

HFS Small Applied Research Report No. 7

**COST RECOVERY AND
QUALITY OF CARE IN THE CONGO**

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ABSTRACT

This report documents a study conducted in the summer of 1992 to examine the relationship between quality of services and fees in the Congo. The study hypothesized that private facilities can charge higher fees than public facilities because health care is perceived as providing higher quality services.

The authors also based conclusions on data that compared pricing practices in rural and urban areas and analyzed patient characteristics in conjunction with their choice of facility. A total of 399 out-patients at eight health centers were surveyed. Five general topics were addressed in the questionnaire: patient and household identification, socio-economic information, curative care, patient satisfaction, and payment.

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FOREWORD

The Health Financing and Sustainability (HFS) Project provides technical assistance and conducts applied research, training, and information dissemination to developing countries in health economics, health sector policy development, and health services management. The Applied Research (AR) component of the project provides opportunities to increase knowledge of the complex issues underlying health financing problems, and augments the supply of qualified individuals who can contribute to policy analysis and reform. HFS is emphasizing the following policy areas for applied research activities: cost recovery, productive efficiency, social financing, and private sector development in the health sector.

As part of the project's AR component, HFS will complete up to 30 small applied research (SAR) activities over the life of the project, from 1989 through 1994. These include studies undertaken by developing country researchers, HFS researchers, or academics at universities in the United States. The objectives of the SAR program are to carry out practically oriented research in developing countries, and to encourage the development of local capacities to undertake research.

Most SAR activities are initiated through proposals to the HFS Project. The proposals are evaluated by HFS staff, including criteria such as: practical policy orientation, resource and time requirements, and appropriateness to the HFS research agenda. Most proposals for SAR activities accepted by HFS undergo several revisions, as the researchers refine their research objectives, hypotheses, and methodologies, based on suggestions and comments from the HFS staff. Once approved, SAR activities are overseen by HFS task managers who work closely with principal investigators to monitor the timeliness and quality of the work, and facilitate logistics.

Other small applied research studies are done in conjunction with technical assistance or major applied research activities of the HFS Project. In these cases, the SAR contributes to the technical guidance provided to clients, or adds to the body of knowledge on topics of health financing and economics.

As with all HFS research, drafts of small applied research reports are reviewed by HFS staff. Drafts are then evaluated by external technical reviewers selected on the basis of area of substantive and/or geographic expertise.

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Applied Research Coordinator

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This study was undertaken as part of the small applied research component of the Health Financing and Sustainability (HFS) Project. A proposal for research in the Congo was submitted by Basile Tsongo, the principal investigator for the study. Based on comments and suggestions from the HFS staff, Mr. Tsongo revised and narrowed the scope of work for this activity.

Mr. Tsongo directed all of the field activities for this study. In this effort, he was joined by Carla Willis of Abt Associates, who worked with Mr. Tsongo to design the questionnaires, train the enumerators, and pre-test and finalize the survey instruments. Upon completion of the data collection, Mr. Tsongo travelled to Bethesda, Maryland, to work with HFS staff on analyzing the data and writing this report.

A preliminary version of this report was presented by Carla Willis at the HFS Annual Technical Advisory Group (TAG) meeting held in March 1993. This version incorporates many of the useful comments and suggestions offered by the TAG members.

Mr. Tsongo, as principal investigator, held primary responsibility for the design and conduct of this study. Ms. Willis participated in the preparatory field work and developed the framework for data analysis. David Deal analyzed the data, and Holly Wong assisted with finalizing the report.

Several other people made important contributions to this activity, and should be acknowledged: Marty Mäkinen, Ricardo Bitran, Jim Setzer, and Brad Barker of the HFS staff provided useful suggestions regarding the study design; Mahmud Khan of the Tulane University School of Public Health and Tropical Medicine provided technical guidance in the design of the questionnaire; Colleen Cavanaugh of Abt Associates assisted with data entry and analysis; and Cheryl Bailey, Carolyn Kahn, and John Novak of the HFS Project assisted with logistical and administrative arrangements. This paper has also benefitted from numerous comments and ideas provided by the technical reviewer, Jim Setzer of Emory University School of Public Health.

EXECUTIVE SUMMARY

This study was carried out during the summer of 1992 as part of the Applied Research Program of the Health Financing and Sustainability (HFS) Project. It was designed to examine the relationship between quality of services and fee systems in the Congo, in public and private health facilities, and in rural and urban areas.

Specific objectives of the study were to:

- ▲ Examine and compare pricing practices in rural and urban areas, and between public and private facilities;
- ▲ Assess quality of care from patients' perspectives; and
- ▲ Analyze patient characteristics in conjunction with choice of facility.

The working hypothesis for this study was that private facilities are able to charge higher fees because they are perceived as providing higher quality services.

Exit interviews were conducted for out-patients at eight health centers. Facilities were chosen to provide an even mix of urban and rural facilities, and an even split of private and public facilities. A total of 399 out-patients was surveyed, and the unit of analysis was the visit. The questionnaire for patient interviews included five basic sections: patient and household identification, socio-economic information, curative care, patient satisfaction, and payment.

The primary results from the survey were as follows:

Patient Characteristics

- ▲ Characteristics of patients sampled at public and private facilities were generally similar, with the exceptions that average age, likelihood of being married, and average household expenditures were higher for public patients.

Quality of Care

- ▲ Reported patient satisfaction was higher in private facilities.
- ▲ The availability of medicines was greater in private facilities, with more than half of all private patients receiving medicines, compared to one-fifth of public patients.

Patient Expenditures

- ▲ Private patients were more likely to pay for their visits, with 78 percent of private patients vs. 31 percent of public patients paying for services.

- ▲ Among patients receiving drugs, public patients paid higher prices.
- ▲ There were more non-paying patients at public facilities than private facilities in the sample, including respondents in the higher socio-economic status range. However, there were also many low income patients at both public and private facilities who did pay for services.

Rural-Urban Comparisons

- ▲ While there were differences in characteristics between urban and rural patients (e.g., income, occupation, and education), the characteristics of public versus private patients (within a geographic category) were similar.
- ▲ Of those patients who paid for consultations in urban areas, public patients paid more, whereas in rural areas, private patients paid more.
- ▲ In rural areas, private patients spent more than four times as much per visit (including transportation) than public patients; in urban areas, public and private patients spent roughly equivalent amounts.

These results suggest two possible conclusions with respect to quality of care and public sector health services in the Congo. First, the government may be able to improve the quality of publicly-provided services by improving drug supplies. Second, consumers are apparently willing and able to pay more for what they perceive as higher quality care.

1.0 INTRODUCTION

The Health Financing and Sustainability (HFS) Project provides technical assistance, applied research, training, and information dissemination to developing countries in health economics, health sector policy development, and health services management. HFS activities fall into five technical areas: cost recovery, social financing, public-private collaboration, resource allocation, and costing, delivery, and production of services.

One of the areas in which HFS is concentrating applied research activities is cost recovery. In particular, HFS is examining the degree to which quality improvements must be made in government, private, and nonprofit health services for consumers to be willing to pay more for them, and the effectiveness of cost recovery in financing quality improvements.

This study was designed to examine the relationship between quality of services and fee systems in the Congo, and was carried out during the summer of 1992 as part of the HFS Applied Research Program.

2.0 OBJECTIVES

The overall objective of this study was to examine the relationship between cost recovery and the quality of curative health care services in the Congo. More specifically, the research focused on:

- (a) Examining and comparing pricing practices in rural and urban areas, and between public and private facilities;
- (b) Assessing quality of care from patients' perspectives, and
- (c) Analyzing patient characteristics in conjunction with choice of facility and views on quality of care.

The working hypotheses for this study were that:

- (a) Private facilities are perceived as providing higher quality services (based on subjective indicators) and are thus able to charge higher fees than government facilities, and
- (b) This relationship holds for both urban and rural facilities.

From a policy perspective, this study was intended to provide insights into the workings of cost recovery and quality of care in a variety of settings. This information can assist the Government of the Congo to plan changes to service delivery to improve public facilities' abilities to recover costs.

3.0 BACKGROUND INFORMATION

3.1 THE CONGO

The Congo is a small country located near the Equator in west central Africa. It has a population of approximately 2.4 million, with an annual growth rate of 3.4 percent. In 1991, per capita GNP was \$1,120, reflecting an annual growth rate for the previous decade of -0.2 percent. Gross domestic product (GDP) for 1991 was \$2.9 billion, with agriculture representing 12 percent, industry, 37 percent, and services and unallocated items (including government service), the remaining 50 percent. Approximately half of the population participates in the formal economic sector, and another fourth is engaged in subsistence farming. The country's major source of revenue has been off-shore petroleum (World Bank, 1993).

By African standards, the population has high literacy and urbanization rates (57 and 60 percent, respectively). Most of the population is concentrated in the capital city of Brazzaville and in Pointe Noire.

3.2 THE HEALTH SECTOR

The Congo has 20 hospitals, 6,376 hospital beds, and 145 maternal and child health centers, with 43 percent of facilities located in Brazzaville, and another 23 percent located in Pointe Noire. The majority of health facilities are public, with roughly five percent of all health facilities being privately run. As of 1989, there were 274 physicians and 1,915 nurses serving the population. According to recent World Bank data, life expectancy in the Congo is 52 years, with an infant mortality rate of 115 per 1000 (World Bank, 1993).

The economic crisis of the 1980s adversely affected the delivery of basic health services in the Congo. Existing public health facilities suffer from chronic underfunding of inputs such as drugs, supplies, fuel, and qualified health workers.

3.3 HEALTH FINANCING AND COST RECOVERY POLICIES

According to a 1990 World Bank study, government expenditures allocated to health services represented 7.3 percent of the national budget. Fees were charged in both government and privately-run facilities, although the official policy of cost recovery seemed to be only weakly enforced. On average, payments for health services were \$7 per visit to a physician, \$10 for prescription drugs, and almost \$1 for transportation to health facilities (Forichon, 1990).

4.0 METHODOLOGY

Data for this study were gathered through exit interviews of out-patients at eight health centers. Fifty out-patients were selected at each of the facilities, with a total of 399 interviews being completed. The unit of analysis for the patient survey was the visit (as opposed to the patient or the episode of illness). Exit interviews are an excellent way to compare populations of patients seeking care at public and private facilities; however, it should be noted that exit interviews fail to gather information (such as health and socio-economic status) from people who do not seek care. Thus, results cannot be broadly extrapolated to the general population. A much more costly population-based household survey would be required to gather such information.

Facilities were chosen to provide an even mix of urban and rural facilities, and an even split of private and public facilities. All facilities were of approximately the same size and provided exclusively or predominantly primary curative care to out-patients. Although the facilities were not drawn randomly, the sampling procedure allowed for the desired comparisons between public and private facilities.

The survey instrument for patients (contained in the Appendix) took approximately half an hour to administer. It included the following sections:

- ▲ Patient and household identification
- ▲ Socio-economic information
- ▲ Curative care
- ▲ Patient satisfaction
- ▲ Payment

Exhibit 1 describes the structure and content of the out-patient questionnaire.

Data collection was carried out by a team of nine enumerators, supervised by the principal investigator. The enumerators underwent a week-long training session, which included a review of the study's objectives and research design, role-playing, and interviewing techniques. At the end of the week, the questionnaire was pre-tested in both an urban and a rural facility. The pre-test demonstrated that patients were willing to participate in the study without exception. Several refinements were made to the questionnaire subsequent to the training. The questionnaire was translated into French, and enumerators agreed upon standard translations of key terms into Lingala and Kituba to ensure uniformity among the survey responses.

EXHIBIT 1
STRUCTURE AND CONTENT OF OUT-PATIENT QUESTIONNAIRE

QUESTIONNAIRE SECTION	TYPES OF DATA
Patient and Household Identification	<ul style="list-style-type: none"> ▲ Age, Sex, Marital Status, Religion ▲ Size and Composition of Household
Socio-economic Information	<ul style="list-style-type: none"> ▲ Occupation, Education, Income of Patient or Head of Household ▲ Monthly Household Market Expenditure
Curative Care	<ul style="list-style-type: none"> ▲ Primary Symptom and Duration of Illness ▲ Services and Medicines Received ▲ Reason for Choice of Facility ▲ Mode and Cost of Transportation
Patient Satisfaction	<ul style="list-style-type: none"> ▲ Availability of Services, Medicines, and Supplies ▲ Competence of Personnel ▲ Physical Conditions of Facility
Payment	<ul style="list-style-type: none"> ▲ Amount Paid ▲ Reasons for Non-payment ▲ Previous Payments for Same Episode ▲ Insurance

Patients to be interviewed were chosen through a process of random selection. As they entered the facility, each patient was given a number. As they exited the facility, all of those with the selected number of the day were asked to participate in the out-patient survey. The response rate was extremely high, and many patients who were not selected through this process requested that they be included as well. Of course, in order to preserve the validity of the random selection process, these requests were not accommodated.

5.0 PATIENT SURVEY RESULTS

Results from the interviews of out-patients are presented in three sections: patient characteristics, patient satisfaction, and patient expenditures.

5.1 PATIENT CHARACTERISTICS

Exhibit 2 presents basic information about patients, divided by urban and rural areas, and for private and public facilities. In general, patients attending private and public facilities were found to be quite similar, although there are a few exceptions. (The reader is advised that the terms "public patient" and "private patient," as used throughout this report, indicate the type of facility at which that patient was interviewed as part of this study. However, patients who are "public" for one visit may be "private" on another day or visit, and vice versa. Moreover, references to "public patients" or "private patients" refer only to those patients in the sample; no attempt is made to extrapolate results to the broader population, and results of this study should not be interpreted in such a way.)

Patients surveyed at the private facilities were, on average, younger than those seeking care at the public facilities. Twice as many private patients were five years of age or younger, suggesting that private facilities might have a comparative advantage in maternal and child health (MCH).

Private patients were more likely to be married than public patients. In terms of household composition, public and private patients were quite similar, with mean household sizes of just over six persons. Both public and private patients were predominantly Catholic or Protestant.

Exhibit 3 includes indicators of socio-economic status of patients interviewed. Education levels of patients were relatively consistent across private and public facilities, although there was a higher proportion of secondary level attendees in urban areas compared to rural areas. The occupation of the patient (or the head of household, in cases where the patient was a child) was relatively similar across private and public facilities. However, there was a higher proportion of civil servants among the public facility patients, and a much higher percentage of homemakers among the private facility patients.

Information on both income and household market expenditures was sought, with the latter intended to be a proxy for or confirmation of income. As indicated in the table, the non-response rate for questions about income was quite high (41 percent in private facilities, and 51 percent in public facilities). On the other hand, non-response rates for the questions on household expenditures were 12 and 10 percent respectively for private and public facilities. Expenditure data were felt to be more reliable indicators of socio-economic status, since respondents are less likely to provide inaccurate answers. Socio-economic status of public patients, as indicated by expenditures, was surprisingly higher than for private patients, based on reported mean monthly expenditures of 26,302 FCFA compared to 19,888 FCFA (US\$ 1 = 243 FCFA in 1992). On a per-person basis, the difference between the two types of patients dropped

a bit, given slightly larger family size for public patients (4,009 FCFA compared to 3,203 FCFA). Not surprisingly, mean household expenditures for urban patients in the sample were approximately twice as high as for rural patients, in both private and public facilities.

**EXHIBIT 2
GENERAL PATIENT CHARACTERISTICS**

TYPE OF FACILITY	PRIVATE			PUBLIC		
	URBAN	RURAL	SUB-TOTAL	URBAN	RURAL	SUB-TOTAL
Facilities	2	2	4	2	2	4
Respondents	100	99	199	99	101	200
Sex						
Male	36	47	83 (41.7%)	43	44	87 (43.5%)
Female	63	52	115 (57.8%)	55	56	111 (55.5%)
Age*						
0 - 5	36	27	63 (31.7%)	19	9	28 (14.0%)
6 - 15	10	9	19 (9.5%)	7	15	22 (11.0%)
16 - 29	26	29	55 (27.6%)	46	29	75 (37.5%)
30 - 45	19	13	32 (16.1%)	20	33	53 (26.5%)
45+	8	21	29 (14.6%)	7	15	22 (11.0%)
Marital Status (15+ only)						
Single	22	11	33 (28.4%)	35	31	66 (44.0%)
Married	29	42	71 (61.2%)	27	38	65 (43.3%)
Divorced	0	6	6 (5.2%)	8	3	11 (7.3%)
Widowed	2	4	6 (5.2%)	2	5	7 (4.7%)
Household Composition*						
Child 0-5	1.70	1.42	1.55 (25.0%)	1.17	1.50	1.34 (20.4%)
Child 6-15	2.22	1.26	1.70 (27.4%)	1.85	1.83	1.84 (28.0%)
Adult	3.24	2.69	2.96 (47.7%)	3.76	3.00	3.38 (51.5%)
Total	7.16	5.37	6.21 (100.0%)	6.78	6.33	6.56 (100.0%)
Religion						
Catholic	49	35	84 (42.2%)	40	27	67 (33.5%)
Protestant	29	29	58 (29.1%)	21	36	57 (28.5%)
Salustiste	8	8	16 (8.0%)	2	4	6 (3.0%)
None	4	24	28 (14.1%)	14	16	30 (15.0%)
Other	10	3	13 (6.5%)	22	18	40 (20.0%)
Notes:						
* Although the age ranges are not inclusive of all possible responses (e.g., 5-1/2), these were the ranges provided to questionnaire respondents, and the figures represent the responses given.						

**EXHIBIT 3
PATIENT SOCIO-ECONOMIC INDICATORS**

TYPE OF FACILITY	PRIVATE			PUBLIC		
	URBAN	RURAL	SUB-TOTAL	URBAN	RURAL	SUB-TOTAL
Education						
None	10	32	42 (21.1%)	8	30	38 (19.0%)
< Primary*	13	23	36 (18.1%)	10	21	31 (15.5%)
Primary	11	8	19 (9.5%)	14	12	26 (13.0%)
Secondary	62	34	96 (48.2%)	63	35	98 (49.0%)
University	3	2	5 (2.5%)	4	2	6 (3.0%)
Occupation						
Farmer	4	46	50 (25.1%)	3	52	55 (27.5%)
Merchant	13	23	36 (18.1%)	30	15	45 (22.5%)
Homemaker	32	12	44 (22.1%)	12	3	15 (7.5%)
Student	12	6	18 (9.0%)	11	12	23 (11.5%)
Civil Servant	11	2	13 (6.5%)	16	9	25 (12.5%)
Private Sector	10	1	11 (5.5%)	6	0	6 (3.0%)
Other	10	5	15 (7.5%)	9	5	14 (7.0%)
Unemployed	8	4	12 (6.0%)	12	5	17 (8.5%)
Income (FCFA)**						
< 10,000	3	17	20 (10.1%)	2	14	16 (8.0%)
10K - 25K	8	33	41 (20.6%)	5	3	8 (4.0%)
26K - 40K	10	2	12 (6.0%)	10	7	17 (8.5%)
41K - 55K	10	6	16 (8.0%)	4	1	5 (2.5%)
56K - 75K	8	2	10 (5.0%)	12	7	19 (9.5%)
> 75,000	17	2	19 (9.5%)	23	10	33 (16.5%)
No Response	44	37	81 (40.7%)	43	59	102 (51.0%)
Monthly HH Market Expend. (FCFA)**						
Range						
0 - 5K	5	38	43 (21.6%)	0	20	20 (10.0%)
6 - 10K	11	14	25 (12.6%)	13	20	33 (16.5%)
11 - 15K	10	20	30 (15.1%)	9	13	22 (11.0%)
16 - 20K	3	7	10 (5.0%)	5	2	7 (3.5%)
21 - 25K	3	3	6 (3.0%)	4	5	9 (4.5%)
26 - 30K	30	1	31 (15.6%)	19	22	41 (20.5%)
31 - 40K	4	2	6 (3.0%)	3	2	5 (2.5%)
41 - 50K	11	1	12 (6.5%)	21	6	27 (13.5%)
51 - 75K	13	0	13 (6.5%)	10	0	10 (5.0%)
76 - 100K	0	0	0 (0.0%)	5	1	6 (3.0%)
No Response	10	13	23 (11.6%)	10	10	20 (10.0%)
Mean	29,660	9,548	19,888	34,846	17,946	26,302
Mean Per Person	4,142	1,778	3,203	5,140	2,835	4,009
Notes: * "< primary" reflects those who began but did not complete primary education, whereas "primary" includes those who completed that level of education. ** Although the income and expenditure ranges are not inclusive of all possible responses (e.g., 5.5K), these were the ranges provided to questionnaire respondents, and the figures represent the responses given.						

Characteristics of patient illness are shown in Exhibit 4. In both private and public facilities, the most commonly reported primary symptoms were fever and gastrointestinal problems. Patients reported similar durations of illness, with median answers of three or four days. In both public and private facilities, just over 60 percent of patients interviewed were there for return visits. (Medians are reported here, as a few outlier responses [for patients with chronic illnesses] skewed the means. For the sample as a whole, responses ranged from one day to 36 months, with the majority falling in the range of one to seven days.)

**EXHIBIT 4
CHARACTERISTICS OF PATIENT ILLNESS**

TYPE OF FACILITY	PRIVATE			PUBLIC		
	URBAN	RURAL	SUB-TOTAL	URBAN	RURAL	SUB-TOTAL
Primary Symptom						
Fever	42	24	66 (34.7%)	28	19	47 (24.0%)
GI Problem	16	13	29 (15.3%)	19	19	38 (19.4%)
Dermatological	9	8	17 (8.9%)	8	1	9 (4.6%)
Headache	3	5	8 (4.2%)	9	9	18 (9.2%)
Cut / Wound	0	13	13 (6.8%)	2	10	12 (6.1%)
Cough	9	8	17 (8.9%)	12	5	17 (8.7%)
Other	15	25	40 (21.1%)	20	35	55 (28.1%)
Duration of Illness						
Median (Days)	4	4	4	4	3	4
% > 30 Days	11.0%	13.1%	12.1%	6.1%	15.8%	11.0%
Return Visit	62	71	133 (66.8%)	67	56	123 (61.5%)

5.2 PATIENT SATISFACTION

Patients at public and private facilities appeared less similar once we turned to measures of quality of care, based upon subjective satisfaction ratings. As shown in Exhibit 5, there were consistent differences in the level of satisfaction reported by private and public patients in the sample. Although the highest of three satisfaction ratings (satisfied, somewhat satisfied, not satisfied) was given most often for general satisfaction by both private and public patients, a higher proportion of private patients gave that rating (75 percent vs. 45 percent for public patients).

When asked about specific aspects of the services received -- availability of medicines and supplies, competence of personnel, and cleanliness of the facility -- in all cases, private patients reported higher levels of satisfaction than their public counterparts, with the biggest difference in the area of availability of medicines. Over 80 percent of patients at private facilities were satisfied with the availability of medicines, compared to nearly 80 percent of patients at public facilities who were not.

**EXHIBIT 5
PATIENT SATISFACTION**

TYPE OF FACILITY	PRIVATE			PUBLIC		
	URBAN	RURAL	SUB-TOTAL	URBAN	RURAL	SUB-TOTAL
General Satisfaction						
Satisfied	75	75	150 (75.4%)	60	29	89 (44.5%)
Somewhat Satisfied	21	20	41 (20.6%)	31	59	90 (45.0%)
Not Satisfied	4	3	7 (3.5%)	6	9	15 (7.5%)
No Response	0	1	1 (0.5%)	2	4	6 (3.0%)
Availability of Medicines						
Satisfied	71	90	161 (80.9%)	4	4	8 (4.0%)
Somewhat Satisfied	20	4	24 (12.1%)	9	5	14 (7.0%)
Not Satisfied	6	1	7 (3.5%)	75	79	154 (77.0%)
No Response	3	4	7 (3.5%)	11	13	24 (12.0%)
Availability of Supplies						
Satisfied	35	34	69 (34.7%)	11	5	16 (8.0%)
Somewhat Satisfied	15	20	35 (17.6%)	16	23	39 (19.5%)
Not Satisfied	7	5	12 (6.0%)	53	39	92 (46.0%)
No Response	43	40	83 (41.7%)	19	34	53 (26.5%)
Competence of Personnel						
Satisfied	66	87	153 (76.9%)	51	56	107 (53.5%)
Somewhat Satisfied	27	7	34 (17.1%)	38	40	78 (39.0%)
Not Satisfied	1	1	2 (1.0%)	2	1	3 (1.5%)
No Response	6	4	10 (5.0%)	8	4	12 (6.0%)
Cleanliness of Facility						
Satisfied	69	87	156 (78.4%)	22	27	49 (24.5%)
Somewhat Satisfied	20	6	26 (13.1%)	36	23	59 (29.5%)
Not Satisfied	3	1	4 (2.0%)	38	48	86 (43.0%)
No Response	8	5	13 (6.5%)	3	3	6 (3.0%)

Exhibit 6 reports respondents' rationales for choosing facilities. The most frequent response to the question, "Why did you choose this facility?" was that patients, both public and private, usually went there. The second most frequent response among private patients was the availability of medicines and supplies. Public patients, however, rarely gave that response, and instead frequently cited competence of personnel, short waiting times, or proximity to residences.

**EXHIBIT 6
CHOICE OF FACILITY**

TYPE OF FACILITY	PRIVATE			PUBLIC		
	URBAN	RURAL	SUB-TOTAL	URBAN	RURAL	SUB-TOTAL
Reasons for Choosing This Facility						
Usually Go There	79	85	164 (24.0%)	77	96	173 (31.4%)
Competent Personnel	60	65	125 (18.3%)	57	70	127 (23.0%)
Short Waiting Time	38	58	96 (14.1%)	62	45	107 (19.4%)
Close to Home	28	48	76 (11.1%)	56	49	105 (19.1%)
Availability of Medicines & Supplies	76	72	148 (21.7%)	8	3	11 (2.0%)
Low Price	43	17	60 (8.8%)	9	16	25 (4.5%)
Religious Reasons	5	9	14 (2.0%)	2	1	3 (0.5%)
This Facility Considered Best in the Area	86	85	171 (85.9%)	65	65	130 (65.0%)
Reasons That Best Facility is Considered the Best						
Competent Personnel	21	20	41 (20.6%)	35	41	76 (38.0%)
Short Waiting Time	4	4	8 (4.0%)	14	4	18 (9.0%)
Close to Home	6	14	20 (10.1%)	21	34	55 (27.5%)
Availability of Medicines & Supplies	49	50	99 (49.7%)	13	13	26 (13.0%)
Low Price	17	6	23 (11.6%)	4	1	5 (2.5%)
Other	2	3	5 (2.5%)	2	5	7 (3.5%)
No Response	1	2	3 (1.5%)	10	3	13 (6.5%)

A majority of both private and public patients in the sample considered the facility they attended to be the best in the area. This proportion, however, was higher for private patients (86 percent vs. 65 percent).

Patients were asked what distinguished the best facility from its competition, regardless of whether or not the one visited was considered the best. In this case, private and public patients gave different answers, perhaps suggesting differing consumer preferences. Private patients were most likely to place the highest value on the availability of medicines and supplies, whereas public patients were most likely to value the competence of personnel or proximity to home.

Some subjective quality indicators are shown in Exhibit 7. (These indicators were intended to represent quality as perceived by the patient, not necessarily technical quality as measured by the medical profession. Thus, for example, the authors do not suggest that all services desired by patients were appropriate, nor that care given by doctors - as opposed to nurses or medical assistants - was of higher quality.) Patients were asked if there were services which they desired but did not receive (e.g., laboratory exams, surgery, drugs, dental services). One-fourth of the private patients in the sample did not receive services they desired, compared with 42 percent of the public patients. The primary reason for not receiving these services given by respondents was that supplies were not available; in some cases, however, the explanation was lack of personnel or high prices of services.

**EXHIBIT 7
QUALITY INDICATORS**

TYPE OF FACILITY	PRIVATE			PUBLIC		
	URBAN	RURAL	SUB-TOTAL	URBAN	RURAL	SUB-TOTAL
Services Desired But Not Received	26	23	49 (24.6%)	22	62	84 (42.0%)
Principal Caregiver						
Doctor	10	3	13 (6.5%)	4	19	23 (11.7%)
Medical Assistant	5	3	8 (4.0%)	31	5	36 (18.4%)
Nurse	85	89	174 (87.4%)	61	45	106 (54.1%)
Midwife	0	4	4 (2.0%)	2	29	31 (15.8%)
Pharmacist	0	0	0 (0.0%)	0	0	0 (0.0%)
Other	0	0	0 (0.0%)	0	0	0 (0.0%)
Mean Time w/ Patient (Minutes)	6	7	6	6	5	5

In the majority of cases in both public and private facilities, the principal caregiver was a nurse. That proportion, however, was higher in private facilities (87 percent) than in public facilities (54 percent). Patients in public facilities were more likely to be seen by doctors and medical assistants than in private facilities. Lastly, the mean time spent with the patient was relatively consistent across all facilities, approximately five to six minutes.

Exhibit 8 includes information about medicines received or prescribed. (Although patients were asked if they wanted drugs but did not receive them, the authors do not suggest that "desired" drugs were always or necessarily appropriate. While this may indicate one factor in patients' perceptions of quality of care, it is recognized that such perceptions may not correlate with technical quality of care.) Results demonstrate that patients attending private facilities were much more likely to receive medicines than public patients. Almost one-fourth of public patients in the sample desired but did not receive medicines, compared with six percent of the private patients. Only seven percent of private patients left the facility without drugs, either because they did not appear to be needed or because patients were only given a prescription. In comparison, a majority of public patients (54 percent) were given prescriptions rather than drugs, and most of the small number who were given drugs were also given a prescription for additional requirements. Of patients given either drugs or prescriptions, those at private facilities were given or prescribed a higher number of products than patients at public facilities. These differences in prescription modality do not seem to be explained by differences in the case mix seen by private and public facilities (see Exhibit 4).

**EXHIBIT 8
MEDICINES RECEIVED OR PRESCRIBED**

TYPE OF FACILITY	PRIVATE			PUBLIC		
	URBAN	RURAL	SUB-TOTAL	URBAN	RURAL	SUB-TOTAL
Medicines Desired But Not Received	5	7	12 (6.0%)	13	33	46 (23.0%)
Prescription Modality						
(1) Medicines Only	62	57	119 (59.8%)	7	6	13 (6.5%)
(2) Medicines + Prescription	20	32	52 (26.1%)	19	17	36 (18.0%)
(3) Prescription Only	2	4	6 (3.0%)	55	52	107 (53.5%)
(4) Nothing	4	4	8 (4.0%)	18	23	41 (20.5%)
No Response	12	2	14 (7.0%)	0	3	3 (1.5%)
Mean Number of Medicines Given or Prescribed						
Those Receiving Medicines [(1) & (2)]	2.8	2.7	2.8	2.5	1.7	2.1
Full Sample	2.7	2.6	2.7	2.1	1.3	1.7

5.3 PATIENT EXPENDITURES

The last area addressed by the out-patient interviews was expenditures for health services. As shown in Exhibit 9, the most striking aspect of these data is the proportion of patients who paid for their visits. Over 85 percent of patients interviewed at private facilities paid something for the visit, either out-of-pocket or, in a few cases, through an employer-paid prepayment plan. This contrasts with patients at the public facilities, of which only 31 percent paid for consultations, all of which were out-of-pocket payments.

Averaging over all patients, including paying and non-paying, private patients paid more per visit (775 FCFA compared to 288 FCFA for public patients). However, including only those patients who paid out of pocket, the average fee paid was higher in public facilities in urban areas. In rural areas, the average fee paid was higher in private facilities.

Although public facility patients were less likely to receive drugs, when they did, they were more likely to pay for them (84 percent compared to 60 percent for private patients). Moreover, when public patients in the sample paid, they faced higher costs than private patients, paying an average of 1,961 FCFA compared with 1,310 FCFA.

Finally, nearly half of all respondents attending public facilities paid for neither consultations nor drugs, whereas only 10 percent of the private patients paid nothing. While this may suggest that private facilities are more stringent in collecting payments from patients, it also reflects the probability that there are more exemptions given in public facilities (e.g., to civil servants, students, military officers). Nevertheless, the data indicate that there was cost recovery activity occurring in the public sector.

**EXHIBIT 9
PATIENT PAYMENT FOR CONSULTATION AND MEDICINES**

TYPE OF FACILITY	PRIVATE			PUBLIC		
	URBAN	RURAL	SUB-TOTAL	URBAN	RURAL	SUB-TOTAL
Payment for Current Consultation						
Prepay	17	0	17 (8.6%)	0	0	0 (0.0%)
Pay	79	74	153 (77.7%)	33	24	57 (30.5%)
No Pay	4	23	27 (13.7%)	63	67	130 (69.5%)
Mean (Paying Patients, FCFA)	721	1,303	1,002	1,168	639	945
Mean (Full Sample, FCFA)	563	994	775	401	168	288
Payment for Medicines						
Number Paying	31	71	102 (51.3%)	21	20	41 (20.5%)
As % of Those Receiving Medicines			(60.0%)			(84.0%)
Mean (Paying Patients, FCFA)	784	1,543	1,310	2,289	1,615	1,961
Mean (Full Sample, FCFA)	243	1,102	668	486	320	402
Paid for Neither Consultations Nor Medicines (Excluding Prepay)	3	17	20 (10.1%)	45	43	88 (44.0%)
<p>* Note: All 17 respondents reporting prepayment were from the same facility. All reported paying 3,500 FCFA per month per family through employer. Prepayment covered both consultation and medicines. Principal occupation of patient or head of household shows a mixture of private sector and civil service employees.</p> <p>* Note: Seventy-four private patients (27 urban, 47 rural) reported identical (non-zero) payments for consultation and medicines, suggesting that in at least some cases, a single payment covered both consultation and drugs and that the payment was double counted. Only one public patient reported identical (non-zero) payments for both consultation and drugs.</p>						

Exhibit 10 presents characteristics of patients who did not pay for services (consultations, other services, or drugs). As shown in both Exhibits 9 and 10, there was a much higher proportion of public patients (70 percent) than private patients (14 percent) who did not pay for consultations. A majority of private patients interviewed who did not pay claimed that they would pay later, or that they had paid previously. In contrast, most public patients in the sample (53 percent) said that they had not been asked for payment, or that they believed that care was free of charge. None of the patients who was unemployed (or whose head of household was unemployed) received an exemption at private facilities, although most public patients reporting unemployment did not pay for services.

EXHIBIT 10
CHARACTERISTICS OF PATIENTS NOT PAYING FOR CONSULTATIONS

TYPE OF FACILITY	PRIVATE			PUBLIC		
	URBAN	RURAL	SUB-TOTAL	URBAN	RURAL	SUB-TOTAL
Number of Non-Paying Patients	4	23	27 (13.7%)	63	67	130 (69.5%)
Reasons For Non-payment						
Not Asked for Payment	1	1	2 (7.4%)	38	31	69 (53.1%)
Incapable of Paying	0	0	0 (0.0%)	1	1	2 (1.5%)
Paid Previously	0	4	4 (14.8%)	1	0	1 (0.8%)
Will Pay Later	0	14	14 (51.9%)	3	0	3 (2.3%)
Friend or Relative						
Works at Facility	2	1	3 (11.1%)	3	2	5 (3.8%)
Other	1	3	4 (14.8%)	2	0	2 (1.5%)
No Response	0	1	1 (3.7%)	15	33	48 (36.9%)
Monthly HH Market Expend. (FCFA)*						
0 - 5K	1	7	8 (29.6%)	0	17	17 (13.1%)
6 - 10K	0	3	3 (11.1%)	7	13	20 (15.4%)
11 - 15K	0	3	3 (11.1%)	6	8	14 (10.8%)
16 - 20K	2	4	6 (22.2%)	3	1	4 (3.1%)
21 - 25K	0	2	2 (7.4%)	3	2	5 (3.8%)
26 - 30K	0	1	1 (3.7%)	11	13	24 (18.5%)
31 - 40K	0	0	0 (0.0%)	2	1	3 (2.3%)
41 - 50K	0	1	1 (3.7%)	16	6	22 (16.9%)
51 - 75K	0	0	0 (0.0%)	4	0	4 (3.1%)
76 - 100K	0	0	0 (0.0%)	4	0	4 (3.1%)
No Response	1	2	3 (11.1%)	7	6	13 (10.0%)
Occupation						
Farmer	1	13	14 (51.9%)	0	37	37 (28.5%)
Merchant	2	6	8 (29.6%)	18	10	28 (21.5%)
Homemaker	0	0	0 (0.0%)	6	1	7 (5.4%)
Student	0	2	2 (7.4%)	9	7	16 (12.3%)
Civil Servant	1	1	2 (7.4%)	10	6	16 (12.8%)
Private Sector	0	0	0 (0.0%)	5	0	5 (3.8%)
Other	0	1	1 (3.7%)	7	2	9 (6.9%)
Unemployed**	0/8	0/4	0/12 (0.0%)	8/12	4/5	12/17 (9.2%)

Notes:

* Although the expenditure ranges are not inclusive of all possible responses, these were the ranges provided to questionnaire respondents, and the figures represent the responses given.

** The first number refers to the number of non-paying patients who are unemployed. The second number refers to the total number of unemployed respondents at the given type of facility.

Exhibit 11 combines information from Exhibits 3 and 10, and examines socio-economic status and payment for consultations. Patients providing responses about household expenditures were divided into three expenditure groupings: 0 to 10K FCFA (34 percent of respondents); 11 to 30K FCFA (44 percent of respondents); and 30K FCFA and above (22 percent of respondents). A comparison was then made between total respondents and those reporting non-payment for consultations.

As indicated above, there was a higher proportion of non-paying patients in public facilities (65 percent) than in private facilities (14 percent). (These

percentages differ slightly from those in the first row of Exhibit 10, because this table reflects only those patients in the sample providing responses regarding monthly household expenditures.) Comparing non-paying respondents with all respondents, a few points are of note. First, within the lowest socio-economic status (SES) category (based on household expenditures), only 16 percent of private patients did not pay, compared to 70 percent of public patients. Second, among private patients, the likelihood of not paying for services decreased as the level of socio-economic status rose. However, among public patients, those in the highest of three SES levels were just as likely to not pay for services as those in the lowest SES level. Third, there were many patients in the lowest SES category, at both public and private facilities, who did pay for services. Seventy-three respondents in the lowest SES category did pay for services, representing 60 percent of all respondents in that expenditure grouping.

One possible explanation for the level of non-payment among higher SES patients at the public facilities is the fact that civil servants are much more likely to be granted exemptions at public facilities. Sixty-four percent of the civil servants at public facilities received exemptions, compared to 15 percent at private facilities. This might also explain why a higher proportion of public versus private patients were civil servants.

**EXHIBIT 11
SOCIO-ECONOMIC STATUS AND NON-PAYMENT FOR CONSULTATIONS**

TYPE OF FACILITY	PRIVATE			PUBLIC		
	URBAN	RURAL	SUB-TOTAL	URBAN	RURAL	SUB-TOTAL
Total Respondents in Sample, Range of Monthly HH Expenditures						
0 - 10 K	16	52	68	13	40	53
11 - 30 K	46	31	77	37	42	79
31K +	28	3	31	39	9	48
Subtotal	90	86	176	89	91	180
Non-Paying Respondents, Range of Monthly HH Expenditures						
0 - 10K	1	10	11	7	30	37
11 - 30K	2	10	12	23	24	47
31K +	0	1	1	26	7	33
Subtotal	3	21	24	56	61	117
Non-Paying as % of Total						
0 - 10K	6.3%	19.2%	16.2%	53.8%	75.0%	69.8%
11 - 30K	4.3%	32.3%	15.6%	62.2%	57.1%	59.5%
31K +	0.0%	33.3%	3.2%	66.7%	77.8%	68.8%
Subtotal	3.3%	24.4%	13.6%	62.9%	67.0%	65.0%

Exhibit 12 provides information on modes of transportation utilized by patients and their time requirements. The majority of both public and private patients interviewed arrived at the health facilities on foot. Median round-trip travel times (for all modes of transport) were 60 minutes for private respondents and 30 minutes for public respondents.

**EXHIBIT 12
TRANSPORTATION TO FACILITY**

TYPE OF FACILITY	PRIVATE			PUBLIC		
	URBAN	RURAL	SUB-TOTAL	URBAN	RURAL	SUB-TOTAL
Mode of Transport						
Foot	67	79	146 (73.4%)	70	96	166 (83.0%)
Bus	25	11	36 (18.1%)	22	0	22 (11.0%)
Taxi	7	0	7 (3.5%)	6	0	6 (3.0%)
Bicycle or Moped	0	7	7 (3.5%)	0	2	2 (1.0%)
Personal Car	1	0	1 (0.5%)	1	0	1 (0.5%)
Other	0	0	0 (0.0%)	0	1	1 (0.5%)
Round Trip Travel Time Median (Minutes, of Those Responding)	56	93	75	41	49	45
Transportation Expenditure Those w/Expenditure Mean (FCFA, Those w/ Expenditures)	31	12	33 (21.6%)	25	0	25 (12.5%)
Mean (FCFA, Full Sample)	171	97	134	123	0	61

For those patients paying transportation costs, private patients had slightly higher expenditures. Including only those patients who had transportation expenditures, private facility patients paid an average of 621 FCFA for transportation, compared with 488 FCFA for public patients.

Exhibit 13 summarizes total patient expenditures for current visits. In urban areas, public and private patients paid approximately the same amounts, whereas in rural areas, private patients spent more. Including both urban and rural respondents, private patients spent more than their public counterparts. These figures did not include any additional expenditures to fill prescriptions subsequent to the clinic visit.

**EXHIBIT 13
TOTAL PATIENT EXPENDITURE FOR CURRENT VISIT**

TYPE OF FACILITY	PRIVATE			PUBLIC		
	URBAN	RURAL	SUB-TOTAL	URBAN	RURAL	SUB-TOTAL
Consultation	563	994	775 (48.6%)	401	168	288 (44.8%)
Medicines	243	1,102	668 (41.9%)	486	320	402 (46.9%)
Transport	171	97	134 (8.4%)	123	0	61 (7.1%)
Food & Lodging	17	21	19 (1.2%)	7	15	11 (1.3%)
TOTAL	994	2,214	1,596 (100.0%)	1,017	503	762 (100.0%)

Note: For private patients, the reported average total payment may overestimate the true average total payment, as it is suspected that in some of these cases a single payment covered both consultation and drugs and the payment was incorrectly reported twice. (See note in Exhibit 9).

5.4 SUMMARY OF RESULTS

The out-patient survey provides some insight into the relationships among perceived quality of care, prices, and utilization of health care services in public and private facilities in the Congo. To summarize, the results in four areas indicate the following:

Patient Characteristics

- ▲ Characteristics of patients sampled at public and private facilities were generally similar, with the exceptions that average age, likelihood of being married, and average household expenditures were higher for public patients.

Quality of Care

- ▲ Reported patient satisfaction was higher in private facilities.
- ▲ The availability of medicines was greater in private facilities, with more than half of all private patients receiving medicines, compared to one-fifth of public patients.

Patient Expenditures

- ▲ Private patients were more likely to pay for their visits, with 78 percent of private patients vs. 31 percent of public patients paying for services.
- ▲ Among patients receiving drugs, public patients paid higher prices.
- ▲ There were more non-paying patients at public facilities than private facilities in the sample, including respondents in the higher socio-economic status range. However, there were also many low income patients at both public and private facilities who did pay for services.

Rural-Urban Comparisons

- ▲ While there were differences in characteristics between urban and rural patients (e.g., income, occupation, and education), the characteristics of public versus private patients (within a geographic category) were similar.
- ▲ Of those patients who paid for consultations in urban areas, public patients paid more, whereas in rural areas, private patients paid more.
- ▲ In rural areas, private patients spent more than four times as much per visit (including transportation) than public patients; in urban areas, public and private patients spent roughly equivalent amounts.

6.0 CONCLUSIONS

The results from the out-patient survey in The Congo confirm the study's original hypothesis that private facilities provide higher quality care, as measured by patients' perceptions. The perception of higher quality is likely generated by greater availability of drugs and related medical supplies. In rural areas, patients are willing to pay higher prices for these private services.

Although it is recognized that this research was not population-based, and therefore care must be taken in extrapolating the results too broadly, the results may suggest two conclusions with relevance for health sector policies:

- ▲ *The government can improve the quality of its services by improving drug supplies.* Among respondents at both public and private facilities, an important aspect of perceptions of quality of care was the availability of drugs and other supplies. In general, patients sampled felt that the availability of drugs was higher at private facilities, and that quality was higher at those facilities.
- ▲ *Consumers are apparently willing and able to pay more for what they perceive as higher quality care.* Among the patients sampled, total expenditures for visits (including consultations, other services, drugs, travel, food, and lodging) were higher for private patients. At the same time, over 80 percent of the lowest SES patients surveyed at private facilities reported paying for their visits, compared to 30 percent of low SES patients at public facilities who paid for services, indicating a willingness to pay for what are perceived as quality health care services.

APPENDIX
OUT-PATIENT SURVEY QUESTIONNAIRE

ENQUETEUR: TOUTES LES QUESTIONS DOIVENT ETRE POSEES AU PATIENT OU PERSONNE ACCOMPAGNANT LE PATIENT SI LE PATIENT EST UN ENFANT OU S'IL EST TRES MALADE ET NE PEUT PAS REpondRE. SI LA PERSONNE ACCOMPAGNANT LE PATIENT REpond AUX QUESTIONS, L'ENQUETEUR UTILISE "LE PATIENT" AU LIEU DE "VOUS." LE SIGNE "#" DANS LA MARGE INDIQUE QUE PLUS QU'UNE REponse EST PERMI. LE SIGNE "##" INDIQUE QUE PLUS QU'UNE REponse EST OBLIGITOIRE.

SECTION I: IDENTIFICATION DU PATIENT ET DU MENAGE

1. QUI REpondRA AUX QUESTIONS?

1. Le patient
2. La personne qui accompagne le patient

2. QUELLE EST LA RELATION ENTRE VOUS (LE PATIENT) ET LA PERSONNE QUI VOUS ACCOMPAGNE?

1. Mère
2. Père
3. Autres membres de la famille
4. Ami
8. Autre (précisez) _____

3. QUEL EST VOTRE AGE?

1. 0 - 5
2. 6 - 15
3. 16 - 29
4. 30 - 45
5. 45+

4. SEXE:

1. Masculin
2. Feminin

5. QUEL EST VOTRE SITUATION MATRIMONIALE?

(ENQUETEUR: SI LE PATIENT EST UN ENFANT, LA QUESTION S'APPLIQUE AU CHEF DU MENAGE.)

1. Célibataire
2. Marié
3. Divorcé
4. Veuf
9. Pas de réponse

6. COMBIEN D'ENFANTS VIVENT DANS VOTRE MENAGE?

1. 0 - 5 _____
2. 6 - 15 _____

7. COMBIEN D'ADULTES VIVENT DANS VOTRE MENAGE? _____

8. QUEL EST VOTRE RELIGION?
1. Catholique
 2. Protestant
 3. Kimbanguiste
 4. Musulman
 5. Salutiste
 6. Ne prie pas
 8. Autre (précisez) _____

SECTION II: STATUT SOCIO-ECONOMIQUE

9. QUELLE EST VOTRE PRINCIPALE OCCUPATION?
(ENQUETEUR: SI LE PATIENT EST UN ENFANT, LA QUESTION S'APPLIQUE AU CHEF DU MENAGE.)

1. Agriculteur
2. Pêcheur
3. Commerçant
4. Fonctionnaire de l'état (autre que l'armée)
5. Militaire
6. Travaille dans le privé
7. Ménagière
8. Etudiant
10. Chômeur sans emploi
9. Autre (précisez) _____

10. QUELLE EST LA PRINCIPALE OCCUPATION DE VOTRE EPOUSE?
(ENQUETEUR: POSE CETTE QUESTION SI LE PATIENT EST MARIE.)

1. Agriculteur
2. Pêcheur
3. Commerçant
4. Fonctionnaire de l'état (autre que l'armée)
5. Militaire
6. Travaille dans le privé
7. Ménagière
8. Etudiant
10. Chômeur sans emploi
9. Autre (précisez) _____

11. QUEL EST VOTRE NIVEAU D'ETUDES?

(ENQUETEUR: SI LE PATIENT EST UN ENFANT, DEMANDER LE NIVEAU D'ETUDE DE LA MERE OU DE LA GARDE DE L'ENFANT.)

1. Etudes primaires non-terminées
2. Etudes primaires terminées
3. Etudes secondaires (faites ou terminées)
4. Etudes universitaires (faites ou terminées)
5. N'a jamais été à l'école

12. EST-CE-QUE VOUS POUVEZ LIRE ET ECRIRE?

(ENQUETEUR: SI LE PATIENT EST UN ENFANT, LA QUESTION S'APPLIQUE A LA MERE OU LA GARDE DE L'ENFANT.)

1. Oui
2. Non

13. QUEL EST LE REVENU MENSUEL DE VOTRE MENAGE?
(ENQUETEUR: SI LE REpondANT RESIST A REpondRE, LISEZ LES RUBRIQUES CI-DESOUS.)

- 1. Moins de 10.000 CFAF
- 2. 10.000 - 25.000 CFAF
- 3. 26.000 - 40.000 CFAF
- 4. 41.000 - 55.000 CFAF
- 5. 56.000 - 75.000 CFAF
- 6. Plus que 75.000 CFAF
- 9. Pas de réponse

14. COMBIEN DE FOIS UN MEMBRE DE VOTRE MENAGE VA AU MARCHÉ?

- 1. Seulement une fois/jour
- 2. Deux fois/jour
- 3. Une fois/semaine
- 4. Deux fois/semaine
- 5. Trois fois/semaine
- 6. Une fois/mois
- 7. Deux fois/mois
- 8. Autre (précisez) _____
- 9. Pas de réponse

15. EN MOYENNE, COMBIEN EST DEPENSE CHAQUE FOIS QUE QUELQ'UN DE VOTRE MENAGE VA AU MARCHÉ SANS INCLURE LES PRODUITS ACHETES ET DESTINES POUR LA VENTE?

- 1. _____ CFAF
- 9. Pas de réponse

16. PENDANT LE DERNIER MOIS, COMBIEN EST-CE-QUE VOTRE MENAGE A DEPENSE EN DEHORS DU MARCHÉ EN TRANSPORT, TISSUS, BIÈRE, CIGARETTES, ETC (NE PAS INCLURE DEPENSES EN SOINS DE SANTE ET EDUCATION)?

- _____ CFAF
- 9. Pas de réponse

SECTION III: SOINS CURATIFS

17. QUEL EST VOTRE SYMPTOME PRINCIPAL?

- 1. Fièvre
- 2. Diarrhée
- 3. Fatigue
- 4. Maux de tête
- 5. Maux d'estomac
- 6. Maux de gorge
- 7. Vomissement
- 10. Toux
- 11. Blessure
- 8. Autre (a préciser) _____

18. DEPUIS COMBIEN DE TEMPS AVEZ-VOUS CE SYMPTOME?

- 1. _____ jours
- 2. _____ semaines
- 3. _____ mois
- 9. Pas de réponse

19. AVEZ-VOUS CONTINUE A PERCEVOIR VOTRE SALAIRE REGULIER DURANT CETTE MALADIE?

(ENQUETEUR: SI LE PATIENT EST UN ENFANT, LA QUESTION S'APPLIQUE AU CHEF DU MENAGE.)

- 1. Oui
- 2. Non

20. QUELLE ETAIT LA DUREE DE L'INTERRUPTION DE VOTRE PRINCIPALE ACTIVITE?

- 1. _____ jours
- 9. Pas de réponse

#21. POURQUOI AVEZ-VOUS CHOISI CETTE FORMATION SANITAIRE? EST-CE-QUE C'EST PARCE QUE...

(ENQUETEUR: LISEZ CHAQUE RUBRIQUE CI-DESOUS.)

	Oui	Non
Normalement vous venez ici	1	2
Les tarifs sont moins cher	1	2
Le personnel est compétent	1	2
Les médicaments et matériels sont disponibles	1	2
Le temps d'attente est court	1	2
Les raisons religieuses ou traditionnelles	2	2
Proche du domicile	1	2
Autre (précisez) _____	1	2

22. EST CE QUE VOUS AVEZ UN PARENT OU AMI QUI TRAVAILLE DANS CE CENTRE DE SANTE?

- 1. Oui
- 2. Non

#23. QUELS SERVICES AVEZ-VOUS RECUS AUJOURD HUI?
 (ENQUETEUR: LIRE CHAQUE SERVICE CI-DESSOUS CITE.)

	Oui	Non
Consultation	1	2
Examens de labo	1	2
Radiographie	1	2
Chirurgie	1	2
Soins dentaires	1	2
Soins d'urgence	1	2
Autre (précisez) _____	1	2
Aucun service		3

#24. AVEZ-VOUS RECUS DES MEDICAMENTS OU UNE ORDONNANCE AUJOURD'HUI?

	Oui	Non
1. Médicaments	1	2
2. Ordonnance	1	2

25. QUEL MEDICAMENT ETAIT DONNE OU PRESCRIT AUJOURD HUI? AVEZ-VOUS PAYE? SI OUI, COMBIEN?

	Donné / Payé	Prescrit
1. _____	1 _____ CFAF	2
2. _____	1 _____ CFAF	2
3. _____	1 _____ CFAF	2
4. _____	1 _____ CFAF	2
5. _____	1 _____ CFAF	2

26. LES DOSES ET LES POSOLOGIES DES MEDICAMENTS SONT PRESCRITES OU INDIQUEES CLAIEMENT SUR L'ORDONNANCE OU DANS LE CARNET DES SOINS?

(ENQUETEUR: DEMANDEZ L'ORDONNANCE OU CARNET DES SOINS.)

1. Oui
2. Non

27. QUEL MOYEN DE TRANSPORT AVEZ-VOUS UTILISE POUR ARRIVER A CE CENTRE DE SANTE?
1. A pied
 2. Voiture personnelle
 3. Bus
 4. Taxi
 5. Bicyclette ou vélomoteur
 8. Autre (précisez) _____

28. COMBIEN DE TEMPS AVEZ-VOUS MIS POUR ARRIVER A CE CENTRE DE SANTE (PARTANT DU DOMICILE)?
1. _____ minutes
 2. _____ heures
 9. Pas de réponse

29. QUEL EST LA DISTANCE ENTRE VOTRE DOMICILE EST LE CENTRE DE SANTE?

1. _____ km
2. _____ metres
9. Pas de Reponse

30. OU EST VOTRE DOMICILE?

(A ESTIME APRES PAR LES RESPONSABLES DU CENTRE DE SANTE.)

31. COMBIEN DE PERSONNES ONT VOUS ACCOMPAGNE?

1. Aucune
2. _____

32. COMBIEN COUTE LE TRANSPORT ALLER-RETOUR DE VOTRE DOMICILE A CE CENTRE DE SANTE?

(ENQUETEUR: SI LE PATIENT A PRIS UN BUS OU UN TAXI, POSEZ CETTE QUESTION; SINON, PASSEZ A LA PROCHAINE QUESTION.)

1. Rien
2. _____ CFAF par personne
3. _____ CFAF par groupe
9. Pas de réponse

33. COMBIEN AVEZ-VOUS ET LES PERSONNES QUI VOUS ONT ACCOMPAGNEES ONT
DEPENSES POUR LA RESTAURATION EN ATTENDANT LES SOINS?

1. Rien
2. _____ CFAF
9. Pas de réponse

34. COMBIEN DE VISITES AVEZ-VOUS DEJA EFFECTUE DANS LES LIEUX INDIQUES
SUIVANTS DEPUIS LE DEBUT DE CETTE MALADIE?

(ENQUETEUR: LIRE CHAQUE RUBRIQUE CI-DESSOUS INDIQUEE.)

1. Ce Centre de Santé _____
2. Autre Centre de Santé _____
3. Pharmacie _____
4. Hôpital _____
5. Clinique _____
6. Tradipraticien _____
8. Autre (précisez) _____ _____
7. Aucune visite

35. COMBIEN AVEZ-VOUS DEPENSE POUR CETTE MALADIE AVANT CETTE VISITE?

(ENQUETEUR: LIRE CHAQUE RUBRIQUE CI-DESSOUS INDIQUEE.)

1. Soins de santé _____ CFAF
2. Médicaments..... _____ CFAF
3. Transport _____ CFAF
8. Autre (précisez) _____ _____ CFAF
4. Rien

SECTION IV: LE SATISFACTION DU PATIENT ET LA QUALITE DE SOINS

36. EN GENERAL, COMMENT ETES-VOUS SATISFAIT DES SERVICES RECUS AUJOURD'HUI?
(ENQUETEUR: LIRE LES TROIS REPONSES POSSIBLE CI-DESSOUS.)

Satisfait	Plus ou Moins Satisfait	Non Satisfait
1	2	3

##37. COMMENT ETES-VOUS SATISFAIT DU CENTRE DE SANTE EN CE QUI CONCERNE LES ASPECTS SUIVANTS?
(ENQUETEUR: LIRE CHAQUE ASPECT CI-DESSOUS INDIQUE.)

	Satisfait	Plus ou Moins Satisfait	Non Satisfait
Disponibilité des médicaments	1	2	3
Propreté des lieux	1	2	3
Disponibilité du matériel	1	2	3
Compétence du personnel	1	2	3
Autres (précisez) _____	1	2	3

38. APRES VOTRE ARRIVEE COMBIEN DE TEMPS AVEZ-VOUS ATTENDU POUR RECEVOIR LES SOINS?

1. _____ minutes

2. _____ heures

9. Pas de réponse

39. Y A-T-IL DES SERVICES DONT VOUS AVEZ EU BESOIN ET QUE VOUS N'AVEZ PAS PUS RECEVOIR? SI OUI, LESQUELS ET DITES POURQUOI?

1. Aucune service non reçu

SERVICE NON-RECU	Personnel Non Disponible	Materiel Non Disponible	Prix Tres Cher	Autre * (Precisez ci-dessous)	Ne Connait Pas
2. Consultation	1	2	3	8	9
3. Médicaments	1	2	3	8	9
4. Examens Labo	1	2	3	8	9
5. Radiologie	1	2	3	8	9
6. Chirurgie	1	2	3	8	9
7. Soins dentaires	1	2	3	8	9
8. Soins d'urgence	1	2	3	8	9
8. Autre (précisez)	1	2	3	8	9

* AUTRES RAISONS SERVICES NON RECUS (NUMERO CORRESPONDANT AU SERVICE NON-RECU)

1. _____ ()
2. _____ ()

40. QUEL EST LA PRINCIPALE AGENT QUI VOUS A ADMINISTRE LES SOINS?

1. Docteur
2. Assistant sanitaire
3. Infirmier
4. Sage femme
5. Pharmacien
8. Autre (précisez) _____

41. COMBIEN DE TEMPS A-T-IL PASSE AVEC VOUS?

1. _____ minutes
9. Pas de réponse

#42. QUEL SONT PARMIS LES GESTES SUIVANTS CEUX QU'IL VOUS A FAIT?
 (ENQUETEUR: LIRE CHAQUE RUBRIQUE CI-DESSOUS INDIQUEE.)

	Oui	Non
Vous a salué des qu'il vous a vu	1	2
Agit poliment avec vous	1	2
A posé des questions supplémentaires au sujet de votre maladie	1	2
A pris votre température en vous touchant ou en utilisant un thermometre	1	2
A pris le pouls	1	2
A pris le pois	1	2
A pris la tension arterielle	1	2

43. COMMENT QUALIFIEZ-VOUS SA COMPETENCE?
 (ENQUETEUR: LIRE LES REponses CI-DESSOUS.)

Très competent	Competent	Pas competent
1	2	3

#44. VOUS AVEZ ETE EXAMINE PAR UN AUTRE MEMBRE DU PERSONNEL MEDICAL? SI OUI,
 INDIQUEZ SA COMPETENCE.
 (ENQUETEUR: LIRE LES REponses CI-DESSOUS.)

	Très competent	Competent	Pas competent
1. Aucune autre personne			
2. Docteur	1	2	3
3. Assistant sanitaire	1	2	3
4. Infirmier	1	2	3
5. Sage femme	1	2	3
6. Pharmacien	1	2	3
8. Autre (précisez) _____	1	2	3

75

45. A VOTRE AVIS QUELLE EST LA MEILLEURE FORMATION SANITAIRE DE CETTE ZONE?

1. Ce Centre de Santé
2. Autre (précisez) _____
9. Pas de réponse

46. QUELLE EST D'APRES VOUS LA PRINCIPALE RAISON QUI FAIT QUE CETTE FORMATION SANITAIRE SOIT LA MEILLEURE?

1. Tarifs moins chers
2. Personnel competent
3. Disponibilité des médicaments et du materiel
4. Temps d'attente très court
5. Proche du domicile
8. Autre (précisez) _____

SECTION V: SYSTEME DE PAIEMENT

47. COMBIEN AVEZ-VOUS PAYE AUJOURD'HUI POUR LES SERVICES RECUS?

1. _____ CFAF
2. Rien
9. Pas de réponse

48. QUELLE EST LA RAISON QUE VOUS N'AVEZ PAS PAYE AUJOURD'HUI?

1. Incapable de payer (indigent)
2. Parent ou ami travaillant dans le Centre de Santé
3. Va payer plus tard
4. Traitement d'aujourd'hui y compris dans le 1er paiement

8. Autre (précisez) _____
9. Pas de réponse

49. RAPPELEZ-MOI, EST-CE-QUE C'EST VOTRE PREMIERE VISITE A CE CENTRE DE SANTE POUR CETTE MALADIE?

- 1. Oui
- 2. Non

50. COMBIEN AVEZ-VOUS PAYE POUR LES AUTRE VISITES AVANT AUJOURD'HUI?

- 1. La première visite _____ CFAF
- 2. La deuxième visite _____ CFAF
- 3. La troisième visite _____ CFAF
- 4. Autres visites _____ CFAF

(ENQUETEUR: NE POSEZ PAS LES DEUX QUESTIONS SUIVANTES SI L'ENQUETE N'A PAS PAYE POUR LES SERVICES RECUS AUJOURD'HUI.)

#51. A QUI AVEZ-VOUS PAYE AUJOURD'HUI?

(ENQUETEUR: LIRE LES REPONSES CI-DESSOUS.)

	Oui	Non
Gestionnaire	1	2
Personnel traitant	1	2
Autre (précisez) _____	1	2
Pas de réponse		9

52. QUI A PAYE POUR LES SOINS? COMBIEN?

(ENQUETEUR: LIRE LES REPONSES CI-DESSOUS.)

- 1. Patient _____ CFAF
- 2. Epouse _____ CFAF
- 3. Parent ou ami _____ CFAF
- 4. Sécurité Sociale _____ CFAF
- 5. Employeur _____ CFAF
- 6. Assurance privée _____ CFAF
- 8. Autre (précisez) _____ ... _____ CFAF

53. AVEZ-VOUS UNE ASSURANCE MALADIE?
1. Oui
 2. Non
 9. Pas de réponse

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