, W., Kamugisha, J., Jacobs, P., Burnham, G., & Rubaale, T. (2001). User fees, health staff incentives, and service utilisation in Kabarole District, Uganda. *Bulletin of the World Health Organisation, 79*(11), 1032-1037. Retrieved from http://www.who.int/bulletin/archives/79(11)1032.pdf

Kiwanuka, S.N., Ekirapa, E.K., Peterson, S., Okui, O., Hafizur Rahman, M., Peters, D., Pariyo, G.W. (2008). Access to and utilisation of health services for the poor in Uganda: A systematic review of available evidence. *Royal Society of Tropical Medicine and Hygiene, 102,* 1067-1074. doi:10.1016/j.trstmh.2008.04.023

Klemick, H., Leonard, K.L., & Masatu, M.C. (2009). Defining access to health care: Evidence on the importance of quality and distance in rural Tanzania. *American*

Journal of Agricultural Economics, 91(2), 347-358. doi: 10.1111/j.1467-8276.2009.01252.x

Krippendorff, K. (2010). Content analysis. In N. Salkind (Ed.), *Encyclopaedia of research design.* (pp. 234-239). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412961288.n73

Lagarde, M., & Palmer, N. (2008). The impact of user fees on health service utilisation in low- and middle-income countries: How strong is the evidence? *Bulletin of the World Health Organisation, 86*(11), 839-848. Retrieved from http://search.proquest.com/docview/229652775

Lalta, S. (1995). *Review of health financing in Jamaica and a survey of the feasibility of national health insurance*. Kingston, Jamaica: University of the West Indies, Mona, Institute of Social and Economic Research (SALISES). Retrieved from http://www.healthsystems2020.org/content/resource/detail/994/

Laterveer, L., Munga, M., & Schwerzel, P. (2004). *Equity implications of health sector user fees in Tanzania: Do we retain the user fee or do we set the user f(r)ee?* Leusden, The Netherlands: ETC Crystal.

Lewis, M.A. (1993). User fees in public hospitals: Comparison of three country case studies. *Economic Development and Cultural Change, 41*(3), 513-532. http://www.jstor.org/stable/1154314

Lipsedge, M. (1993). Mental health: Access to care for black and ethnic minority group people. In A. Hopkins & V. Bahl (Eds.), *Access to health care for ethnic minorities* (pp. 169-185). London, UK: Royal College of Physicians of London.

Litvack, J.I., & Bodart, C. (1993). User fees plus quality equals improved access to health care: Results of a field experiment in Cameroon. *Social Science & Medicine, 37*(3), 369-383. doi: 10.1016/0277-9536(93)90267-8.

Liu, X., & Mills, A. (2002). Financing reforms of public health services in China: Lessons for other nations. *Social Science & Medicine, 54*(11), 1691-1698. doi: 10.1016/s0277-9536(01)00337-9

Lockyer, S. (2008). Textual analysis. In L. Given (Ed.), *The SAGE encyclopaedia of qualitative research methods.* (pp. 866-867). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412963909.n449

Lopushinsky, S.R., Austin, P.C., Rabeneck, L., Kulkarni, G.S., & Urbach, D.R. (2007). Regional Variation in Surgery for Gastroesophageal Reflux Disease in Ontario. *Surgical Innovation, 14*(1), 35-40. doi: 10.1177/1553350606298967

Luton, D. (2009, February 23). Free health flop - Avalanche of woes predicted before user fees scrapped. *Jamaica Gleaner*. Retrieved from http://jamaica-gleaner.com/gleaner/20090223/lead/lead1.html

Maharaj, S. (2010). The relationship between healthcare services and the political economy with reference to the Jamaican experience. *West Indian Medical Journal, 59*, 706-708. Retrieved from http://caribbean.scielo.org/pdf/wimj/v59n6/v59n6a19

Mariko, M. (2003). Quality of care and the demand for health services in Bamako, Mali: The specific roles of structural, process, and outcome components. *Social Science & Medicine, 56*(6), 1183-1196. doi: 10.1016/S0277-9536(02)00117-X.

Masiye, F., Chitah, B.M., Chanda, P., & Simeo, F. (2008). *Removal of user fees at primary health care facilities in Zambia: A study of the effects on utilisation and quality of care*. Harare, Zimbabwe: University of Zambia & University of Cape Town. Retrieved from http://www.equinetafrica.org/bibl/docs/Dis57FINchitah.pdf

Mbugua, J.K., Bloom, G.H., & Segall, M.M. (1995). Impact of user charges on vulnerable groups: The case of Kibwezi in rural Kenya. *Social Science & Medicine*, *41*(6), 829-835. doi: 10.1016/0277-9536(94)00400-n

McCaw-Binns, A. (2008). Can research accelerate progress toward Millennium Development Goal 5 (Maternal Health) in Jamaica? *West Indian Medical Journal*; *57*(6): 549. Retrieved from http://dspace.mona.uwi.edu/handle/123456789/265

McCaw-Binns, A. M., Moody, C. O., & Standard, K. L. (1998). Forty years: An introduction to the development of a Caribbean public health. *West Indian Medical Journal, 47*(Supplement 4), 8-12.

McCaw-Binns, A., & Moody, C.O. (2001). The development of primary health care in Jamaica. *West Indian Medical Journal, 50* (Supplement 4), 6-10.

McCaw-Binns, A., Standard-Goldson, A., Ashley, D., Walker, G., & MacGillivray, I. (2001). Access to care and maternal mortality in Jamaican hospitals: 1993–1995. *International Journal of Epidemiology, 30*(4), 796-801. doi: 10.1093/ije/30.4.796

McIntyre, D.I., Thiede, M., & Birch, S. (2009). Access as a policy-relevant concept in low- and middle-income countries. *Health Economics, Policy and Law, 4*(2), 179-193. doi: 10.1017/s1744133109004836

McLachlan, A., Kerr, A., Lee, M., & Dalbeth, N. (2011). Nurse-led cardiovascular disease risk management intervention for patients with gout. *European Journal of Cardiovascular Nursing, 10*(2), 94-100. doi: 10.1016/j.ejcnurse.2010.05.001

McPake, B., Brikci, N., Cometto, G., Schmidt, A., & Araujo, E., (2011). Removing user fees: Learning from international experience to support the process. *Health Policy and Planning, 26*, ii104-ii117. doi:10.1093/heapol/czr064

McPake, B., Schmidt, A., Araujo, E., & Tashobya, C.K. (2008). *Freeing up healthcare: A guide to removing user fees*. London, UK: The Save the Children Fund. http://eresearch.qmu.ac.uk/1360/1/eResearch_1360.pdf

Meessen, B., Hercot, D., Noirhomme, M., Ridde, V., Tibouti, A., Tashobya, C.K., & Gilson, L. (2011). Removing user fees in the health sector: A review of policy processes in six sub-Saharan African countries. *Health Policy and Planning, 26*(suppl 2), ii16-ii29. doi: 10.1093/heapol/czr062

Meessen, B., Van Damme, W., Tashobya, C.K., & Tibouti, A. (2006). Poverty and user fees for public health care in low-income countries: Lessons from Uganda and Cambodia. *Lancet, 368,* 2253–57. Retrieved from http://www.strengtheninghealthsystems.be/doc/1/

Merzel, C. (2000). Gender differences in health care access indicators in an urban, low-income community. *American Journal of Public Health*. *90*(6), 909–916. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446268/pdf/10846508.pdf

Meuwissen, L.E. (2002). Problems of cost recovery implementation in district health care: A case study from Niger. *Health Policy and Planning, 17*(3), 304-313. doi: 10.1093/heapol/17.3.304

Miles, K., Clutterbuck, D.J., Seitio, O., Sebego, M., & Riley, A. (2007). Antiretroviral treatment roll-out in a resource-constrained setting: Capitalising on nursing resources in Botswana. *Bulletin of the World Health Organisation, 85*(7), 555-60. http://www.scielosp.org/pdf/bwho/v85n7/a14v85n7.pdf

Miles, M.B., & Huberman, A.M. (1994). *An expanded sourcebook: Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: SAGE Publications Inc.

MOH. (1992). *Job descriptions* (professional nurses). Kingston, Jamaica: Author.

MOH. (2008a). *Annual report 2006.* Kingston, Jamaica: Author.

MOH. (2008b, March 28). *Statement on abolition of user fees in public health facilities*. [News release]. Kingston, Jamaica: Author.

MOH. (2008c, March 28). *Question and answer sheet on abolition of user fees*. [News release]. Kingston, Jamaica: Author.

MOH. (2008d, April 9). *Successful first week for the abolition of fees with 58% increase in accident and emergency registration*. [News release]. Kingston, Jamaica: Author.

MOH. (2009a). *Patient utilisation one year after the abolition of user fees*. Retrieved from http://www.moh.gov.jm/general/latestnews/1-news?start=24

MOH. (2009b, February 24). *Jamaicans saved over 1 billion dollars under no user fees policy*. [News release]. Kingston, Jamaica: Author.

MOH. (2009c). *Annual report 2007.* Kingston, Jamaica: Author.

MOH. (2010). *Annual Report 2009.* (Unpublished, Preliminary Report). Kingston, Jamaica: Author.

Mooney, G.H. (1983). Equity in health care: Confronting the confusion. *Effective Health Care, 1*(4), 179-185.

Mooney, G.H. (2009). Is it not time for health economists to rethink equity and access? *Health Economics, Policy and Law, 4*(02), 209-221. doi:10.1017/S1744133109004848

Mrug, S. (2010). Survey. In N. Salkind (Ed.), *Encyclopaedia of research design.* (pp. 1473-1477). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412961288.n449

Nabyonga, J., Desmet, M., Karamagi, H., Kadama, P., Omaswa, F., & Walker, O. (2005). Abolition of cost-sharing is pro-poor: Evidence from Uganda. *Health Policy and Planning, 20*(2), 100-108. doi: 10.1093/heapol/czi012

Nabyonga-Orem, J., Karamagi, H., Atuyambe, L., Bagenda, F., Okuonzi, S.A., & Walker, O. (2008). Maintaining quality of health services after abolition of user fees: A Uganda case study. *BMC Health Services Research, 8,* 102-111. doi: 10.1186/1472-6963-8-102

Nanda, P. (2002). Gender dimensions of user fees: Implications for women's utilisation of health care. *Reproductive Health Matters, 10*(20), 127-134. Retrieved from http://www.jstor.org/stable/3776333

Nandi, A., Galea, S., Lopez, G., Nandi, V., Strongarone, S., & Ompad, D.C. (2008). Access to and use of health services among undocumented Mexican immigrants in United States urban area. *American Journal of Public Health, 98*(11), 2011-2020. doi: 10.2105/AJPH.2006.096222

NHF. (2008). *Aims and objectives*. Retrieved from http://www.nhf.org.jm/dynaweb.dti?dynasection=aboutus&dynapage=aims_objectives

National Health services Act 1997. Retrieved from http://www.moj.gov.jm/node/77

Neal, D., Stewart, D., & Grant, C.C. (2008). Nurse-led newborn resuscitation in an urban neonatal unit. *Acta Pædiatrica, 97*(12), 1620-1624. doi: 10.1111/j.1651-2227.2008.01000.x.

NERHA. (2009). Retrieved from http://www.nerha.gov.jm/aboutus.html

Netshandama, V.O., Nemathaga, L & Shai-Mahoko, S.N. (2005). Experiences of primary health care nurses regarding the provision of free health care services in the northern region of the Limpopo Province [Abstract]. *Curationis, 28*(1), 59-68. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15850154

Newacheck, P.W., Hung, Y.Y., & Wright, K.K. (2002). Racial and ethnic disparities in access to care for children with special health care needs. *Ambulatory Pediatrics, 2*(4), 247-254. doi: 10.1367/1539-4409(2002)002<0247

Nimpagaritse, M., & Bertone, M.P. (2011). The sudden removal of user fees: The perspective of a frontline manager in Burundi. *Health Policy and Planning, 26*(suppl 2), ii63-ii71. doi: 10.1093/heapol/czr061

Nolan, B., & Turbat, V. (1995). *Cost recovery in public health services in Sub Saharan Africa*. World Bank Publication. [Books Google]. Retrieved from http://books.google.co.nz/books?hl=en&lr=&id=NeH__9wKDbwC&oi=fnd&pg=PR5&dq=Nolan+and+turbat&ots

Nyonator, F., & Kutzin, J. (1999). Health for some? The effects of user fees in the Volta Region of Ghana. *Health Policy and Planning, 14*(4), 329-341. Retrieved from http://heapol.oxfordjournals.org/content/14/4/329.full.pdf+html

Ofori-Adjei, D. (2007). Ghana's free delivery care policy. *Ghana Medical Journal, 41*(3), 94-95. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2279087/

Oliver, A., & Mossialos, E. (2004). Equity of access to health care: Outlining the foundations for action. *Journal of Epidemiology and Community Health (1979-), 58*(8), 655-658. Retrieved from http://www.jstor.org.helicon.vuw.ac.nz/stable/pdfplus/25570447.pdf

Onwuegbuzie, A. J., & Johnson, R. B. (2006). The validity issue in mixed research. *Research in the Schools, 13*(1), 48-63. doi: 10.1037/0003-066x.50.9.741

Owen, J.M. (2006). *Program evaluation: Forms and approaches* (3rd ed.). New York, NY: The Guilford Press.

Pan American Health Organisation & World Health Organisation. (2007). *Jamaica.* (*Health in the Americas Volume II*). Retrieved from http://www.paho.org/hia/archivosvol2/

Penchansky, R., & Thomas, J.W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care, 19*(2), 127-140. Retrieved from http://www.jstor.org/stable/3764310

Penfold, S., Harrison, E., Bell, J., & Fitzmaurice A. (2007). Evaluation of the delivery fee exemption policy in Ghana: Population estimates of changes in delivery service utilisation in two regions. *Ghana Medical Journal, 41*(3), 100–109. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2279083/

Peters, D.H., Garg, A., Bloom, G., Walker, D.G., Breiger, W.R., & Hafizur Rahman, M. (2008). Poverty and access to health care in developing countries. *Annals of New York Academy of Science, 1136*, 161-171. doi: 10.1196/annals.1425.011

Phillips, K.A., Mayer, M.L., & Aday, L.A. (2000). Barriers to care among racial/ethnic groups under managed care. *Health Affairs, 19*(4), 65-75. doi: 10.1377/hlthaff.19.4.65

Picking, D., Younger, N., Mitchell, S., & Delgoda, R. (2011). The prevalence of herbal medicine home use and concomitant use with pharmaceutical medicines in Jamaica. *Journal of Ethnopharmacology, 137,* 305–311. Retrieved from http://www.tramil.net/files/Jamaican_survey.pdf

Pie a la Mode Productions © Action 4 Reel Filmworks. (2011). *Map of Jamaica*. Retrieved from http://piealamodeproductions.com/images/akwantu-map-jamaica-02.png

PIOJ. (2009). National report of Jamaica on Millennium Development Goals for the United Nations Economic and Social Council annual ministerial review. Retrieved from http://www.jm.undp.org/files/GOJ%20National%20Report%20to%20UNAMR-Final.pdf

PIOJ. (2011). *Economic and social survey Jamaica 2010.* Kingston, Jamaica: Author.

PIOJ & MFAFT. (2009). *National report of Jamaica on Millennium Development Goals for the United Nations Economic and Social Council annual ministerial review.* Retrieved from http://www.jm.undp.org/files/GOJ%20National%20Report%20to%20UNAMR-Final.pdf

PIOJ & STATIN. (2008). *Jamaica survey of living conditions 2007.* Kingston, Jamaica: Author.

PIOJ & STATIN. (2010). *Jamaica survey of living conditions 2009.* Kingston, Jamaica: Author.

Polit, D.F., & Tatano Beck, C. (2008). *Nursing Research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Ponsar, F., Van Herp, M., Zachariah, R., Gerard, S., Philips, M., & Jouquet, G. (2011). Abolishing user fees for children and pregnant women trebled uptake of malaria-related interventions in Kangaba, Mali. *Health Policy and Planning, 26*(suppl 2), ii72-ii83. doi: 10.1093/heapol/czr068

Posavac, E.J., & Carey, R.G. (2007). *Program evaluation: Methods and case studies* (7th ed.). Upper Saddle River, NJ: Pearson Education Inc.

Powell, F.D., & Wessen, A.F. (1999). *Health care systems in transition: An international perspective*. Thousand Oaks, CA. Sage Publications Inc.

Public Health Act. (1985). Retrieved from http://www.moj.gov.jm/sites/default/files/laws/Public%20Health%20Act.pdf

Reference.Md. (2012). *Risk sharing*. Retrieved from http://www.reference.md/files/D020/mD020414.html

Ridde, V. (2003). Fees-for-services, cost recovery, and equity in a district of Burkina Faso operating the Bamako Initiative. *Bulletin of the World Health Organisation, 81*(7), 532-8. Retrieved from http://search.proquest.com/docview/229634770?accountid=14782

Ridde, V., & Diarra, A. (2009). A process evaluation of user fees abolition for pregnant women and children under five years in two districts in Niger (West Africa). *Biomedical Central Health Services Research, 9,* 89. doi: 10.1186/1472-6963-9-89

Ridde, V., Diarra, A., & Moha, M. (2011). User fees abolition policy in Niger: Comparing the under five years exemption implementation in two districts. *Health Policy, 99,* 219–225. Retrieved from http://www.lasdel.net/Niger_userfees.pdf

Ridde, V., & Morestin, F. (2011). A scoping review of the literature on the abolition of user fees in health care services in Africa. *Health Policy and Planning, 26*(1), 1-11. doi: 10.1093/heapol/czq021

Ridde, V., Robert, E., & Messen, B. (2012). A literature review of the disruptive effects of user fee exemption policies on health systems. *Biomedical Central Public Health, 12,* 289. doi:10.1186/147-2458-12-289.

Robertson, J. (2002). “Stories” and “Histories” in late seventeenth century Jamaica. In K.E.A. Monteith & G. Richards (Eds.) *Jamaica in slavery and freedom: Heritage, history and culture* (pp. 25-51). Kingston, Jamaica: The University of the West Indies Press.

Robinson, F. (2004). Nurse-led diabetes care. *Community Practitioner, 77*(3), 82-84. Retrieved from http://search.proquest.com/docview/213329430?accountid=14782

Rogers, A., Flowers, J., & Pencheon, D. (1999). Improving access needs a whole systems approach: and will be important in averting crises in the millennium winter. *British Medical Journal, 319*(7214), 866-867. Retrieved from http://www.jstor.org/stable/25185940

Rogers, A.E., Hwang, W-T., Scott, L.D., Aiken, L.H., & Dinges, D.F. (2004). The working hours of hospital staff nurses and patient safety. *Health Affairs, 23*(4), 202-212. doi: 10.1377/hlthaff.23.4.202

Russell, S., & Abdella, K. (2002). *Too poor to be sick: Coping with the cost of illness in East Hararghe, Ethiopia*. London, UK: The Save the Children Fund. Retrieved from http://www.savethechildren.org.uk/sites/default/files/docs/Too_Poor_to_be_Sick_Ethiopia_1.pdf

Russell, S., & Gilson, L. (1997). User fee policies to promote health service access for the poor: A wolf in sheep's clothing [Abstract]? *International Journal of Health Services, 27*(2), 359-379. http://baywood.metapress.com.helicon.vuw.ac.nz/app/home/contribution.asp?

Rutebemberwa, E., Pariyo, G., Peterson, S., Tomson, G., & Kallander, K. (2009). Utilisation of public or private health care providers by febrile children after user fee removal in Uganda. *Malaria Journal, 8*(1), 45. doi:10.1186/1475-2875-8-45

Safriet, B.J. (1992). Health care dollars and regulatory sense: The role of advanced practice nursing. *Yale Journal on Regulation, 9, 417-488*. http://www.lexisnexis.com.helicon.vuw.ac.nz/hottopics/lnacademic/?verb=sr&csi=7384

Sagicor Life Jamaica. (2012). Retrieved from http://www.sagicorjamaica.com/

Schoen, C., & Doty, M. M. (2004). Inequities in access to medical care in five countries: Findings from the 2001 Commonwealth Fund International Health Policy Survey. *Health Policy, 67*(3), 309-322. doi: 10.1016/j.healthpol.2003.09.006

Scott, C. (2001). *Public and private roles in health care systems*. Suffolk, UK: St Edmundsbury Press.

Scott, A., Shiell, A., & King, M. (1996). Is general practitioner decision making associated with patient socio-economic status? *Social Science & Medicine, 42*(1), 35-46. doi: 10.1016/0277-9536(95)00063-1

Scott, L.D., Rogers, A.E., Hwang, W-T, & Zhang, Y. (2006). Effects of critical care nurses' work hours on vigilance and patients' safety. *American Journal of Critical Care, 15*(1), 30-7. Retrieved from http://search.proquest.com/docview/227910762?

Seaga, E. (2005). The folk roots of Jamaican cultural identity. *Caribbean Quarterly, 51*(2), 79-95. Retrieved from http://www.jstor.org/stable/40654507

Sepehri, A., Chernomas, R., & Akram-Lodhi, H. (2005). Penalising patients and rewarding providers: User charges and health care utilisation in Vietnam. *Health Policy and Planning, 20*(2), 90-99. doi: 10.1093/heapol/czi011

Shepard, D.S. (1993). *Cost recovery in Jamaican health facilities*. Kingston, Jamaica: Health Sector Initiatives Project/Ministry of Health.

Shepard, D., Anthony, Y., McNaught, A., & Davis, K.L. (1998). *Evaluation of health sector initiatives program*. Prepared for USAID, Kingston, Jamaica. Retrieved from http://people.brandeis.edu/~shepard/j-eval3.PDF

Soucat, A., Gandaho, T., Levy-Bruhl, D., de Bethune, X., Alihonou, E., Ortiz, C., ... Knippenberg, R. (1997). Health seeking behaviour and household health expenditures in Benin and Guinea: The equity implications of the Bamako Initiative. *International Journal of Health Planning and Management, 12,* S137–S163. doi: 10.1002/(SICI)1099-1751(199706)12:1+<S137::AID-HPM469>3.0.CO;2-G

SRHA. (2011). Retrieved from http://www.srha.gov.jm/RegionProfile.aspx

SERHA. (2010). Retrieved from http://www.serha.gov.jm/ProfileRegion.aspx

Spence, D., Crath, R., Hibbert, A., Phillips-Jackson, K., Barillas, A., Castagnier, T., ...Webley, N. (2010). Supporting cancer patients in Jamaica – A needs assessment survey. *West Indian Medical Journal, 59*(1), 59-66.

STATIN. (2010). *Demographic statistics 2009*. Kingston, Jamaica: Author.

Steinhardt, L.C., Aman, I., Pakzad, I., Kumar, B., Singh, L.P., & Peters, D.H. (2011). Removing user fees for basic health services: A pilot study and national roll-out in Afghanistan. *Health Policy and Planning, 26*(suppl 2), ii92-ii103. doi: 10.1093/heapol/czr069

St George, I., Cullen, M., Gardiner, L., Karabatsos, G., Ng, J. Y., Patterson, A., & Wilson, A. (2008). Universal telenursing triage in Australia and New Zealand: A new primary health service. *Australian Family Physician, 37*(6), 476-9. Retrieved from http://search.proquest.com/docview/216300274?accountid=14782

Sudore, R.L., Mehta, K M., Simonsick, E.M., Harris, T.B., Newman, A.B., Satterfield, S., ... Yaffe, K. (2006). Limited literacy in older people and disparities in health and healthcare access. *Journal of American Geriatrics Society, 54*, 770-776. doi: 10.1111/j.1532-5415.2006.00691.x

Swaby, G. (2005). *Profession of nursing*. Kingston, Jamaica: Stephensons Litho Press Ltd.

Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches*. Thousand Oaks, CA: SAGE Publications Ltd.

Thorndike, R. (2008). Inferential statistics. In N. Salkind (Ed.), *Encyclopaedia of educational psychology*. (pp. 525-531). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412963848.n141

To, T., & Langer, J. (2010). Does access to care affect outcomes of appendicitis in children? A population-based cohort study. *BMC Health Services Research, 10*(1), 250. doi:10.1186/1472-6963-10-250

Turner, R. (2009, April 8). “Free” care prompts staff upgrade at health centres. *Jamaica Gleaner*. Retrieved from http://www.jamaica-gleaner.com/gleaner/20090408/

UNDP. (2011). *International human development indicators*. Retrieved from http://hdrstats.undp.org/en/countries/profiles/JAM.html

UNICEF. (2010). *Jamaica statistics*. Retrieved from http://www.unicef.org/infobycountry/jamaica_statistics.html

University of North Texas. (2007). *Health disparity search terms*. Retrieved from http://library.hsc.unt.edu/guides/HealthDisparitySearchTerms.cfm

Uzochukwu, B., Onwujekwe, O., & Eriksson, B. (2004). Inequity in the Bamako Initiative programme—Implications for the treatment of malaria in South-East Nigeria. *The International Journal of Health Planning and Management, 19*(S1), S107-S116. doi: 10.1002/hpm.779

Vanderstoep, S.W., & Johnston, D.D. (2009). *Research methods for everyday life: Blending qualitative and quantitative approaches*. San Francisco, CA: John Wiley & Sons Inc.

van Doorslaer, E., Masseria, C., & Koolman, X. (2006). Inequalities in access to medical care by income in developed countries. *Canadian Medical Association Journal, 174*(2), 177-183. doi: 10.1503/cmaj.050584.

van Doorslaer, E., Wagstaff, A., van der Burg, H., Christiansen, T., Citoni, G., Di Biase, R., ... Winkelhake, O. (1999). The redistributive effect of health care finance in twelve OECD countries. *Journal of Health Economics, 18*(3), 291-313. doi: 10.1016/s0167-6296(98)00043-5

Vedung, E. (1997). *Public policy and programme evaluation*. New Brunswick, NJ: Transaction Publishers.

Walker, L., & Gilson, L. (2004). ‘We are bitter but we are satisfied’: Nurses as street-level bureaucrats in South Africa. *Social Science and Medicine, 59*(6), 1251-1261. doi: 10.1016/j.socscimed.2003.12.020

Ward, E., & Grant, A. (2005). *Epidemiological profile of selected health conditions and services in Jamaica 1990 – 2002*. Kingston, Jamaica: Ministry of Health & Environment.

Warner Lewis, M. (2002). The character of African-Jamaican culture. In K.E.A. Monteith & G. Richards (Eds.), *Jamaica in slavery and freedom: Heritage, history and culture* (pp. 89-114). Kingston, Jamaica: The University of the West Indies Press.

Watson Williams, C. (2008). *Realising rights through social guarantees: The case of Jamaica*. Final Report submitted to the World Bank. Retrieved from http://siteresources.worldbank.org/EXTSOCIALDEV/Resources/3177394-1168615404141/3328201-1192042053459/Jamaica_fullReport.pdf?

Weaver, S.R. (2003). *Health and illness in a rural community: A study of traditional health care practices in the parish of St. Thomas, Jamaica* (Unpublished PhD thesis). University of the West Indies, Mona, Kingston, Jamaica. [Email communication].

Wells, K., Klap, R., Koike, A., & Sherbourne, C. (2001). Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *The American Journal of Psychiatry, 158*(12), 2027-32. Retrieved from http://search.proquest.com/docview/220467437?

West India Commission Report 1945. (2006). *House of Commons Parliamentary Papers online*. London, UK: ProQuest Information and Learning Company.

Whitehead, M. (1991). The concepts and principles of equity and health. *Health Promotion International, 6*(3), 217-228. doi: 10.1093/heapro/6.3.217

Wilkinson, D., Gouws, E., Sach, M., & Abdool Karim, S.S. (2001). Effect of removing user fees on attendance for curative and preventive primary health care services in rural South Africa. *Bulletin of the World Health Organization, 79*(7), 665-671. Retrieved from http://www.scielosp.org/pdf/bwho/v79n7/v79n7a12.pdf

Witter, S., & Adjei, S. (2007). Start-stop funding, its causes and consequences: A case study of the delivery exemptions policy in Ghana. *International Journal of Health Planning and Management, 22*(2), 133-143. doi: 10.1002/hpm.867

Witter, S., Adjei, S., Armar-Klemesu, M., & Graham, W. (2009). *Providing free maternal health care: Ten lessons from an evaluation of the national delivery exemption policy in Ghana*. Global Health Action, 2. doi:10.3402/gha.v2i0.1881

Witter, S., Arhinful, D.K., Kusi, A., & Zakariah-Akoto, S. (2007a). The experience of Ghana in implementing a user fee exemption policy to provide free delivery care. *Reproductive Health Matters, 15*(30), 61-71. doi: 10.1016/S0968-8080(07)30325-X

Witter, S., Dieng, T., Mbengue, D., Moreira, I., & De Brouwere, V. (2010). The national free delivery and caesarean policy in Senegal: Evaluating process and outcomes. *Health Policy and Planning, 25*(5), 384-392. doi: 10.1093/heapol/czq013

Witter, S., Kusi, A., & Aikins, M. (2007b). Working practices and incomes of health workers: evidence from an evaluation of a delivery fee exemption scheme in Ghana. *Human Resources for Health, 5*(1), 2. doi:10.1186/1478-4491-5-2

World Bank. (2005). *Madagascar health sector note*. Washington, DC 2005. Retrieved from http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/0,,contentMDK:20978587~pagePK:41367~piPK:51533~theSitePK:40941~isCURL:Y,00.html

World Bank. (2006). *Health, nutrition and population*. Retrieved from http://www.worldbank.org/povertyandhealth

World Bank. (2011). *World development indicators, Jamaica*. International Bank for Reconstruction and Development/ The World Bank, Washington D.C. Retrieved from http://www.worldbank.org

WHO. (2000). *Millennium development goals*. Retrieved from http://www.who.int/topics/millennium_development_goals/en/

WHO. (2002). *Traditional medicine strategy 2002–2005*. Retrieved from http://whqlibdoc.who.int/hq/2002/WHO_EDM_TRM_2002.1.pdf

WHO. (2008). *Beijing declaration 2008*. Retrieved from http://www.who.int/medicines/areas/traditional/TRM_BeijingDeclarationEN.pdf

WHO. (2010a). *Country cooperation strategy at a glance: Jamaica*. Retrieved from http://www.who.int/countryfocus/cooperation_strategy/

WHO. (2010b). *The World Health report 2010*. Retrieved from http://www.who.int/whr/2010/10_summary_en.pdf

WRHA. (2009). Retrieved from http://www.wrha.gov.jm/content/wrha_profile.html

Wyatt, L. (2006). A nurse-led community approach to asthma management for children. *Australian Nursing Journal, 14*(6), 18-18. Retrieved from http://search.proquest.com/docview/236640730?accountid=14782

Xu, K., Evans, D.B., Kadama, P., Nabyonga, J., Ogwal, P.O., Nabukhonzo, P., & Aguilar, A.M. (2006). Understanding the impact of eliminating user fees: Utilisation and catastrophic health expenditures in Uganda. *Social Science & Medicine, 62*(4), 866-876. doi: 10.1016/j.socscimed.2005.07.004

Xu, K., Evans, D.B., Kawabata, K., Zeramdini, R., Klavus, J., & Murray, C.J.L. (2003). Household catastrophic health expenditure: A multi-country analysis. *Lancet, 362*(9378), 111-117. doi: 10.1016/S0140-6736(03)13861-5

Yamada, T., Chen, C.C., Yamada, T., Chiu, I.M., & Smith, J. (2009). Healthcare services accessibility of children in the USA. *Applied Economics, 41*(4), 437-450. doi: 10.1080/00036840701720762

Yates, R. (2006). *International experiences in removing user fees for health services: Implication for Mozambique*. London, UK: DFID Resource Centre.

Yates, R. (2009). Universal health care and the removal of user fees. *The Lancet, 373*(9680), 2078-81. Retrieved from http://search.proquest.com/docview/199041142?accountid=14782

Yates, J., Cooper, R., & Holland, J. (2006). Social protection and health: Experiences in Uganda. *Development Policy Review, 24*(3), 339-356. doi: 10.1111/j.1467-7679.2006.00328.x

Yin, R.K. (2009). *Case study research: Design and methods.* Los Angeles, CA: Sage Publications.