Private medical practice in Benin: dynamics of a growing sector

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1. Introduction

In Benin, as in many African countries, the establishment of structural adjustment programmes in the mid 1980s required the Benin Government to limit recruitment to the public sector. Whereas previously all doctors were automatically employed by the State, from 1987 onwards, many of them were without a job. In the context of economic and political liberalisation, these doctors turned therefore to the private sector. Since then, the private healthcare sector has progressively developed, in the absence of any legislative framework, through the establishment of formal and informal healthcare centres and private clinics.

The aim of this paper is to focus on the development of private medical practice in Benin, from the perspective of Beninese doctors. Initially, the paper will take an historical look at the development of private medical practice in Benin and Government responses to this phenomenon. Secondly, it will look how Beninese doctors in this private medical sector enter the labour market, through examining the practices and strategies which they use to find a place in this highly competitive market.

2. Methodology

This paper is based on three field studies conducted in Benin between March 2009 and April 2011, in Cotonou, the economic capital, and in the department of Atacora, a rural region in the north of the country. The paper primarily looks at around fifty qualitative interviews conducted with Beninese doctors working the private and public sectors. It also relies upon observations carried out in different types of private healthcare settings: a religious hospital in a rural area, and one general medical and surgical clinic, one specialised clinic, one religious hospital and one medical practice in urban areas. Finally, the paper is also based upon interviews conducted with representatives of different professional organisations (the Order of Doctors, professional and trades union organisations) and public health policy officials in the Ministry for Health, as well as upon grey literature from relevant institutions.

3. The development of private medical practice in Benin: an historical perspective

3.1. *The introduction of modern medicine to Dahomey*

Although healthcare had never previously been systematically organised in French West Africa and more specifically in Dahomey, the construction of a healthcare system became an objective of the colonial power from the end of the 19th Century. The foundations of the healthcare system were put into place by colonial doctors, who had been involved in colonising the territory. They established a

highly hierarchical and centralised structure, similar to the French administrative model of the time (Berche, 1998). Initially, this primarily consisted of individual, curative medicine, mirroring the European system, based on healthcare staff working within medical centres in the major towns, where French doctors delivered care free of charge.[1] At the end of the 1930s, mobile health teams[2] were added to the system (Bado, 1996). Mass medicine thus gradually took the place of individual medicine, with a focus upon prevention.

Other than these initial colonial health infrastructures, the country had only a few small private clinics, most often religious ones. However, the role of the missions in managing healthcare remained limited because of the secular nature of the French State. Generally speaking, private medical practice was small and limited to areas where colonisers were concentrated (Van Dormael, 1997).

During the first two decades of the colonial period, only a few Dahomean nurses were trained on the job by the colonial doctors and a few "indigenous auxiliary nurses" operating as healthcare workers. It was only in 1918 that the first Dahomean auxiliary nurses were trained in medicine, chemistry and obstetrics at the African School of Medicine and Pharmacy in Dakar, in order to support colonial doctors and health professionals.

3.2. The first years of independence: an insignificant private medical sector

The healthcare system inherited from the French administration was retained upon independence of the Republic of Dahomey in 1960. The new State thus opted for a public medical sector and retained the principle of free healthcare introduced during the colonial period. However, although it faced a very concerning health situation, the Republic of Dahomey was poorly equipped in terms of healthcare infrastructure. The very large majority of this was in the public sector. Thus, at the start of the 1960s, there were two hospitals in Dahomey and 126 public medical facilities, compared to only one private hospital and seven private clinics (Assogba, 1964). These structures were unevenly distributed across the region, with rural zones being largely lacking in facilities. Moreover, there was a serious lack of healthcare professionals, the young country having only a handful of Dahomean doctors,[3] all trained abroad.[4]

[1] This mechanism was called Indigenous Medical Assistance (*Assistance Médicale Indigène*, AMI) programme, established from 1905 and driven by General Roume (Bado, 1996; Berche, 1998).

[2] This was the General Service of Mobile Hygiene and Prophylaxis (*Service Générale de l'Hygiène Mobile et de Prophylaxie* (SGHMP))(Bado, 1996; Berche, 1998).

[3] It is estimated thus that the ratio of doctors to inhabitants was 1:28,000. Moreover, it appears that even this estimate is optimistic, as around 10% of doctors were actually involved in administrative tasks and performed practically no clinical medicine. In addition, 30% of doctors practiced in the city of Cotonou (Assogba, 1964).

[4] The Department for Medical and Paramedical Studies (which was to later become the Faculty of Health Sciences (*Faculté des Sciences de la Santé*, (FSS)), was created at the University of Dahomey in 1970. The first intake of Dahomean doctors graduated in 1977.

3.3. Unemployed doctors

At the start of the 1980s, Benin still only had a few private healthcare centres in addition to the public healthcare system: on the one hand these were religious structures essentially based in rural areas and on the other a few private clinics and practices in urban areas, launched by "pioneering" independent doctors. However, in the context of the economic crisis of the 1980s, the Government ran into growing difficulties in terms of funding an inadequate healthcare system. While health represented around 9% of the Government budget in the 1970s, this reduced by half in less than ten years.[5] In reality, the Government's contribution to funding the health sector was practically limited to paying the salaries of public sector employees, and participating in a few other current expenditures (Brunet-Jailly, 1992).

At the same time, the establishment of the first structural adjustment plans required the Beninese government to strongly limit recruitment into the public sector, including into the health sector. Whereas previously all doctors were automatically employed by the State, from 1987 onwards many of them were without a job. They were thus forced to open private clinics and practices.

> *"During out studies, we realised that there were problems in terms of employment, because previously, when you finished your studies you were directly employed in the public sector, you were guaranteed a job and you didn't have to worry about finding one. But the public sector had become very clogged up, to the point that the State no longer systematically recruited doctors upon graduation. So at that point, we began to see what our future might be like." (Dr S, graduate of the FSS in 1988).*

3.4. Liberalisation of medical practice

After twenty years of a Marxist-Leninist regime, the political and economic climate was conducive to the development of private initiatives and the medical sector slowly opened up to the privatisation of a new market (Boidin, 1996). But this liberalisation of the profession took place without any planning and outside any legislative framework (Boidin & Savina, 1996). Moreover, entry into the market took place without any professional supervision, the Order of Doctors which had been created in the 1970s having been rapidly dissolved. Thus, there were no institutional barriers to determine the shape which private medical practice would take, favouring the development of a significant number of informal structures. Doctors, like other healthcare workers, set up private clinics and practices without any checks being made on the infrastructure or workers' qualifications, leading to sometimes vast differences in terms of skills, deontology and quality of care.

> *"We waited for them to recruit us. One day the Minister said to us "the State has no more money, go and sort yourselves out!" Everyone looked out for themselves. Opening a practice required no authorisation, so everyone did what they could to get through it." (Dr. A, graduate of the FSS in 1987).*

Moreover, these new graduates were not prepared for private practice. Trained in a university hospital environment to work in the public sector, they found themselves in the private sector with no skills in terms of managing a private centre, as this doctor testifies:

[5] The proportion of the State budget allocated to the health sector was thus 9.31% in 1976, 4.31% in 1984 and 3.22% in 1992 (Boidin & Savina, 1996; Ministry for Public Health, 1982 and 1985).

"1986 was the year that our Government stopped recruiting anyone to the public sector. (...) So when we graduated, we opened clinics but we had no training in how to manage them. We had not been trained in managing medical practices. But because our degree was a professional degree, we were obliged to throw ourselves in at the deep end." (Dr. B, graduate of the FSS in 1986).

Of this first generation of doctors in the private sector, some found it difficult to make a name for themselves, while others were quick to build up a patient list. However, people were used to having free healthcare and during their first few years of practice these young practitioners often encountered difficulties getting their services paid for.

3.5. An attempt to regulate medical practice

It was as late as 1997 that the first measures to support and regulate the sector were established, with Law no. 97-020, which lay down the conditions for private practice for medical and paramedical professions. From this point onwards, Beninese doctors had to follow a highly regulated procedure to obtain the right to practice in the private sector, either fully or partially, and had to submit a request for the right to open a healthcare establishment[6].

"It is tolerated. It's not authorised, the law doesn't allow it but ... nobody says anything. Everyone knows, and everyone keeps quiet about it. There we go. We don't have the strength to go against the grain. We say we do but ... there we go. It's too difficult." (Dr. J, Director of a private clinic in Cotonou)

However, although doctors working in the public sector do not legally have the right to work in the private sector, this practice is extremely common. A not insignificant number of doctors, and all other kinds of healthcare professionals, exercise in the private sector without authorisation[7] (Adeya *et al.*, 2007). Establishing regulation has not, thus far, prevented the proliferation of a large number of informal structures, leading to parallel and even illicit activities (Decaillet & May, 2000). The fluid nature of the legal texts and the gaps in them as well as the personal issues around these questions explain why, at least partly, there is such a lack of control over the private healthcare sector.

"The Order of Doctors can't go to the police, as the law doesn't allow them to and we don't have any strength either. It is the Ministry which is informed about the situation and it can then have the power to close down these centres. However there is a fairly troubling situation at Ministry level in terms of when they are asked to write a text defining the procedures for closing down these centres, because these same people are also advisors all over the place, nothing definitive has been done to date. Who will close down a centre? The Ministry? The Commission? Who? These are the questions which have been asked, and because we still don't have a very pedagogical justice system, free from corruption, money rules everything at the moment. (A manager for the Order of Doctors.)

[6] Law no. 997-020 was subsequently supplemented with several decrees and orders, including Order no. 2723/MSP/DC/SGM/DNPS in 1999, relating to the creation and appointment of members of the technical committee responsible for studying applications for authorisation to enter into private practice and the opening of healthcare establishments for medical and paramedical practices, and Decree N° 2000-449 of 11 September 2000 on setting the conditions for private practice for medical and paramedical professions and relating to the methods of opening private healthcare establishments.

[7] The Adeya et al. study (2007) shows that in 2005, only 12% of private healthcare centres had Ministerial authorisation.

4. Entering the private medical sector labour market

Despite the fact that most Beninese doctors prefer to work in the public sector, mainly because of job security and prospects for promotion, recruitment to the public sector remains limited. Although the State re-launched the recruitment of health workers in 1998 (Decaillet & May, 2000), this was interrupted once more in 2008, and currently no one can say when it will start again. The last three intakes of doctors will thus have to wait for the next public sector recruitment exercise, without any further information. In this context, Beninese doctors choosing to work in their country largely turn towards the private medical sector. Generally speaking, this is the preferred market for doctors wishing to practice in urban areas.

4.1. Context of private medical practice

A heterogeneous urban market

The "explosive" development of the private healthcare sector has led to what is today a very heterogeneous market,[8] with a wide variety of healthcare workers (Decaillet & May, 2000). Within the sector, private medical facilities[9] can be divided into two main types: on the one hand independent structures, including profit-making medical practices, clinics and hospitals and, on the other hand, non-profit making healthcare facilities, including religious centres and NGO structures.[10] This private medical sector attracts a significant number of doctors: thus, according to a Ministry of Health study, the private sector includes 982 doctors in the communes of Cotonou, Porto-Novo and Abomey-Calavi alone (MS, 2009).

Nevertheless, these private medical facilities are very unevenly distributed across the Benin territory, being mainly concentrated in urban areas. Thus, 75% of private healthcare centres, including all categories, are situated in the Atlantic department in the south of the country, where only 22% of the population of the country live, and 60% are based in Cotonou, which accounts for 15% of the national population (Décaillet & May, 2000). This is explained by the desire of most doctors to live in urban areas, but also by the rarity of solvent demand for medical care in rural areas.

Medical services and patient lists

Generally speaking, the independent sector concentrates on basic curative activities, while the public sector takes on preventative and promotional activities, and basic curative services. Patient lists change depending on the type of structures. In the profit-making private sector, consultations cost

[8] In their study of the private medical sector in Cotonou, Decaillet and May (2000) distinguish no less than 14 categories of private healthcare centres.

[9] The term 'private medical facility' is understood to include private healthcare centres offering doctors' services, as opposed to structures which only deliver paramedical care.

[10] A Ministry of Health study indicated that in 2009 the independent private sub-sector in Cotonou consisted of to 60.5% private medical structures, as opposed to 3.1% religious structures and 34.5% health centres with NGO status (MSP, 2009).

up to 5,000 FCFA for a general practitioner and up to 8,000 FCFA for a specialist,[11] while in religious centres they go up to 1,000 FCFA and 3,000 FCFA respectively.[12]

Despite the cost of medical services, some doctors in private practice note changes in their patients. While the private profit-making sector was previously reserved for the wealthiest parts of the population, some of the people are now expressing a demand for better quality care. Expressing their dissatisfaction with care delivered in public hospital settings, these patients say they are ready to pay more for a better relationship with their doctor.

> *"Today, it is not only wealthier patients who go into the private sector, because people want a certain level of quality. They prefer to pay 8,000 francs and to have a high quality service, rather than to pay 2 or 3,000 francs and after a month not have the results they had expected. So today, people decide to come in order to reduce the length of their illness. (Dr M., specialist doctor, employed in private practice)*

For the past few years, an increase in agreements between private healthcare structures and insurance companies and private companies on the other hand has been noted. Thus the proportion of patients covered by insurance may be significant for private structures, some reaching up to 80% of their clientele. Doctors often apply much higher tariffs for illnesses which are covered by insurance, in order to cover the administrative costs entailed.[13]

Doctors' incomes

Beninese doctors generally consider their income to be insufficient in relation to their qualifications, their responsibilities and the services they provide. The private sector has long had the reputation for being better paid than the public sector. However, while private independent structures remain profitable for doctors who have been self-employed for several years, this is not always the case for young doctors employed within these private structures. Since 2010, public sector doctors have benefited from various bonuses in addition to their salaries.[14] This has led to private sector remuneration losing some of its attraction. Now the private sector is finding it difficult to compete with public hospitals.

> *"I think doctors who work in the private sector are not well paid. (...) I am here as a replacement, and it makes me just about 140,000 per month. Normally a general doctor gets between 150,000 and 200-250,000 per month. There are no other perks. A good salary would be a minimum of 400,000 francs!" (Dr V. general practitioner, graduated in January 2010, employed full-time in a private clinic).*

Doctors' salaries vary from one structure to the next. Most often, it is the wealth of the patients and the price of the services which determines the salary of practitioners. In terms of religious structures,

[11] These amounts correspond to the official tariffs set by the Beninese Association of Private Clinics, which are adhered to by the majority of doctors in private practice.

[12] By means of comparison, in a communal public healthcare centre in Cotonou, consultation with a doctor costs 500 FCFA.

[13] In private independent structures, consultation with a specialist generally costs up to 10,000 FCFA for insured patients.

[14] In the public sector, the basic salary for a general practitioner, and for a specialist doctor, is 132,333 FCFA (Codo *et al.*, 2009). Specialists receive a specialisation bonus representing 30% of their basic salary. Moreover, hospital doctors of all categories, now receive a bonus, 100,000FCFA.

AMCES[15] sets a shared salary grid for all member healthcare centres[16], ranging from 151,368 FCFA per month for a newly employed doctor and rising to 317,873 FCFA per month for a doctor at the end of his or her career[17]. Within private clinics, doctors are paid either according to a monthly fixed salary (on average between 130,000 and 200,000 FCFA for a young graduate), or as a *pro rata* of services provided (generally implemented in structures with few patients). As for specialist doctors undertaking consultations in private clinics, they generally pay the clinic a percentage of the amount of services provided (often around 25-30%).

4.2. Doctors' strategies in the private sector

Because the private healthcare market is highly diversified, different options are available to doctors, such as establishing themselves in the private sector either on their own or with colleagues, working as an employee in one of the many healthcare structures, replacing a doctor who is on training, or working in a combination of structures at the same time.

Starting out in the private medical world

Taking account of the low recruitment rate for the public sector and the constraints of setting up in private business, young doctors starting their professional careers very often look for employment with private structures. They prefer lucrative private clinics to the religious hospitals or NGO-type health centres. There are different reasons for this.

For young generalist doctors, this includes above all the need to save money in order to be able to specialise. Some doctors without a government grant or a technical or financial partner, and in the absence of family money, decide to work for a few years in a private institution in order to save the required amount of money to fund their specialisation. Moreover, access to some specialities, in particular in the field of public health, requires hands-on work for at least two years, which these young doctors acquire within private institutions.

Others wish to get the hang of working as a generalist doctor before specialising. In this way, practising general medicine for a few years allows them to acquire a certain level of experience and to build upon their knowledge. For these young doctors whose training was based on public hospitals, working in the private sector is an opportunity to discover other realities of the profession, to acquire new skills with experienced doctors and to learn techniques which they had never had the chance to use during their training.

> *"Well, I'd heard talk about this religious hospital, I learned that they did good things here. Because I want to specialise in surgery, I wanted to do a bit of general work before specialising. This allowed me also to take a break in my life, to reflect a little, to stop and think a bit before getting stuck back into*

[15] The AMCES, the association for private and social medical professions in Benin is open to everyone working in the private, non-profit-making health sector.
[16] This salary grid is not legally enforceable however and organisations which are members of AMCES remain free to adjust their salaries.
[17] This equates to around 230€ per month for a young doctor and around 490€ per month after 20 years in the job.

the university system. Have a break before continuing. (Dr V. general practitioner, graduated in December 2010, employed full-time in a religious hospital).

When an opportunity to specialise arises, they will quickly leave the private institution to go and study. This habit which young doctors have thus involves a significant turn-over of generalist doctors in private clinics, which some clinic managers complain about.

For specialist doctors, working with a private clinic or hospital or a religious hospital is often a step which is taken prior to setting up in private practice. It constitutes some time to save a sufficient amount of money and to gain a little experience. Another argument in favour of the private sector is the need to have the required equipment for the practice. While the public sector can experience a lack of medical equipment, the private sector is generally adequately equipped.

"It has to be said that I'd long thought about private practice and had it all planned out more or less before I'd finished studying (...) Throughout my training I always had the impression that a doctor was like a person who had nothing, no baggage, but who could care for people, but in reality ... you need equipment! Too often it is insufficient and isn't always available. Psychologically, this is hard to handle! When you are there, every day you see children who come to you and who die. So I said to myself there was no way I would work in the public sector where you have no control over this, you can't organise things for yourself, you can't plan your own equipment, while in the private sector you are better placed to establish the working conditions which you want. (Dr C., specialist doctor since 2009, working in a private clinic)

The challenges of setting up in private practice

When Beninese doctors decide to setting up in private practice, they often favour small individual surgeries rather than group surgeries or clinics with other doctors. Nevertheless, there are two main obstacles to setting up in private practice, in particular for young practitioners: the financial costs on one hand, and building up a client base on the other.

Financing your own premises (renting premises, buying furniture and medical equipment, paying paramedical staff salaries ...) is a major undertaking. Banks, which are not keen on funding young doctors' projects, generally don't make loans to them. Faced with the difficulty of obtaining a bank loan, doctors who want to open their own practice have to find other sources of funding. In most cases they turn to their families, as this young specialist doctor who set up in private practice a few months ago testifies:

"It's quite hard at the beginning. Setting yourself up when you haven't got any financial savings ... I haven't had a salary yet. I'm not losing money, but I still can't afford to give myself a salary. And I won't have one for six months or a year, however long it takes to build up my patient list. I manage thanks to my parents, otherwise I wouldn't be able to manage. I tried to get a loan but they said that no bank would fund a start-up. So imagine, thankfully I had my parents who were ready to support me, otherwise it wouldn't have been possible. I am a travelling cardiologist. (Dr A., specialist doctor since 2008, working in a private clinic)

Another strategy consists of working for several years abroad, in a developed country, in order to save and then return to Benin to open their own practices. This opportunity is mostly open to specialist doctors or those who are specialising and go abroad for their degree. Nevertheless, returning to set up in private practice after having studied or worked for several years abroad is not

easy. As well as having to make a name for oneself, there is a need to re-adapt to the context of employment in Benin, which is very different to that in developed countries.

Despite these financial difficulties, Beninese doctors still tend to set themselves up "independently". As well as the aspiration for independence and "to be your own boss", the option of working with colleagues worries many doctors, mainly out of the fear of misappropriation of funds or of patients. Unfortunate experiences of some clinics back up doctors' fears, to the point of discouraging those who would like to try it.

> *"Let's just say that it's quite unusual, because most often everyone has their own surgery (...) but it's only in the big clinics that people work together. Otherwise people prefer to work alone because there is not yet a climate of confidence between the different partners. Everyone has the feeling that the other one will steal their money or their patients. So there are very, very, very few partnerships in the town of Cotonou." (Dr. PR., working both in a public hospital and in a partnership clinic)*

However, for the past few years, some doctors have seen several advantages of working in a clinic with colleagues in the same specialisation or in a private hospital with other types of specialisation. Sharing resources, continuity of care, the ability to take time off, sharing duty rosters, and timekeeping flexibility are all arguments in favour of practitioners working together. The difficulty consists in maintaining a healthy partnership.

> *"The benefits of working in a clinic are above all that there is continuity of care, because in this clinic there are at least five gynaecologists, so if you aren't available there is always a gynaecologist who can take patients on. (...) And in general in private practice you don't hold consultations (...) But the fact of working in a clinic allows you to provide all services, consultations as well as child birth and surgical activities. (Dr. PE, working in a clinic in partnership with other doctors).*

Medical students and young graduates also show a desire to develop private structures in partnership. Besides sharing costs, the main motivation in opting for grouping together is that it allows bigger infrastructures to be established, offering a wider range of care, thus able to attract patients and get a foothold in what is a highly competitive market.

In effect, building up a patient list takes time, in particular in a highly competitive market. The intensive development of medical facilities in Cotonou now makes it more complex to set up in private practice. Thus, a number of doctors stress the difficulty of opening up a private surgery or clinic in the country's economic capital, because of this acute competition. While more experienced doctors can avoid this obstacle more easily because of their experience and the fact that patients know them, the same doesn't hold for newly graduated doctors who have to make a name and a niche for themselves. For these young practitioners, the first few years are often laborious until they have made their name.

> *"Nowadays when a specialist doctor graduates with a view to setting themselves up, they have at least two years of hell ahead of them! When nobody knows who you are, they're not going to bring their child to see you! (...) People prefer to go to see someone who has already made a name for themselves in town. They are experienced, and no-one's going to do the young one any favours!" (Dr. AL, specialist doctor, employed in two private clinics)*

Composite medical practice

As has been seen, it is not easy in Benin to start up a career as a doctor, either as a specialist or a generalist, and to work in a single private structure. Most often, they arrange their working hours in several clinics, or supplement a full time post in one infrastructure by carrying out duty rotas in other health centres, or consultations in private practices.[18] Until they can live exclusively off their own clientele, some practitioners (mainly specialists) continue to undertake consultations with patients from other clinics.

> *"I am here for two days a week, and one weekend in four (because we share the weekends between four of us), and every second Tuesday. (...) I'm here Mondays and Fridays. The rest of the time I work elsewhere. On Wednesdays, for example, from time to time I go a clinic in Porto-Novo (...) Otherwise I also have a gynaecologist with whom I work too. (...) I go there on Thursdays, I see the newborns, and sometimes follow-up with those who have problems. That's all, that's how I manage my week. (Dr F., specialist doctor, graduated in October 2010)*

Thus, working conditions are sometimes arduous for some doctors who stretch themselves between different jobs and duty rotas in different private facilities in order to make extra money. In addition, employment contracts can, in some cases, be precarious, mainly for young practitioners working duty rotas in informal structures where they are not always working legally or paid appropriately.

Working in two places, public and private

Although the law forbids[19] simultaneously working in private practice alongside work in the public sector, it is currently tolerated. Working for the state remains an attractive option for practitioners, the vast majority of public sector doctors also work in the private sector. The main reasons for doing so are financial. Many doctors are subject to strong pressure from their families, and see themselves as "forced" to look for other sources of income.

> *"Yes, I work in a gynaecological consultation practice. So, outside opening hours I am there, and on Saturdays I also work there. And if I finish work, I'll go there to undertake consultations. But I do that because I have to, not because it's fun! It's because my costs are huge! (...) But I have lots of children, I have three. That's not a problem. But I also have lots of nephews, nieces, and cousins whom I put up, for whom I have rented accommodation in houses to go to university. That means that if I had to live on my salary alone, I could never manage. (...) conditions are such that if you don't do that, you'll never make ends meet." (Dr. AO., working both in a public hospital and in a private clinic)*

Clinical doctors in the private sector complain about what they often call "disloyal" competition with these small surgeries, because the fact that they are unauthorised means they don't pay taxes and they accuse them of draining patients from the public sector towards private practice. From their point of view, the fact that the Ministry of Health and the Order of Doctors prefer to ignore these illegal practices means that the problems in the private sector get even worse.

[18] It should be noted that some religious hospitals forbid their medical staff, in their employment contracts, from working with private clients, or from practising within a certain radius around the healthcare facility.
[19] It should be noted, however, that the National University Hospital Centre authorises qualified professors to take on a few hours of private consultation in the hospital.

"You have those people who have no regular training, but because they did a short internship with a midwife, they are going to open a birthing clinic. You have nurses setting themselves up and opening surgeries when they don't have the right to do so. I think it is unreasonable not to resolve these questions and to go and attack doctors who are skilled, who are trained and to close down their surgeries just because they don't have the right authorisation. There are better things to do, that's what I always say. They aren't the danger, the danger is elsewhere. (A manager for the Order of Doctors.)

Finally, another form of collaboration between the private and the public consists of sending patients to doctors exclusively working in the private sector, to carry out examinations for which the public hospital does not have the necessary equipment, or because the equipment is broken or the public sector are on strike. Some forms of collaboration also exist between doctors working in the private sector, to rent out rare or expensive equipment or to organise for replacements in the event of absence.

Conclusion

In the context of the Beninese Government disengaging from the healthcare sector, over the last twenty years the private medical market has enabled medical graduates to set themselves up professionally in their country. In this sense, the development of the private sector has limited the well established process of emigration of Beninese doctors. However, the unplanned development of private medical practice has increased the gaps between urban and rural areas. While previously young doctors were "forced" to work in rural areas when they graduated, the private sector enables them to set up immediately in urban areas, mainly in Cotonou, leaving rural areas with vacant doctors' posts.

Today, the increased competition between the country's main urban centres pushes young doctors to develop new ways of practising medicine, such as working in partnership with other doctors in surgeries and in group clinics, as well as working in smaller towns. However, taking account of the recent suspension of recruitment in the public sector, the increasingly complex conditions for setting up in private medical practice, and the low demand for profitable medical care in the most far-flung areas, emigration of Beninese doctors risks picking up again and growing over the coming years.

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