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Benin

Private Health Sector Assessment



BRIEF

SHOPS
Strengthening Health Outcomes
through the Private Sector

Summary: This brief is a summary of the Benin Private Health Sector Assessment, March 2013, conducted by the SHOPS project. Andrew Carmona prepared this brief, which presents the assessment methods, findings, and the following key recommendations:

1. Grow the formal sector by streamlining registration and licensing processes for businesses and supporting provider networks.
2. Strengthen the role of the private health sector at the national policy level and through advocacy groups.
3. Streamline registration, licensing processes, and business operations for pharmaceutical businesses and products.
4. Improve access to finance and the business capacity of providers.
5. Foster the growth of private sector health financing mechanisms (health insurance).

The overall goal of these recommendations is to present actionable steps for USAID and the public and private sectors to fully leverage private sector resources and formalize, comprehend, and strengthen the private health sector, with a focus on family planning, maternal and child health, urban populations, and service provider networks.

Keywords: access to finance, Benin, health insurance, maternal and child health, policy, private sector assessment, private sector health, public-private dialogue, reproductive health, service provision, tuberculosis, urban populations

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Cover photo: Andrea Dee Harris

Project Description: The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in the private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV and AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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Benin Private Health Sector Assessment

The USAID Mission to Benin seeks practical strategies to strengthen collaboration between the country's public and formal private health sectors. For the period 2012 to 2016, USAID/Benin has made strengthening the private sector to improve health outcomes a strategic priority. In mid-2012, USAID/Benin commissioned the Strengthening Health Outcomes through the Private Sector (SHOPS) project to conduct an assessment of the private health sector in Benin to assist USAID and other stakeholders in developing a strategy to further engage the private sector. The strategy will complement efforts within the public and private sectors that focus on family planning, maternal and child health, urban populations (particularly the urban poor), and service provider networks. This brief is a summary of the methods, findings, and key recommendations discussed in the assessment report.¹

Background

Independent since 1960, Benin is a West African francophone country with a population of 9.3 million. Benin's economy is based on agriculture, with 56 percent of the population working or involved in this sector. Urbanizing at a rate of 1 percent per year, Benin is currently 42 percent urban and by some estimates is expected to reach a rate of 50 percent by 2017. According to the UNDP 2012 Human Development Index, Benin ranks 166 out of 177 countries, with 39 percent of the population living below the poverty line. Life expectancy at birth of the average Beninese is 57 years.

Benin's GDP is \$7.3 billion with a GDP per capita of \$737 and a GNI per capita of \$1,630. Benin has experienced between 3 and 5 percent annual GDP growth since 2003. The World Economic Forum's *Global Competitiveness Report 2012–2013* (Schwab, 2012) ranks the country 119 out of 144 economies. According to the report, the most problematic factors for doing business are corruption (23.8 percent), access to financing (17.2 percent), tax rates (4.0 percent), inadequate supply of infrastructure (11.1 percent), and tax regulations (6.6 percent).

Benin has the potential to reach several of the UN Millennium Development Goals, namely, achieving universal primary education, ensuring access to sanitation and safe drinking water, developing an open and nondiscriminatory trade and financial system, and reducing its debt in a sustainable manner by 2015. However, the country lags significantly in progress toward the goals of eradicating extreme poverty and hunger, and reducing biodiversity loss. It also lags behind other countries in the region with respect to promoting gender equality, reducing child mortality, improving maternal health, and combatting HIV and AIDS, malaria, and other diseases (United Nations, 2010).

¹ Cuellar, Carlos, Andrew Carmona, Andrea Harris, and Piotr Korynski. March 2013. *Benin Private Health Sector Assessment*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

Child health indicators in Benin have improved over the past decade, yet much work remains to be done. Under-five mortality and infant mortality rates, 120 and 76 per 1,000 live births, respectively in 2006, have steadily decreased to 106 and 68 today (World Bank, 2011). According to the Global Health Initiative 2011 strategy paper (DOS et al., 2011), malaria is the number-one killer of all children under the age of five years; in 2008, it was responsible for 23 percent of all under-five deaths. Related care-seeking constitutes 40 percent of outpatient health center visits. As of 2010, 83 percent of children were immunized against diphtheria, pertussis (whooping cough), and tetanus, and there was a 69 percent measles vaccination coverage rate. The 2011–2012 Benin Demographic Health Survey preliminary report indicates that 28.4 percent of children under five test positive for malaria, and 44.6 percent are severely or moderately stunted due to chronic malnutrition—a rate that has worsened significantly in the past decade.

Benin has a 30 percent unmet need for contraceptives among married women aged 15 to 49.

The fertility rate in Benin has decreased, from 5.6 in 2006 to 4.9 in 2012, as has maternal mortality—it was 350 per 100,000 live births in 2010, down from 770 two decades earlier. Eighty-four percent of live births are attended by a skilled attendant, up from 78 percent in 2006 (INSAE and Macro International Inc., 2012). With regard to family planning, Benin has a 30 percent unmet need for contraceptives among married women aged 15 to 49. The Benin Demographic Health Survey 2012 preliminary report seems to indicate that change in contraceptive use among married women aged 15 to 49 is stagnant at best; the contraceptive prevalence rate of this group fell to 12.9 percent from 17.0 percent in 2006. However, this group's modern contraceptive prevalence rate rose from 6.0 to 7.9 percent. Thirty-nine percent of males aged 15 to 24 report using condoms.

The existence of a private health sector is a relatively new development in Benin. At the beginning of the 1980s, few private health care providers existed in Benin; most health care providers were hired by the state after completion of their studies. This reflected the country's Marxist-Leninist orientation when the government was closely allied with the USSR, Cuba, and Angola. In 1986, the Ministry of Health stopped recruiting doctors because it reached its hiring capacity. This triggered a large expansion of the then-negligible private health sector. Private practices that sprang up mostly consisted of faith-based facilities located in urban areas. Other private health facilities emerged on an ad hoc basis until 1997 when Law 1997-020 authorized the private practice of medicine in Benin (Adeya et al., 2007). To gain a clearer understanding of the private health sector, its role in Benin, and challenges to its growth, USAID/Benin commissioned the SHOPS project to conduct an assessment of the sector.

Scope of the Assessment

The Benin private sector assessment focused on the policy environment, professional orders and associations, advocacy organizations, service provision, provider networks, pharmaceutical products and supply, access to finance, and health insurance. The specific tasks of the assessment were:

- Determine the size, scope, and scale of private sector providers.
- Assess the policy and regulatory environment for private provision of health products and services.
- Assess business and financing needs of the private health sector with an emphasis on ProFam, a network of facilities run by the *Association Béninoise de Planification Familiale et la Communication pour la Santé* (ABMS), the Population Services International (PSI) affiliate in Benin; and the *Association des Oeuvres Médicales Privées Confessionnelles et Sociales du Bénin* (AMCES), a network of faith-based hospitals in Benin.
- Identify areas of collaboration with existing USAID field support activities focused on improving health outcomes in Benin.
- Identify opportunities to increase access to private sector health financing options by examining current initiatives.

For the purpose of this assessment, the private health sector included a diversity of actors—nongovernmental organizations (NGOs), faith-based and professional associations, and for-profit (commercial) health care businesses that offer treatment, prevention, pharmaceutical distribution, and financing services.

METHODS

The assessment team collected data in two stages. First, it reviewed published and gray literature and conducted a secondary analysis of Benin Demographic and Health Survey data. Second, the team traveled to Benin between October and November 2012 to interview key stakeholders whom it had identified with guidance from in-country partners. The team members interviewed representatives from the public and private sectors, as well as development partners, to understand the prevailing attitudes toward private sector engagement and identify opportunities, challenges, and potential solutions for formalizing and strengthening the private health sector in Benin.

FINDINGS

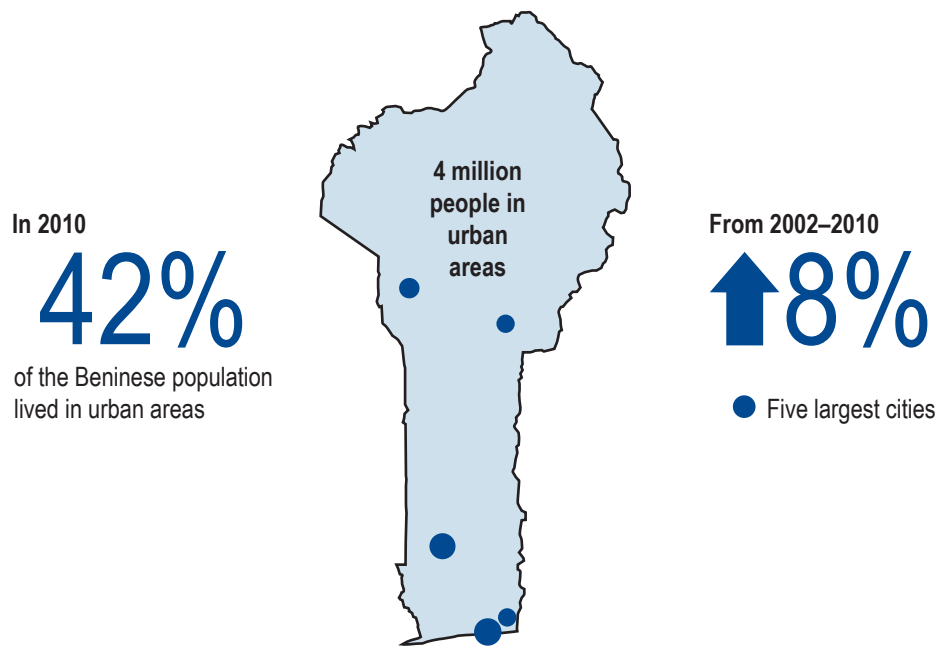
The private side of Benin's health system is expanding significantly, with the potential to meet more health needs. Private practitioners face a variety of challenges, many of which stem from the fact that the country's health system has traditionally focused on the public sector, with a history of strict regulation and inflexibility due to centralized decisionmaking.

General Findings

The private health sector in Benin is growing significantly as a result of several factors:

- **Accelerated urbanization.** It is estimated that 50 percent of the population in Benin will be urban or peri-urban by the year 2017. This is sure to increase demand for health products and services (see Figure 1).
- **Poor access/quality of public services.** It is expected that the public sector will not be able to respond to the growing demand in the urban/peri-urban areas. This presumably will result in the growth of private health care facilities operated by modern providers as well as traditional healers.
- **High willingness to pay.** High out-of-pocket expenses may reflect a willingness to pay for health care. The general population, including the poor, is used to making direct payments for certain health care services and products received in either a public or private facility.
- **Inability of the government of Benin to absorb newly graduated doctors.** The number of new doctors has long exceeded the number that could be employed, and this increased after the Ministry of Health (MOH) froze systematic hiring in 1986. The surplus doctors usually emigrate or open their own practices.

Figure 1. Increasing Urbanization



Note: In 2010, the total population of Benin was 9.5 million.

Source: World Bank, 2013

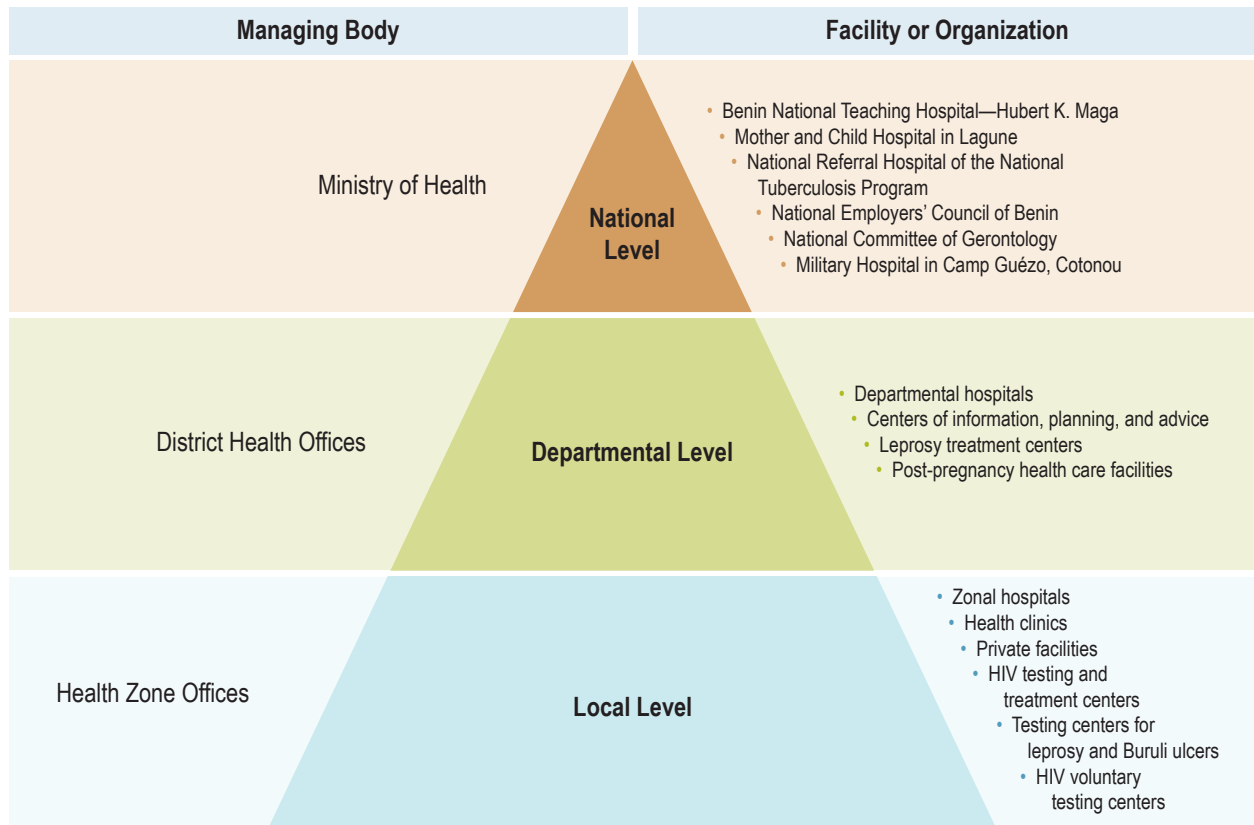
With urbanization, there is increasing recognition of the private sector as an important player in the Benin health market. Additionally, the private health sector has significant untapped potential to speed progress toward expanding the population's access to health care. However, there are factors that impede growth of the sector, as discussed in the following sections.

The country's 12 departments are split into 34 health zones. These health zones contain one to four communes, and are managed by health zone committees and health zone management teams. Each zone has arrondissement health centers, commune health centers, and a hospital. A health zone office oversees all public and private health entities in a zone, including private nonprofit and for-profit hospitals, clinics, and pharmacies. Figure 2 illustrates the organizational structure of the public health system of Benin.

Policy Environment for Services

The potential contributions of a growing private health sector are compromised by overregulation. Benin’s colonial and communist heritage—a predominant public sector with top-down decisionmaking and strict oversight—influences the current policy environment. This has resulted in a highly regulated health sector that hinders efficient growth of private enterprise and poses significant hurdles for both entrepreneurs and potential international investors. This regulatory approach is, incidentally, fueling the growth of the unregulated informal sector, which has consequences for quality of care.

Figure 2. Health System in Benin



Source: *Health Systems 20/20, 2012*

The major issues are:

- Registration and licensing processes are bureaucratic and time-consuming.
- Professional groups, or orders, don't have the resources to respond effectively to the registration and licensing processes.
- Major barriers exist for establishing group practices and provider networks.
- Legislation restricts the private sector in the following ways:
 - Physical location of clinics, hospitals, maternity clinics, and pharmacies are decided somewhat arbitrarily by professional orders.
 - Providers can own only one facility and networks are highly discouraged
 - Advertisement and marketing of services are prohibited.
 - Provider honoraria are not market-based and cannot be changed unless approved by their respective orders.
 - Pharmaceutical prices and margins are not market-based.

The formal private sector favors sole practitioners. Although there is no legal restriction, the policy environment is not conducive to setting up group practices or provider networks. The main reasons for this are a perception that medical practice is best done by an individual, a sense of mistrust among physicians, and a lack of confidence in the judiciary system.

There is a de facto dominance of public agencies in initiating and overseeing the implementation of public-private partnerships. Effective partnerships that add value to the delivery of better health outcomes can and must be initiated from both the public and the private sectors. Innovative, flexible approaches to problem solving are often a characteristic of private sector entrepreneurs. A creative dialogue between these two sets of players is critical to jump-starting effective cross-sectoral collaboration that will produce better public health outcomes.

Policy Environment for Products

Product registration is a centralized, highly controlled, and protracted process within the MOH, which limits competition and product availability, particularly of key pharmaceuticals. These regulatory practices restrict the ability of the private sector to sustainably serve the specialty-medicine needs of the population, and ultimately deny a full range of product choices to consumers, preventing effective market segmentation. The public sector tends to view private providers as a source of service delivery problems, while the private sector tends to distrust public regulatory authorities.

Margins for wholesalers are set by central authorities and are limited to a specific percentage spread of the wholesale price, which is often so slim it does not allow wholesalers to make a reasonable profit. There are

strict rate controls for markups on private wholesalers' importation and distribution of non-generic products, which also decreases margins.

The Order of Pharmacists has a conflicting role. In discharging its regulatory functions, there is not a clear enough separation of powers and personnel or a clear policy on conflict of interest. Individuals who wish to open pharmacies find the criteria for pharmacy placement confusing, with too much control given to the Order of Pharmacists over the location of specific retail locations. Regulations governing the establishment and expansion of pharmacies can be restrictive and serve as disincentives for entrepreneurs wishing to create new business.

Professional Orders and Associations

Within the Benin health system, there are three professional orders (physicians, midwives, and pharmacists), and one professional association for nurses. These professional orders and the association are legally state-supporting technical bodies that have three basic functions: (1) regulate the professional practice of the public and private health sectors; (2) implement ethical codes; and (3) support activities that contribute to public health.

In general, professional orders and other provider associations have limited ability to enforce registration and licensing requirements. Members are volunteers and cannot devote the time that is required to inspect prospective health facilities. This has resulted in a considerable delay in the facility approval process. Furthermore, there is a great potential for conflict of interest between members of professional orders and applicants. Orders appear to play a dual role of approving new members, and providing services to existing members. Assigning these two functions to a single organization creates tension between the regulatory and nonregulatory functions. This is exacerbated by the fact that core revenues for the order (and all funds available for service provision to members) come solely from the voluntary contributions of eligible, approved members. Orders and the provider association are not involved in the development of quality assurance initiatives for their members.

Despite the growing prominence of the private health sector, there is no evidence that professional orders and associations are fully engaged with the public sector and therefore considered important actors in the health system.

Advocacy Organizations

Réseau des ONG Béninoises de Santé (ROBS), or Network of Beninese Health NGOs, seems to play a relatively active coordinating role in supporting its 80 NGO members and represents them in key committees and forums. ROBS has the potential to become a leading force for NGO capacity building and to play a strong advocacy role. It could improve access and use of family planning and reproductive health services to the communities its member NGOs serve. However, the

There is no evidence that professional orders and associations are fully engaged with the public sector and therefore considered important actors in the health system.

effectiveness of ROBS' work is restricted by its low level of sustainability and organizational capacity. The main constraints are: limited capacity in financial management, insufficient membership fees to serve as a financial base, operations are largely based on small projects, and serious cash flow problems between projects.

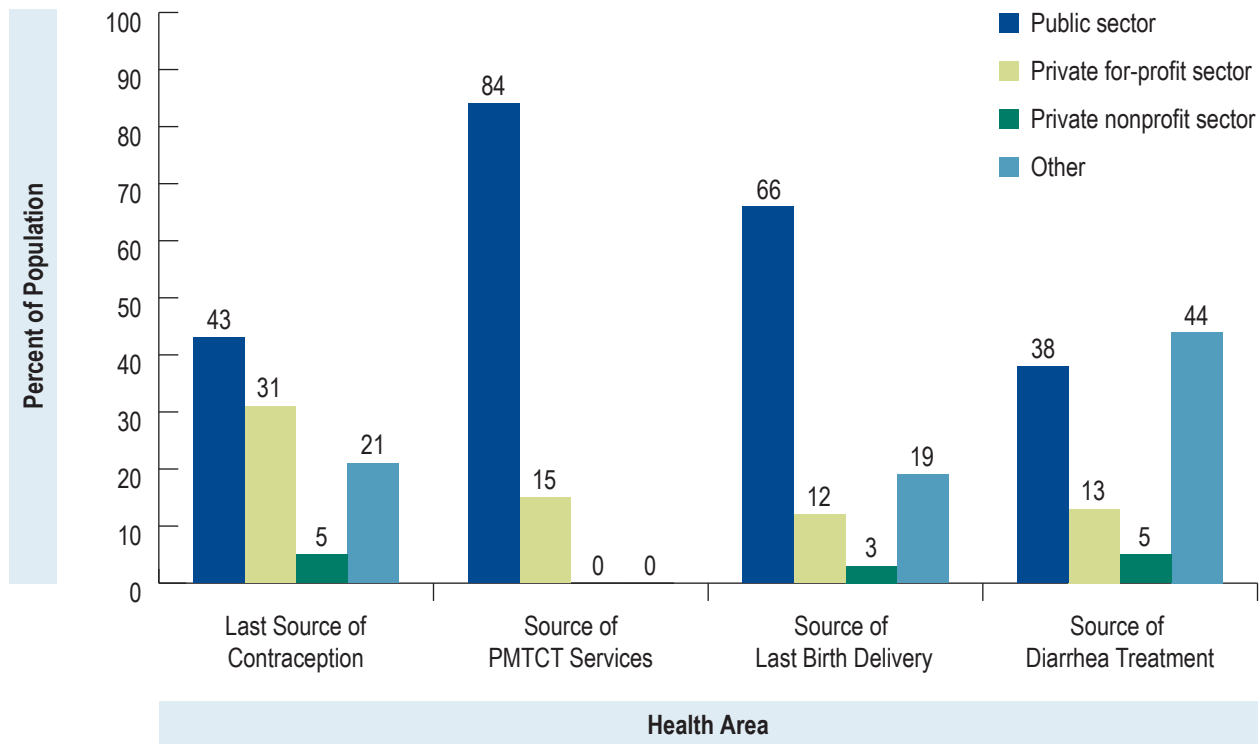
Coalition des Entreprises Béninoises et Associations contre le Sida, la Tuberculose et le Paludisme (CEBAC STP), or Benin Business Coalition against AIDS, Tuberculosis, and Malaria, is a significant advocate for the improvement of health outcomes among the employees of private sector enterprises. Its board is young, intelligent, and enthusiastic about making the coalition more effective. The leadership willingly accepted feedback from the assessment team, and is eager to expand the organization's mission to include a larger focus on family planning provision in the workplace programs of its member enterprises. CEBAC constitutes a prime vehicle through which family planning can be increased in some of the larger workplace clinics in Benin, and the coalition's status as a grantee of the Global Fund and Medical Care Development International ensures its sustainability into the future.

The **Association of Private Clinics** has the potential to be a significant, if not the most important, advocate for private sector practices in Benin. It is keenly positioned to affect change for the private sector, and is able to engage in policy dialogues with the MOH. Regarding financial resources, the association lacks status as a professional order, and is registered as an NGO that operates almost exclusively from member fees. The association expressed understandable skepticism of donor-funded assistance to the private sector, citing past projects or monetary commitments by donors that went unfulfilled or whose primary beneficiary was the public sector. Growth of the association is constricted by the lengthy formal registration process for private clinics. The fact that private practices must be formally registered with the MOH as a prerequisite to becoming a member of the association may hinder growth of the association's membership and revenues.

Service Provision

The size of the role that the private sector plays in the delivery of selected health services in Benin varies by health area (see Figure 3). While maternal and child health indicators in Benin have steadily improved over the course of the last decade, there is still a considerable gap in the use of public and private facilities for obtaining these services. The private sector can and should play a larger role in helping to improve quality of care, reliability of services, and availability of products.

Figure 3. Public-Private Mix in Key Health Areas (%)



Source: Benin Demographic and Health Survey, 2006

Note: PMTCT = Prevention of mother-to-child transmission of HIV

The private sector also has an opportunity to expand its share of the market in the delivery of quality family planning services. Forty-three percent of women used the public sector to obtain their most recent method of contraception, while 36 percent used the private sector (31 percent for-profit, 5 percent nonprofit) (INSAE and Macro International Inc., 2007). The private sector accounts for a significant portion of the family planning and reproductive health market, probably due to the fact that the Laafia® brand, produced and distributed by PSI and *Association Béninoise pour le Marketing Social et la Communication pour la Santé*, or the Beninese Association for Social Marketing and Health Communication, through their ProFam clinics, dominates the family planning market in Benin.

The structure of the private sector in Benin can be laid out in a fairly straightforward manner, as shown in Table 1.

Estimating the size of the private health sector is more difficult, as simply counting registered private practices does not accurately reflect the true size of the sector. A 2005 *Direction Nationale de la Protection Sanitaire* (National Health Protection Directorate) survey of 231 private providers in four districts of Benin found that only 12 percent were registered with the MOH (Adeya et al., 2007).

Table 1. Structure of the Private Health Sector in Benin

	For-profit (commercial)		Nonprofit
	Standalone	Network	
Services	Clinics Hospitals Midwifery practices Nursing practices	ProFam	Hospitals ABPF ProFam AMCES
Products (retail)	Pharmacies Depots Semi-wholesalers	Not allowed	ABMS
Products (distribution)	Wholesale distributors i.e., GAPOB	Not allowed	
Products (production)	Not available in the country	Not applicable	In-country packaging for some products

Notes: ABPF = Association Béninoise pour la Planification de la Famille; GAPOB = Groupement d'Achat des Pharmacies d'Officine du Bénin

The private health sector in Benin is broken into six major types of practices: medical office/clinic, midwife practice, nurse practice, hospital, specialized practice, and pharmacy. In 2011, the MOH released a list of all registered private practices; registered doctor, midwife, nurse, and dental practices numbered approximately 510. The list does not include private hospitals, pharmacies, and other specialty practices. If these facilities are added to the registry, the total number reaches approximately 750 known practices. Based on interviews with professional provider associations, research firms, and other knowledgeable health sector specialists in Benin, SHOPS estimates that the unregistered sector is far larger, numbering approximately 1,500 practices, with possibly more (see Table 2).

Table 2. Number of Private Health Sector Practices in Benin

Type of Facility	Number	Description
Medical office/clinic	189 registered; estimated that significantly more are unregistered	Commercial sector or networked, such as ProFam or ABPF. Owned by a practitioner. Usually consists of a head doctor or midwife and support staff.
Midwife practice	227 registered; estimated that significantly more are unregistered	A commercial practice operated and owned by a midwife, potentially with support staff.
Nurse practice	69 registered; estimated that significantly more are unregistered	A commercial practice operated and owned by a nurse, potentially with support staff.
Hospital	Approximately 15-20	Commercial sector and national reference hospitals. Majority are faith-based.
Specialized practice	Unknown	Commercial sector practice owned by a qualified specialist practitioner. Services may include radiology, diagnostic/ laboratory, dental, physiotherapy, etc.
Pharmacy	Approximately 240 registered	Private pharmacies run and owned by qualified pharmacists.
Estimated Total	Approximately 750 registered; 1,500 estimated	

The major types of private health sector providers in Benin are doctors, midwives, nurses, pharmacy staff (including pharmacists, pharmacist assistants, and pharmacy technicians), and specialty practitioners. Data gathered from interviews with professional provider associations for doctors, midwives, nurses, and pharmacists establish the total number of known (listed as members of a professional association) providers at approximately 2,500. SHOPS estimates that this number is closer to 4,000, which is in line with the 4,500 estimate in the 2012 health systems assessment carried out by the USAID-funded Health Systems 20/20 project (Health Systems 20/20, 2012).

Private providers serving middle- and low-income populations are particularly affected by a restrictive policy environment that includes a difficult registration process, no market segmentation, and a ban on promotion and marketing (see Table 3). Higher-income populations are not affected by these restrictions, as those individuals typically leave the country to seek significant health services. Generally in the private sector, the volume of users is low and the inability to pay is high. However, there is a relatively high willingness to pay for health care.

Table 3. Factors Affecting the Ability of the Private Sector to Provide Quality Health Services to Middle- and Low-Income Populations

Internal Factor	External Factor
<ul style="list-style-type: none"> • Lack of managerial ability • Lack of business planning • Quality of services suffer from cost-containment coping mechanisms • Inadequate facility infrastructure and maintenance • Insufficient staff training • Insufficient equipment and supplies • Lack of marketing activities 	<ul style="list-style-type: none"> • Difficult economic situation • Demand constrained by ability to pay, despite a relatively high willingness to pay • Intense competition and changes in health care-seeking behavior • Policy barriers to private expansion, such as a ban on advertising and price controls • No access to finance • Lack of access to training

Other factors affecting the volume of users in the private sector include changes in health care-seeking behavior to less expensive alternatives in the public and private sectors (pharmacies, traditional medicine) or simply not obtaining care at all. Additionally, private sector providers have very little access to management and marketing training, due in part to low demand for such training. Furthermore, there is limited or no access to clinical training opportunities; ProFam is the only reliable source of family planning and reproductive health training. Private sector providers are

not using management and marketing tools to improve their businesses. There is a limited availability of, and access to, medical equipment such as sonograms. Where medical equipment is available, providers' inability to pay and low client volume, and thus low demand, affect the decision to purchase. Physical facilities are mainly adapted residential buildings and suffer from structural limitations and lack of maintenance.

The prevalent business model among for-profit facilities is less profitable in both financial and social terms. Having a low-volume operation with a significant amount of downtime is a main factor in relatively high unit costs and consequently low margins in an environment where prices are not market-based. When it comes to quality, there is likely uneven quality in service provision as a result of a lack of quality assurance systems in the commercial sector. Biosafety practices are objectively sub-standard, and there appears to be a lack of incentives from the government; inspection visits were reported as unproductive.

Provider Networks

The ***Association des Oeuvres Médicales Privées Confessionnelles et Sociales du Bénin***, or the Benin Association of Faith-based Medical and Social Work, is a significant actor in the nonprofit health sector. It has succeeded in implementing a public-private partnership with the MOH. AMCES is a faith-based network that includes 28 health facilities: 18 primary health care centers and 10 hospitals representing Catholic, Protestant, and Islamic faiths. All hospitals are designated district hospitals and are part of the MOH delivery system. AMCES services are mainly focused on curative and hospital care, and the network's facilities appear to be a reliable source of family planning counseling and provision of traditional contraceptive methods. Availability of modern methods is contingent on the religious beliefs of the members. The AMCES leadership appears to provide the right type of support to members and has a clear idea of future strategic actions.

ProFam, a network run by the local PSI affiliate, ABMS, operates effectively to support provision of family planning and other priority health services in the private sector. ProFam has a network of 49 privately owned clinics that provide a variety of general primary care, family planning and reproductive health, and maternal and child health services. ABMS is a trustworthy and reliable source of family planning commodities, Orasel Zinc, and insecticide-treated bed nets for the ProFam affiliates. The "fractional franchise" model (the addition of franchised services to an existing practice) seems to balance the need for increasing the uptake of family planning and other priority health programs, while preserving the entrepreneurial spirit of private providers. The environment for pursuing private provider networks is favorable and the lessons learned from the ProFam network experience can be useful in pursuing new network strategies. The growth of the ProFam network is heavily dependent on the number of registered private providers, since only registered providers can become franchisees. Alongside ProFam is the ABMS-run *Ligne Verte*,

a toll-free hotline that offers an anonymous way for clients to receive information about HIV, family planning, and referrals to ProFam clinics; it has shown great success in terms of call volume.

The **Association Béninoise pour la Planification de la Famille (ABPF)**, or the Beninese Association for Family Planning, the local International Planned Parenthood affiliate, plays a limited but important role in the provision of family planning services and promotional activities. The ABPF service network comprises one central clinic, six regional clinics, and eight socio-educational centers. ABPF's potential is constrained by a business model that is narrowly focused on low-price family planning services and products. The association operates a heavily subsidized network of clinics and socio-educational centers that provide family planning services and a limited range of other related services to low-income populations living in peri-urban areas. International CONtraceptive & SRH Marketing Ltd. (ICON) and central medical stores (CAME) are the primary reliable sources of supplies for ABPF and appear to fulfill most of the needs of ABPF and its users. ABPF linkages with commercial private providers via partner clinics are limited to supplying family planning products and some training. Training provided is minimal and there are no quality control activities. The main concern of the association's leadership is the sustainability of its operations, given its high dependency on donor support. The future of ABPF in terms of relevance in the health sector is linked with the development and implementation of a sustainability plan.



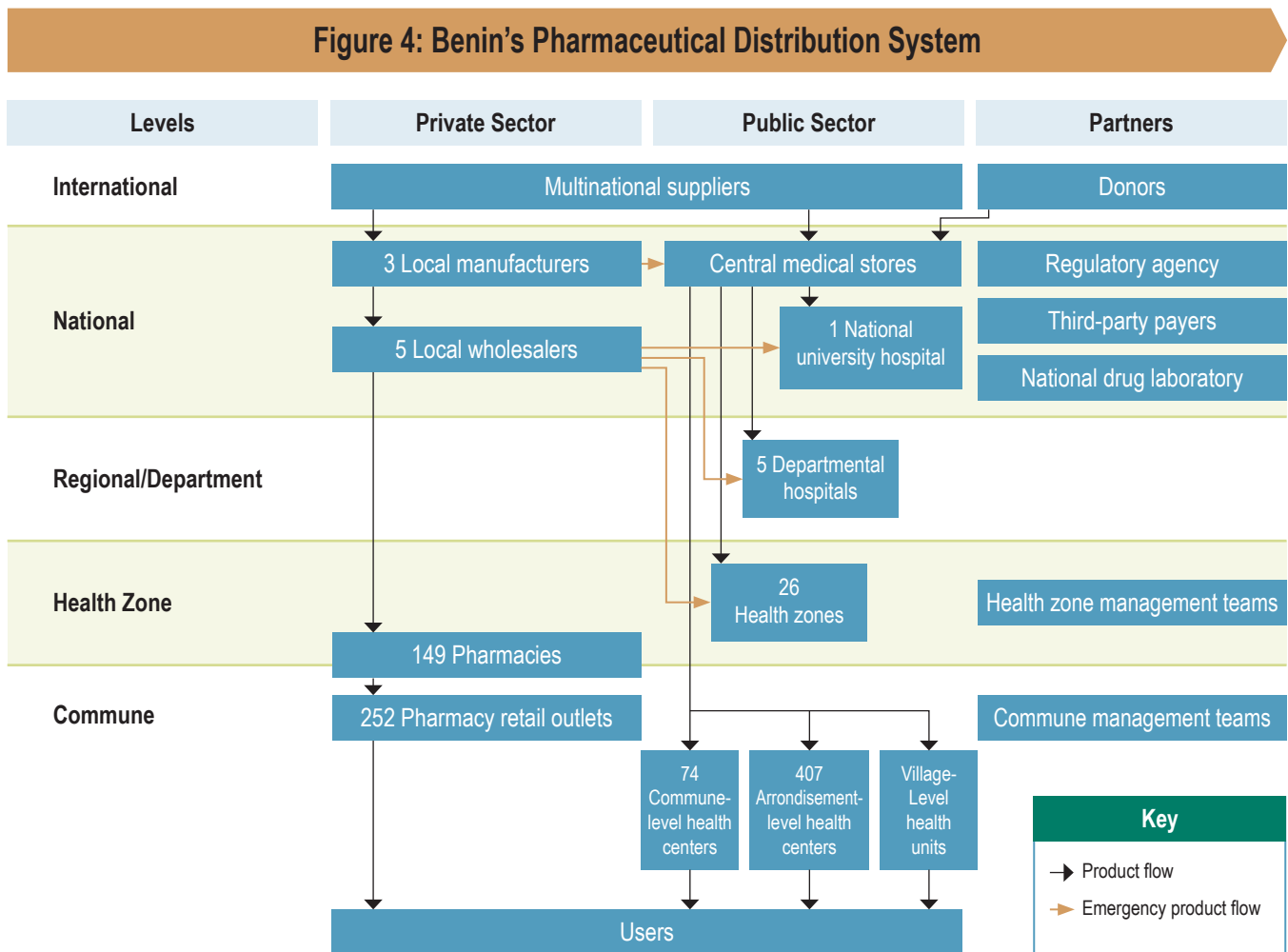
Andrea Dee Harris

Owners of a ProFam clinic in Porto Novo. ProFam has a network of 49 privately owned clinics that provide primary care, family planning and reproductive health, and maternal and child health services.

Pharmaceutical Products and Supply

A lack of pharmaceutical manufacturing capacity exists in Benin, other than informal production of traditional medicinal substances used in the unregulated traditional health care sub-economy (see Figure 4). Three domestic manufacturers are: Pharmaquick, which produces approximately 72 generic antibiotics and other essential medications in pill form; Bio-Benin, which produces infusion solutes; and SOPAB, which produces wound dressings for domestic consumption and for export (Health Systems 20/20, 2012). Virtually all modern family planning, maternal and child health, and antimalarial (and other specialty) pharmaceutical products are imported into Benin from other countries. As such, the efficient development of a robust health sector—both private and public—is heavily dependent on effective acquisition and distribution of imported medications and medical consumables and equipment.

Figure 4: Benin’s Pharmaceutical Distribution System



Source: Adeya et al., 2007

Every retail pharmacy is operated by a single, licensed professional pharmacist with one to over a dozen support staff. Retail pharmacies are required to carry all medicines on the central essential drugs list. Pharmacies located in urban areas tend to be well-stocked. Urban pharmacies vary in size and quality, from small storefronts with one or two employees to large supermarket-type facilities with computerized cataloging systems.

Many private clinics—both for-profit and nonprofit—operate dispensaries on their premises. Depending on the services the clinics offer, the dispensaries provide a broad range of medications, or a specialized subset of essential authorized medications. Choice of commodities to stock appears to be determined by the provider, owner, or management of the facility. The facilities also appear to be free to choose which wholesale supplier(s) they rely on for their stocks.

In distributing its Laafia line of family planning products, PSI/ABMS reports working with a network of semi-wholesale distributors and a large number of small drug seller outlets, which are mostly located in the country's many street market districts. Semi-wholesalers distribute bulk-packaged commodities (most notably a variety of brands of socially marketed male condoms, and to a lesser degree, oral contraceptive pills) to smaller retail establishments. These semi-wholesalers also sell directly to individual consumers who prefer to purchase in bulk. All observed semi-wholesale points adhered strictly to the recommended street price as suggested by PSI/ABMS; no variation from the recommended price points was observed during field visits.



Andrea Dee Harris

Outside the main central medical stores warehouse in Cotonou. The sign reads, "Generics are our craft!"

The central acquisition, warehousing, and distribution of central governmental medical supplies and consumables in Benin is carried out on behalf of the government by CAME, a private nonprofit agency. The CAME headquarters and central warehouse are located on the premises of the MOH in Cotonou. CAME also stocks and operates two major regional warehouses in Parakou (central region) and Natitingou (northern region).

CAME is responsible for a wide variety of functions related to the supply of pharmaceuticals and medical consumables, including:

- Issuing tenders for evaluation of public sector distribution and for government procurement of pharmaceutical commodities
- Managing warehousing and distribution points across the country for the central medical supplies
- Carrying out quality assurance activities for the central stocks warehouse and management
- Providing services to participating medical distribution points, including public sector health facilities and selected nonprofit facilities that have applied for (and received) membership in CAME

Each major public sector health facility operates a dispensary, where basic medications are available to clients and to the public. These dispensaries are stocked exclusively by CAME according to the prescribed monthly quantities of essential medications, as planned and authorized by the MOH.

Private pharmacies source the majority of their specialty products from a number of wholesale distribution outlets in Benin. They also are able to purchase generic medications from CAME. In all, four private wholesalers operate in the country today (GAPOB, UBEPHAR, GB-PHARM, MEDIPHARM).

Below are key challenges for the pharmaceutical sector:

Difficulties exist in ensuring a regular supply to pharmaceutical dispensary points in locations outside of the main metropolitan center of Cotonou. Following the restructuring of CAME and the opening of two regional CAME distribution hubs, the general availability of basic medicines and essential medical consumables is reported to have improved substantially. Occasional stock outages still occur, particularly in the rural areas, but most respondents reported them to be less frequent now than in the past.

Professional stove piping acts as a barrier to collaboration between pharmacists and other providers. The strict segregation of “professional identities” between pharmacists and the other professions (e.g., service providers) hinders the opportunity for creative engagement across these professional boundaries. Collaboration of pharmacies and clinics, such

as prioritizing changes in the national essential medicines list, can help bring about an expansion of private sector-led growth in effective and coordinated health care delivery.

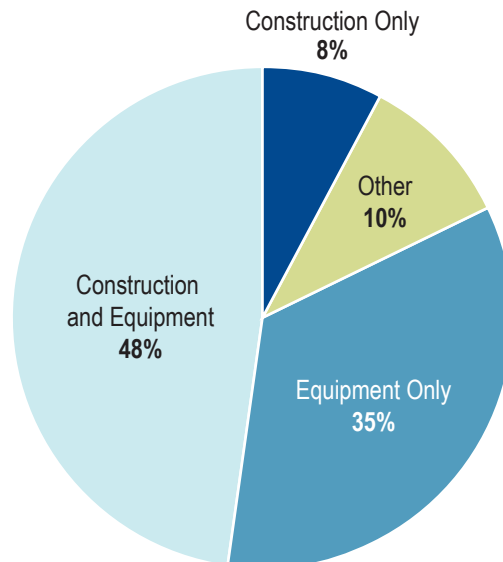
There is a dearth of trained supply chain managers. Pharmacist training is soundly established in Benin and curriculum reform is not a major issue, leading to an apparent abundance of trained pharmacists available in the Beninese labor market. There are, however, shortages of key specialized skills in the labor market. The most acute shortage of personnel relative to effective management of pharmaceutical supplies is the deficit of appropriately trained supply chain managers. No formal training exists for supply chain management today in Benin (Health Systems 20/20, 2012).

There is an incomplete comprehension of the value of market segmentation among public officials, which leads to limitations on consumer choice and sector growth.

Access to Finance

The need for financing is high among private providers in Benin. Nearly two-thirds of practices are in growth phases, characterized by ongoing construction or expansion, or acquisition of new equipment (see Figure 5). The majority of providers expressed a need for between \$20,000 and \$100,000 worth of financing. The current unmet demand is realistically at least \$16 million, or approximately 8 billion West Africa CFA (*Communauté Financière d'Afrique*) francs.

Figure 5. Provider Financing Needs



Source: Adeya et al., 2007

Note: N = 40, providers could select more than one financing need.

At present, there is practically no external financing available for new and early-stage private health businesses. Most existing businesses were started with financial help from friends and families. In some cases, doctors and nurses worked outside of Benin to gain professional experience and save the start-up capital necessary to open their own private practice within the country. Banks tend to loan only to larger facilities and well-established clinics and hospitals, especially those managed or owned by well-known doctors. Small and medium-sized enterprises in the private health sector are rarely considered for loans by banks or microfinance institutions.

Bank and microfinance institutions lending to the private health sector is sporadic and limited. Loans are usually provided only in the short and medium term, of no more than 5 to 10 years duration. The inability of banks and microfinance institutions to adequately assess and analyze their levels of lending to the private health sector poses a problem for future access to finance work with these institutions.

A lack of collateral, as well as poor management skills and a lack of business training, also severely limits borrowing ability for most private providers. Collateral constraints are exacerbated by a weak property rights regime: obtaining a clean and valid property title, which could be used as a loan guarantee, takes years, if it can be obtained at all. Major wholesalers are unwilling to guarantee loans for small and medium-sized providers. Furthermore, private providers do not have the business skills, particularly in record-keeping and financial accounting, and the majority of providers do not track or maintain reliable financial data, which lenders require for loans.

Table 4 summarizes the results of an analysis of the supply of financing for the private sector, taking into account provider size, duration of business, location, level of formalization, and provider type. As the table shows, the supply of credit for the sector is limited and only selectively available. The majority of pharmacists and higher-end, well-established clinics and hospitals can access bank financing if they desire, while smaller clinics and maternity homes, especially in the peri-urban and rural areas, appear to experience major difficulties accessing finance.

Table 4: Supply of Financing for Private Providers in Benin

Provider Characteristic	Private Health Providers Currently Served by Financial Institutions	Private Health Providers Not Served by Financial Institutions
Size	Larger facilities, some medium-sized and smaller providers	Smaller providers
Duration of business	Older, well established	Newer, still building business
Location	Urban areas, some peri-urban areas	Rural and peri-urban areas
Formalization	Registered and authorized to operate in the private sector	Informal, includes providers in the process of registration or awaiting authorization
Provider type	Pharmacists, high-end clinics, hospitals, larger/stronger members of the ProFam network	Individual medical practices, maternity homes

Source: Adeya et al., 2007

There is interest in a Development Credit Authority (DCA) guarantee through FECECAM (a microfinance institution) and Bank of Africa. A guarantee of close to \$7 million, or about 40 percent of the estimated current financing need, would provide a substantial boost to health sector lending while leaving room for other banks to enter the lending market.

Health Insurance

The growth of private sector provision of health insurance is constrained by the lack of purchasing power of most of the population, especially in rural areas. As a result, the proportion of the population covered by health insurance companies remains low (about 3 percent). It is expected that the establishment of the universal health coverage plan, otherwise known as *Régime d'Assurance Maladie Universelle* (RAMU), will greatly increase the financing available to private providers and create an opportunity to widen the market share of health insurance in the private sector. However, RAMU faces significant challenges:

- Lack of planning for its implementation
- Lack of coordination between all concerned ministries, especially with the Ministry of Finance
- Low involvement of the private health sector in the RAMU process
- No prospective actuarial study on health insurance packages and fee amounts
- Weakness of *mutuelles* (community-based health insurance pools) to implement the RAMU in the informal sector

From a private sector perspective, the challenges to RAMU are:

- A lengthy and bureaucratic accreditation and quality improvement process (especially for single provider clinics)
- Lack of clarity over how participants will be made eligible and how providers will know what coverage they are eligible for
- Cost of insurance mechanism, specifically issues with reimbursement and management of claims
- Lack of confidence in timing and transparency of public sector-managed payments

The development of community health insurance schemes as an entry point for the informal sector into the formal health system is far short of expectations. Community health insurance schemes currently cover only 5 percent of the population; there are about 200 schemes active in the country, as opposed to the MOH-projected 2,000 schemes by the year 2012. As mentioned above, the involvement of CHIs in the development of RAMU has been slight. The schemes, often implemented with the support of international development partners, do not appear to be working as a united group and are not recognized as a relevant actor in the conceptualization and implementation of universal health insurance. Nevertheless, these schemes offer an opportunity to reach the vast informal sector, and efforts should be made to expand them.

Providers' lack of business skills and capital, along with perceived corruption and inefficiency in government health clinics, limit the opportunity to develop the national health system. Several community health insurance schemes visited by SHOPS said their members had problems obtaining

services: services were available only at public facilities, where quality can be low, and where employees often expect and may demand out-of-pocket payments by insured patients in excess of their co-payment requirements. This discourages people's participation in the schemes. There is a need to strengthen government-sponsored, community-based health providers in the basics of universal health insurance in order to ensure the adequate provision of services and pricing.

There is an inadequate number of actuaries in general and a complete absence of actuaries trained in health care issues. None of the insurance companies visited by SHOPS has an actuary with a degree in actuarial sciences or a certification that meets international standards. This major weakness must be fixed before the RAMU system becomes operational. According to insurance companies interviewed, many of the recently proposed RAMU tariff packages are not realistic and are not based on actuarial calculations. The inability to provide objective evidence-based actuarial support for the system as a whole, and for RAMU, insurance regulators, and individual insurance providers, could undermine a national health insurance scheme from the outset.

RECOMMENDATIONS

There are five major recommendations from the private sector assessment, each with its own set of actionable sub-recommendations. Detailed information about the recommendations, including the agencies best positioned to implement them, can be found in the full assessment report.



Andrea Dee Harris

A community health worker (center) with a group of mothers and their children at a SHOPS family planning outreach activity in Cotonou.

Assessment Recommendations

1. Expand the formal sector by streamlining registration and licensing processes for businesses and supporting provider networks.

- Initiate a policy dialogue with the MOH to streamline the registration process and improve compliance with and enforcement of officially set time limitations on the review process. The creation of a one-stop shop approach, where providers can take care of all aspects of business registration and licensing, could be part of the solution.
- Provide amnesty for current qualified but unregistered informal providers/facilities. This is necessary to encourage existing facilities to submit an application for registration, especially as it pertains to future growth of the ProFam network.
- Support a mechanism to identify and encourage providers to become registered. Give technical assistance to an organization, such as ABMS, that has a vested interest in the formal health sector to take on this role. Ensure that formal registration qualifies a provider to participate in RAMU.
- Remove barriers in order to convert private sector clinics into high-volume, high-quality, low unit cost facilities. Start and maintain a dialogue with the MOH and professional orders to relax the constraints on marketing and promotion of health services, deregulate prices so that they are more market-based, and develop a package of incentives to promote group practices and provider networks.
- Strengthen the family planning program in the AMCES network. Link AMCES to ABMS and other family planning supply actors to increase the volume of family planning products at their health centers and hospitals, where such products are allowed, and strengthen family planning counseling programs and referrals to emphasize informed choice.
- Improve the financial sustainability of ABPF through targeted assessments. Following on Engender Health's technical assistance to ABPF, support development of a strategic plan, an investment plan, and business plans aimed at reducing financial vulnerability of the organization while preserving its social mission.

2. Strengthen the role of the private health sector at the national policy level and through advocacy groups.

- Identify a high-profile private sector "champion" and an MOH counterpart to organize and coordinate regular dialogue meetings between the MOH and private sector stakeholders.
- Strengthen the advocacy capacity of the professional orders to participate in health systems strengthening efforts of the MOH. Provide technical assistance to orders to strengthen strategic plans, coordination, their role as a secretariat to members, and organization of training and other benefits for members.

- Work with thought leaders in the professional orders to separate and clarify regulatory roles from business interests of members to avoid inherent conflicts of interest, especially within the Order of Pharmacists and Order of Physicians.
- Improve private providers' understanding of government standards and of provider rights surrounding enforcement of time frames for facility and product registration review. Support an association or NGO to educate providers about these rights and responsibilities.
- Assess the feasibility of setting up an independent, NGO-led quality standards and quality assurance system in private sector facilities. Strengthen the role of supervision of quality assurance systems and compliance with standards as part of a certification system. Consider support (in the longer term) for the creation of a self-regulating grading system for private providers.
- Provide technical assistance to ROBS to help develop a thorough sustainability assessment and strategic plan.
- Support CEBAC-STP with targeted technical assistance to integrate family planning services into existing workplace clinics. Create a strategic plan aimed at inclusion of workplace clinics in the ProFam network.
- Include the Association of Private Clinics in any policy dialogues aimed at streamlining the health facility registration process or establishing quality assurance systems and public-private partnerships in support of priority programs, especially family planning and reproductive health.

3. Streamline registration and licensing processes, and business operations for pharmaceutical businesses and products.

- Enforce timely and rational review of pharmaceutical product registration through technical assistance to the MOH. Ease restrictive limitations on the level of product competition, which significantly hampers private sector engagement and end-user choice of products.
- Advocate with the MOH to eliminate conflicts of interest associated with the quasi-regulatory role(s) of Orders of Pharmacists, Midwives, and Physicians, by separating regulatory function(s) in product and facility registration review from other (client-oriented) functions.
- Conduct an in-depth study of pharmaceutical product flows to eliminate inefficiencies. Simplify and harmonize pharmaceutical flow through the supply chain.
- Deliver technical assistance to the *Commission Technique des Medicaments*, or the National Commission on Medicines, to evaluate current government-set pharmaceutical margins and their effect on private wholesalers, ensuring that wholesalers are not inadvertently squeezed by changing fixed costs and exchange

rate fluctuations. Support the commission in conducting quarterly reviews of pricing throughout the supply chain.

- Provide technical assistance to ABMS, CAME, and other wholesalers and retailers on market-based pricing and costing.
- Design and implement targeted training to increase the capabilities of supply chain managers in the labor force. This is a promising arena for promoting public-private partnerships with international industry leaders.
- Create incentives for private pharmaceutical providers to collaborate with other health professionals to provide improved consumer access to pharmaceuticals in remote areas of the country. This could include jointly managed facilities or outreach activities in underserved locations; operating branch dispensaries within faith-based or public health care facilities, or promoting collaboration between pharmacists and providers on stock estimation to avoid stock availability issues.

4. Improve access to finance and the business capacity of providers.

- Design access to finance programs with banks and microfinance institutions to strategically provide an incentive for business formalization. Stimulate a more desired mix of health providers by carefully channeling targeted and supervised loans to the types of providers that would advance health outcomes in the priority geographic areas of the country.
- Provide technical assistance to EcoBank's DCA borrowers receiving funds under the USAID guarantee. This could be structured as pre-borrowing assistance as well as post-borrowing assistance for the funded clinics.
- Arrange two lines of additional credit for private health sector providers with Bank of Africa and FECECAM, in order to provide longer-term funding to smaller providers in rural and peri-urban areas.
- Strengthen business capacity by launching business management trainings and by providing direct technical assistance to increase management capacity of private providers, including developing strategies and business plans, mentoring and coaching senior managers, and facilitating access to finance.

5. Foster the growth of private sector health financing mechanisms (health insurance).

- Support the development of RAMU and its mechanisms, and in particular ensure that private sector providers are taken into consideration. Support a private sector working group that would serve as an advisory body to the government and RAMU, and would serve as a unified voice of the private sector. Provide technical resources to develop evidence-based arguments supporting the terms and conditions of the private sector participation in RAMU.
- Build the capacity of mutuelles by supporting national-level efforts focused on networking and professionalization. Streamline the process of establishing and operating local mutuelles by developing uniform policies, procedures, and documentation; a centralized operational platform for data processing and management; and assisting with the marketing and promotion of insurance among low-income populations. Support the creation of regional unions of mutuelles, which would be responsible for starting new mutuelles and supporting existing ones.
- Support the provision of actuarial expertise to the national health insurance agency (ANAM) to underwrite evidence-based and appropriately priced coverage packages for the formal and informal sectors. Facilitate this process by engaging Actuaries without Borders and similar organizations.

CONCLUSION

The Benin private sector assessment carried out by SHOPS provides multiple recommendations for strengthening the country's private health sector. These include growing the formal private sector by streamlining registration and licensing processes for businesses and supporting provider networks; strengthening the role of the private sector at the national policy level and through advocacy groups; streamlining registration and licensing processes for pharmaceutical businesses and products; improving access to finance and business capacity of providers; and fostering the growth of private sector health financing mechanisms (health insurance). The government of Benin and its development partners, including USAID, can use these recommendations to increase participation of the private sector in health policy and regulation, as well as strengthen the sector's health service and product provision. While the private sector is growing rapidly in Benin, bureaucratic hurdles from the pre-1997 era (before private medical practice was legalized) remain, providing disincentives for formal registration of private businesses and fueling the growth of the informal sector. The MOH would benefit from working with donors to find ways to ease the onerous regulations and recognize the private health sector's potential to be a key partner in providing needed health care services to the people of Benin.

This brief outlines many of the steps that the government and MOH, and their stakeholders and partners need to take to enable the private sector in Benin to play a larger, strengthened role in the health system. These steps include initiating policy dialogues with the MOH; removing obstacles to private sector clinics being high-volume, high-quality, low unit cost facilities; strengthening the family planning programs of nongovernmental organizations, including faith-based ones; building advocacy capacity of the provider associations; clarifying regulatory roles from service provision roles of associations; setting up quality standards and quality assurance systems; and using access to finance as an incentive. However, these recommendations must be considered in the context of an impoverished country with low demand for private sector health services. Strengthening and growing the private health sector needs to occur alongside economic development and poverty reduction throughout the country.

The goal of the assessment and its recommendations is to build a stronger, more relevant, and less constricted private health sector in Benin. The country's traditional focus on the public sector, combined with the current low demand for private sector services will ultimately determine the interventions to be used to improve health indicators in the most efficient and appropriate ways. Private providers, health and non-health sector businessmen and women, and directors of associations and organizations—all with a stake in Benin's health sector—have professed their desire and readiness to see a vibrant and well-supported private health sector. The findings and recommendations of this assessment are a good starting place for understanding and strengthening the sector, and improving health outcomes in Benin.

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BRIEF

Benin Private Health Sector Assessment

For more information about the SHOPS project, visit: www.shopsproject.org



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