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Option: *ETUDES BRITANNIQUES*

# MEMOIRE DE MAITRISE

THEME :

HEALTH SERVICES IN GREAT BRITAIN  
AND IN BENIN REPUBLIC

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# **INTRODUCTION**

A health care system is the organization of people, institutions, and resources to deliver health care services to meet the health needs of target populations. There is a wide variety of health care systems around the world, with as many histories and organizational structures as there are nations. In some countries, health care system planning is distributed among market participants. In others, there is a concerted effort among governments, trade unions, charities, religious, or other co-ordinated bodies to deliver planned health care services targeted to the populations they serve. However, health care planning has been described as often evolutionary rather than revolutionary. The goals for health systems, according to the World Health Organisation, are good health, responsiveness to the expectations of the population, and fair financial contribution. Progress towards them depends on how systems carry out four vital functions: provisions of health care services, resource generation, financing, and stewardship. Other dimensions for the evaluation of health care systems include quality, efficiency, acceptability, and equity.

The management of any health care system is typically directed through a set of policies and plans adopted by government, private sector business and other groups in areas such as personal health care delivery and financing, pharmaceuticals, health human resources, and public health.

The main diseases affecting the population in Great Britain are circulatory diseases, malignant neoplasms (i.e. cancer), diseases of the respiratory system, diseases of the digestive system and infectious diseases. The steadily rising levels of alcohol consumption and alcohol-related deaths

and the sharp increases in adult and child obesity are among the most pressing public health concerns, along with the (albeit steadily decreasing) rate of smoking prevalence. Life expectancy in Scotland has improved over the past decade but remains below that in the rest of the United Kingdom or Western Europe. There are significant inequalities in health linked to socioeconomic status and risk factors such as smoking, alcohol consumption and poor diet, all of which are associated with deprivation.

The sanitary situation in Benin is marked by periodic coming of meningitis' epidemics, cholera and yellow fever that are mastered quickly by the efforts of all actors of the health sector. The bucco - dental affections, blindness, the lymphatic filariose, and others affections are the objectives of specific programs that allies the preventive actions and curative. Upstream to all these actions, are the actions of hygiene and purification of basis that permits to warn most infectious and parasitic illnesses. A particular importance is allowed to fight against the important illnesses (Malaria, Tuberculosis and VIH/SIDA). That is the reason why we have undertaken this research work on the topic: "Health services in Great Britain and in Benin Republic". This is to show how medical care is done in Britain and in Benin Republic, and its weaknesses.

As for the subdivision of this work, it is divided into five parts. Each of them presents an aspect of the question that is the subject of the study and suggests a way of understanding it. Some other parts are included, but they only support the methodological context of the study. The first part deals with the introduction of the study. The problem statement, the purpose of the

study, the significance of the study, the scope and limitation are included. In the second part, methodology and literature review. The third part is historical and social context. The fourth part deals with medical standards in the two countries. Finally, in the last part we have difficulties encountered by the two systems and their perspectives. In addition to all the above parts, the conclusion of the research work appears as the gist of all the analysis and evaluation of health services in Great Britain and in Benin Republic. This part provides essentials aspects to lay down the contribution of the work in terms of resources and strategies put in the balance in order to change the current ways of conceiving health care in Africa, particularly in Benin. Unless Britain is a developed country, we recommended that some aspects of their systems be taken into account in relation with Beninese realities. The bibliography is finally the part in which we show the sources of the materials that help us in building of the present document. Moreover, the annex pages show the results of certain number of data discussed throughout the research work.

# **Chapter One: Introduction to the study**

## **1.1 Problem Statement**

Over the last decade, in Britain life expectancy has continued to increase, but health inequalities have proved stubbornly resistant to improvement. The main diseases affecting the population are circulatory diseases, cancer, diseases of the respiratory system and diseases of the digestive system. Risk factors such as the steadily rising levels of alcohol consumption, the sharp increases in adult and child obesity and prevailing smoking levels are among the most pressing public health concerns, particularly as they reflect the growing health inequalities among different socioeconomic groups. Substantial increases in funding have led to significant growth in the clinical workforce and numerous performance targets have been set to improve population health, the quality and outcomes of health care, and the efficiency of the health system. The organizational and structural changes, in addition, consistent policy objectives, have provided a strong launching pad for achieving improvement. As a result, Britain has made well-documented progress in terms of population health and the quality and effectiveness of care unless many challenges.

The social sanitary situation in Benin is hardly gleaming. It is characterized by a setting of life non acceptable that constitutes the factor encouraging transferable and parasitic illnesses. The pollution, the lack of pure water and the management of garbage are main causes of illnesses. Formerly there are not many health centers throughout the country. Then people cannot go to hospitals but to a tradipractians to heal themselves or give birth to children at home. We have also the problem of money. Most of Benin People

do not go to hospitals because they don't have money. If they go there, they feel abandoned by the workers because they don't keep money. Today, Benin's population grows. This demographic growth involves a very big influence on evolution of the social demand and a strong pressure on the available resources as for health care.

All these situations mean interrogations in our mind. How many people access easily to hospitals and find good care by the workers? Is the health care cheap to people? What can government do to subsidize health care? It is the reason why we choose the theme "Health services in Great Britain and in Benin Republic".

## **1.2 Purpose of the study**

The major problem is related to the “Health services in Great and in Benin Republic”. Benin and Britain carry out differently their health services. Although they may be similar, it happens that social and cultural facts can influence the general aspect of their health systems.

The first aim of this study is providing a detailed description of a health system, reforms and policy initiatives in progress or under development in each country in order to find similarities or differences that can help the improvement of both systems. Our prime preoccupation is to help Benin health care system because its needs should fit the people needs. Meaning by working in those two systems, we have in our mind the idea to drive from our analysis about Britain health care some positives aspects that can impact the improvement of Benin system.

Our second objective is to bring out the way through which health services is carried out in the two countries .In other word we intend to highlight the way through which and the conditions under which people benefit health care in the two countries. Our concern about this theme is to understand the internal configuration of health system in spite of the influenced factors.

Choosing the topic “Health services in Great and in Benin Republic” is the best way for us to bring relevant information to support policy-makers and analysts in the development of health systems in the two countries. There is, in fact, our duty to contribute through our research and knowledge to the improvement of people life in that field.

### **1.3 Significance of the study**

The theme of the study is "Health services in Great and in Benin Republic". Benin and Britain give health services to their people differently. Social and cultural facts influence their health system. Benin's constitution states that the government assures to all citizens equal access to health. We intend in our work to bring light on the ways through which people benefit health care, the main participants of the health system and their roles in the two countries. Our ambition is to have for people of each country easy access to health care in order to reach the state of welfare. We have in our mind how Benin will get inspired from the British model to improve his health system.

### **1.4 Scope and limitation**

The scope of this research work is national and international. It revolves around the theme of health services in Great Britain and in Benin Republic. Then it gives the possibility to study and to evaluate the different aspects of health services and its contribution for socio-economic development of the country in which it's set up. This work focuses on two main countries: Benin and Great Britain. Our approach is to see inside the internal function how it works and how certain good parts of the two countries can help one another in their ways towards the building of a welfare state for each of them.

# **Chapter two: Methodology and literature review**

## **2.1 Methodology**

### **2.1.1 Research instruments and data collection analysis**

This research work is based on two theoretical approaches: the quantitative and qualitative research approaches. We have found some of our important materials from internet. Our method has been based on data collection, data processing and data analysis. Mainly we have gone to the Ministry of health to find information about Benin. These methods provide an opportunity to analyze the available information in order to look into the various aspects of health care in Great Britain and in Benin. It has also helps us to see the difficulties related to data collection social security in our country. We have the opportunity to discuss with some patients in hospitals in order to find out how the providers take care of them in Benin Republic.

The qualitative approach aims at collecting, processing and analyzing data from internet and libraries on the basis of different interpretations that will help us to generate new about the ways in which health care can be improved in the two countries. This method which is used in different studies on culture, socio-economic subjects is an important element of research. In some extent we will apply the socio-analysis of the theme. The use of socio-constructivism approach in this work is the possible way to gather the entire positive elements after discussions to provide affordable solutions or recommendations to foster both systems.

Besides, many materials, ranging from reports, reviews, interviews, articles, novels are also helpful in the carrying out of this work.

### **2.1.2 Geocriticism**

Geocriticism is a method of literary analysis and literary theory that incorporates the study of geographic space. Geocriticism also assumes a literary referentiality between world and text, or, in other words, between the referent and its representation. By questioning the relations between a given space's nature and its actually existing condition, the geocritical approach allows for a study of fiction that points also to the theory of possible. The geocriticism permits to study the field of our work. We will talk about health services in Great Britain and in Benin. This means how health care's are delivered in England, Scotland, Wales and Benin.

### **2.1.3 Sociocriticism**

The specific aim of sociocriticism is to find the third approach to literature between the extremes of the formalist and sociological methods. Unlike most sociological approaches to literature, which leave to the structure of texts untouched, sociocriticism aims to prove that the encounter with "ideological traces", and with antagonistic tensions between classes, is central to any reading of texts.

## **2.2 Literature review and clarification of concepts**

### **2.2.1 The review of available literature**

This part is a panoramic view of what has been written about health services in Great Britain and in Benin Republic. Many research works related to our study have been conducted, ranging from essays, articles to reviews and books. British writers discuss health systems in various ways. Thus, in health system review, *Health System in Transition Vol. 13 No.1 2011*, SEAN BOYLE, provides an overview of how health care system is organised in England. He outlines the main participants, their roles and their responsibilities. He also talks about how the system has evolved overtime. In *SPICE*, KATHLEEN ROBSON, wrote The National Service in Scotland: Subject Profile. Majority of health care is provided by the National Health Service (NHS). It carries on the principle of collective responsibility by the state for the provision of comprehensive health services free at the point of use. Services are funded from central taxation and access is based on need. In addition, NICOLA STURGEON, MSP, Cabinet Secretary for Health, wrote in *STRATEGY REFRESH*, Wellbeing and Cities Strategy April 2012 COMMUNITY HOSPITALS, that the Scottish Government will be promoting the development of community hospitals and community hospital staff through the creation of an Improvement Network and a short life working group. The Improvement Network will be developed in collaboration with community hospitals and hosted by NHS National Education Scotland. It will provide a portal for development opportunities for community hospital staff. The working group

will provide support for the development of the clinical side of community hospitals. Moreover, in *Health System in Transition Vol. 14 No.11 2012* Marcus Longley, Neil Riley, Paul Davies, Cristina Hernández-Quevedo told that for several decades, Wales had a health system largely administered through the United Kingdom Government's Welsh Office. Far greater responsibility for most aspects of health policy was devolved to Wales in a process beginning in 1999. Since then, differences between the policy approach and framework in England and that in Wales have widened. The internal market introduced in the United Kingdom NHS in the 1990s created a separation between purchasers and providers.

In the National Policies of health in Benin, the former minister of health, Dr ISSIFOU TAKPARA, told that a particular effort will be made for improvement of the cares and services of health to all levels of the sanitary pyramid while especially assuring essential cares to the most vulnerable and resourceless populations. The development of the health system must put an accent on the development of the human resources for health. A particular attention must be granted to the initial formation of the health staff and the motivation of the providers. Moreover, in each national statistic yearbook, the government of Benin Republic analyses the health situation and sets up measures for improvement of health care.

## **2.2.2 Clarification of concepts**

### **2.2.2.1 Health**

In 1948 the World Health Organisation (WHO) defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”<sup>1</sup>. Some years later, the statement has been modified to include the ability to lead a “socially and economically productive life”.

Health is indeed human being frame of mind and body state. Being healthy is not only living without diseases but also and above all enjoying a total balance physically, mentally, socially, and economically speaking.

In the medical field, the technical term for health is *homeostasis*: an organism’s ability to efficiently respond to challenges (stressors) and effectively restore as well as sustain a “state of balance”.

In 1986, the World Health Organisation Charter for Health Promotion also updated the definition and said that Health is not the objective of living but the resource for everyday life. It is also a positive concept emphasizing social and personal resources as well as physical capacities.

Health is the most powerful lever in the development of any country. Being then at the core of any sustainable development issue, health, nowadays, is no longer doctor’s only business; but from the simple citizens to the central government, everybody is fighting for good health in Britain.

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<sup>1</sup> World Organisation Constitution 1948, UN, p:16

### **2.2.2.2 Welfare state**

The welfare state refers to the programs paid by the government that provide basic temporary and conditional financial help to those legally unable to provide to themselves because of their current economic situation due to health problems, mental diseases because of a major natural disaster or terrorist attack.

In order to make sense of these competing variables, a working definition of the concept of the welfare state as applied to the British case might prove beneficial. Derek Fraser in his authoritative *The Evolution of the British Welfare State* gives the following outline: "It is a system of social organisation which restricts free market operations in three principal ways: by the designation of a certain groups such as children and factory workers whose welfare is protected by the community; by the delivery of services such as medical care or education, so that no citizen shall be deprived access to them; and by transfer payments which maintain income in times of exceptional need, such as parenthood or the interruption of earnings caused by such things as sickness or unemployment.

In Great Britain, social welfare is administered in three ways: the National Health Services, the Social Services Program, and the Pensions Service Program.

## **Chapter three: Historical and social context**

### **3.1 In Great Britain**

The provision of health care in England in the 19th century depended largely on voluntary hospitals and municipal hospitals, the latter run by local government; ambulatory care was provided by doctors working in the community, who functioned very much as modern-day GPs. There was no centrally organized state health care system although a variety of local and central boards were set up at various times to deal with public health and sanitation issues. Mental health services were primarily state funded through a system of county asylums. Health insurance was not common, although there were some mutual insurance funds; usually costs were borne by individuals or through charitable donations. In the late 19th and early 20th centuries, with the development of trade unions and the establishment of the Labour Party, pressure mounted politically to provide more assistance to the population in matters of health, education and welfare. The Liberal Government of 1906–1914 introduced a compulsory national health insurance scheme in the 1911 National Insurance Act. The scheme covered people in employment and was funded by contributions from employees, employers and the state. It provided for free care from GPs, free prescriptions and treatment for tuberculosis, but it did not cover hospital treatment or childbirth. Although it did not cover workers' dependants, and hence excluded most women and children, one-third of the population was covered. There was a separate system of health care for schoolchildren. The Ministry of Health, established in 1919, consolidated the medical and public health functions of central government, and the coordination and supervision of local health services in England and Wales

(Rivett 1998; Lister 2008). By the end of the 1930s, many commentators recognized the need for changes to the system of health services in the United Kingdom, which was characterized by two hospital systems (the public sector and the voluntary hospitals) operating alongside each other with no coordination of their activities, and the existence of substantial financial barriers to access to health care for many workers, especially women. Building on developments that took place during the Second World War, and in particular the Beveridge Report (Beveridge 1942), the Labour Government, in the face of opposition from some parts of the medical profession, succeeded in passing the National Health Service Act in 1946. The NHS treated its first patients on 5 July 1948. The stated objective of the introduction of the NHS was to create equitable access to health care by making health services free at the point of delivery. From the perspective of patients, the two main changes brought about by the NHS were relief from having to pay direct charges for health care and access to health services for large groups who had previously been excluded (Webster 2002). Throughout the 1950s and 1960s, expenditure on the NHS increased, driven both by demand and by recognition of the need for investment in improved facilities and new technologies. The 1962 Hospital Plan (Ministry of Health 1962) mapped out a national vision of new, larger hospitals (known as district general hospitals) providing services to geographically based populations of up to 150 000 people –although the resulting hospital building programme was only partially delivered as international financial crises in the 1960s and 1970s led to cutbacks in public spending. In 1968, the Department of Health and Social Security was formed by the merger of the Ministry of Health and the Ministry of Social Security, under

the Secretary of State for Social Services. In 1988 the Department of Health and Social Security was once again divided between its two main functions and a Department of Health and a Department of Social Security were set up. The Department of Health today is responsible for health and personal social services in England, including public health matters, and the health consequences of environmental and food issues. A major reorganization of NHS structures took place in 1974 under the National Health Service Reorganisation Act 1973, which was designed to integrate acute (including the teaching hospitals), community and preventive services within 90 new area health authorities based mainly on the same geography as local authorities, who remained responsible for the provision of social services. In addition, 90 Family Practitioner Committees were established with responsibility for contracting with GPs, dentists, opticians and pharmacists, and regional hospital boards, established under the 1946 National Health Service Act, were replaced by 14 regional health authorities. In the 1970s, there was increasing recognition that the allocation of NHS resources between different parts of England was unequal. This led to the development, through the work of the Resource Allocation Working Party, of methods of allocating financial resources between areas based on need rather than historical patterns (Department of Health and Social Security Resource Allocation Working Party 1976).

During the 1980s and early 1990s, the Conservative Government introduced a series of initiatives aimed at improving NHS efficiency, including cost-improvement programmes, use of performance indicators, competitive tendering for non-clinical hospital support services, such as cleaning and

laundry, income-generation schemes and the introduction of general management to health authorities and hospital units, the last based on the recommendations of the Griffiths Report (Griffiths 1983). Area health authorities were abolished under the Health Services Act 1980 and were replaced by 192 district health authorities –the link with local authority boundaries was broken once again. In spite of these measures, financial pressures on the NHS continued throughout the 1980s. One of the results was a fundamental change in the structure of the NHS with the implementation of the National Health Service and Community Care Act 1990, which introduced the “internal market” whereby the commissioning and delivery of services were separated. Change was gradual over several years. District health authorities and GP fundholders were established as “purchasers” of health services. The former were responsible for contracting for services to meet the needs of their patients based on geographic areas of residence; the latter provided GP practices with the option of taking responsibility for the purchase of a limited group of services for their practice populations as well as providing primary care services, all within a cash-limited budget. On the provider side, hospitals and community and mental health services, no longer under health authority control, were established as semi-independent, non-profit-making NHS trusts, which were, however, required to show a surplus on their activities and pay capital charges on a proportion of their assets. Contracts were established between purchasers and providers of services. The intention was to increase efficiency by allowing competition between providers on the basis of price and quality (Oliver 2005). In 1997, the election of a Labour Government led to further changes to NHS structures, although the fundamental division

between purchasers and providers was retained. In the years that followed, there were numerous structural reorganizations as district health authorities were replaced by PCTs, regional health authorities by SHAs, and some NHS trusts were given more independence from the Department of Health as FTs. PCTs became responsible for the provision of primary care and many community-based services, including in some areas mental health, and the commissioning of most secondary care for patients in their geographically defined areas. SHAs became responsible for enabling local health bodies to pursue the wider aims of the health care system. New regulatory agencies, such as NICE and the CQC, were introduced to maintain nationally set standards. Since 1997, there has been a marked increase in private-sector involvement in the provision of services to the NHS, whether through the Private Finance Initiative (PFI), which contracts private firms to build facilities and operate them for the NHS over periods of 30 years or more, or the compulsory introduction of the private sector into NHS provision through “independent sector treatment centres” (ISTCs). A small but significant private sector had always provided services to the NHS but this has become formalized since 2000. For much of the post-war period, the management and organization of the NHS in Scotland were broadly similar to elsewhere in the United Kingdom, and changes in organizational structure in Scotland tended to reflect the changes in the rest of the country (Woods & Carter, 2003). Until 1999, health care policies in Scotland were determined by the Scottish Office, a department of the United Kingdom Government, and headed by the Secretary of State for Scotland, a member of the United Kingdom Cabinet. As a result, while there was some divergence in policy, there were also limits on Scotland's

autonomy (Hunter, 1982; Keating & Midwinter, 1983; Hunter & Wistow, 1987). From 1974 until the early 1990s, 15 geographically based health boards had overall responsibility for the management of health services within their areas. They were allocated funds by the Scottish Office and were accountable to the Secretary of State for the use of these funds, although in practice they were accountable to one of the junior ministers, who combined the health portfolio with other responsibilities such as education or home affairs. The combination within health boards of responsibility for hospital and community services and for primary care differed from the arrangements in England (although the latter were provided as in the rest of the United Kingdom by independent contractors) as did the absence of a regional tier of management. In the early 1990s this hierarchical model of organization for the NHS was replaced by one based on market principles, the so-called "internal market". This new system was announced at the same time in Scotland as in other areas of the United Kingdom, but its implementation was significantly slower, reflecting a general reluctance towards adopting policies "imposed" by a Conservative government in London. Health boards became "purchasers" of health care for their resident populations, and hospitals and community health services, which had previously been directly managed by the boards, were now established as separate NHS trusts that supplied services to the boards. In the same vein, GPs were able to become fundholders who could purchase a limited range of services from NHS trusts on behalf of their patients. At the time of the 1992 general election there were only 2 NHS trusts in Scotland (compared with almost 60 in England) but by the end of 1996 there were 47, covering all of mainland Scotland; by the same date 43% of the Scottish population were

registered with a GP fundholder. In 1997 a Labour government that was committed to abolishing this internal market replaced the Conservative government in London. Although initially the Scottish Office retained the organizational distinction between health boards and NHS trusts, there was increased emphasis on partnership and on the need for different organizations within the NHS to work together in a more integrated manner. The number of NHS trusts was reduced, with generally a single acute and a single primary care trust in each board, and fund holding by GPs was abolished. Following devolution, the Scottish Executive announced in 2000 the unification of health boards and NHS trusts, a process that was completed by 2004. The number of area boards was reduced to 14 in 2006 as a result of the dissolution of Argyll and Clyde Health Board following financial difficulties. The SNP government that took office as a minority administration from 2007 to 2011, and with an overall majority since 2011, maintained the NHS structure established by the previous administration. Post-devolution health policy has been dominated by the desire to reduce and eventually eliminate the role of the internal market in health care, which the newly devolved administration inherited. So, during the first decade of the 21st century, successive governments in Wales abolished general practice fundholding, and initially experimented with creating a different form of health service commissioning. The latter was organized through 22 LHBs, established in 2004, and involved entering into agreements with NHS trusts for community and secondary care services, but on the basis of collaboration rather than market operations. In addition the LHBs managed the local primary care system and worked with other local agencies to improve health and reduce health inequalities, building on the fact that they shared the

same populations as the 22 local authorities, who organized such services as housing, environmental health, leisure services and social services. In 2009, this structure was replaced by a simplified model that no longer had any separation into health service providers and commissioners. Instead, seven larger LHBs were created, differing from their predecessors in that they were now responsible for the planning and delivery of all health services within their geographical boundaries, including hospital, community and primary care.

### **3.2 In Benin Republic**

The medical pluralism reigns in Benin Republic. The notion of medical pluralism defines a situation in which cohabit mainly two types of systems of cares: A modern care system and traditional one. For the first, it is necessary to understand a set of practices essentially based on axioms coming from the positive sciences and, for the second, a containing vaguer whole care practices in the country before the colonial influence. A shape of original pluralism exists therefore to which it is added various elements to give birth to medical systems in which history superimposed many strata. For example, the cults of possessions bound to religious shapes, animists who represent most traditional medical practices were added of the monotheistic inspiration cults as the cults 'maraboutists' descended of the Islam or the prophetic cults descended of Christianity.

The contemporary time counts the increasing development of the exchanges and migrations which have been hybrid with more complex therapeutic systems. This phenomenon occurs in urban surrounding where coasts themselves traditional and modern healers; among whom we have the priests and other charismatic prophets. Some are connected to the powers of the plants. Others use the therapies based on massages and the soothsayers. Finally, it is necessary to mention the use of the self-medication by the people. Each person is able to use plants or drugs at home without any indications of specialists. They generally by counterfeit medicines in contraband market which is parallel to official channels.

# **Chapter four: Medical standards in Great Britain and in Benin Republic**

## **4.1 Medical standards in Great Britain**

This part provides an overview of how the provisions of services is organised, and outlines the main participants and their roles and responsibilities.

### **4.1.1 Organisation and regulation**

Health services in England are largely free at the point of use. Established in 1948, the NHS provides preventive medicine, primary care and hospital services to all those “ordinarily resident” in England. Over 12% of the population is covered by PMI, which mainly provides access to acute elective care in the private sector. Responsibility for publicly funded health care rests with the Secretary of State for Health, who is accountable to parliament. The Department of Health is the central government body responsible for setting policy on the NHS, public health, adult social care and other related areas. The main role of the Department is to support the government in improving the health of the population in England; it sets overall health policy and strategy, as well as dealing with legislation and regulation. The Department of Health operates at a regional level through 10 SHAs, which are responsible for ensuring the quality and performance of local health services within their geographic area. Responsibility for commissioning health services at the local level lies with 151 primary care organizations, mainly PCTs, each covering a geographically defined population of, on average, just over 340 000 people. Since 2005, GPs have also played a role in commissioning through the development of practice-based commissioning. In the health care sector, most regulatory activity is independent (self-) regulation through a range of bodies.

NHS hospitals are in the process of attaining greater autonomy from the Department of Health through achieving FT status, although they remain subject to a system of external audit and inspection that has been developed and extended since 1999. PCTs still operate within a target-based framework, reflecting their responsibility for the use of public funds to meet the health needs of their local populations. The CQC regulates the health care sector through registration, annual inspection, monitoring complaints and enforcement. Health care professionals have retained a significant degree of autonomy in regulating their practice through their professional associations, although there have been significant changes in recent years to strengthen oversight.

Health services in Scotland are financed almost entirely out of general taxation and are largely free at the point of need and available to all inhabitants. There is a very small independent health care sector, both private and non-profit-making. Responsibility for health and for health services rests with the Scottish Cabinet Secretary for Health, Wellbeing and Cities Strategy, who is accountable to the Scottish Parliament. Supported by officials in the Scottish Government health and social care directorates, ministers set policy, oversee delivery of services by the NHS and regulate the small independent sector. Many of their functions are delegated to 14 integrated territorial NHS boards responsible for planning and delivering all health services –acute, primary and community –to the population in their areas. Following devolution in 1999, NHS trusts were merged with boards and the purchaser–provider split introduced by the United Kingdom Government in the 1990s was dismantled.

Each board delegates responsibility for delivery to operating divisions for acute services and to community health partnerships (CHPs) for community and primary care services. Nine national health bodies are responsible for services that are best provided by a single national organization, such as ambulance transport, information, education and training, and quality improvement. There is strong accountability to the Scottish Parliament via ministers and through scrutiny by the parliamentary Health Committee, Audit Scotland and Healthcare Improvement Scotland within a broader National Performance Framework. Nevertheless, NHS boards have significant powers to determine the pattern of local care provision and to set local priorities. In recent decades, the extent and scope of patient and public involvement in the NHS has increased, with greater provision of information; the establishment of a national body dedicated to promoting and monitoring patient focus and public involvement; and the introduction of waiting time guarantees, stronger public participation on NHS boards and a patient experience programme.

For several decades, Wales had a health system largely administered through the United Kingdom Government's Welsh Office. Far greater responsibility for most aspects of health policy was devolved to Wales in a process beginning in 1999. Since then, differences between the policy approach and framework in England and that in Wales have widened. The internal market introduced in the United Kingdom NHS in the 1990s created a separation between purchasers and providers. This system has been abandoned in Wales. In 2009, seven LHBs were created, responsible for all aspects of planning and providing health services in their geographical areas.

The boards of these bodies, together with those of the three remaining NHS trusts (for ambulance services, specialized cancer care and public health), are appointed by and accountable to the Minister for Health and Social Services. There is no formal competition between providers. Patients' views are reflected through the internal mechanisms of LHBs or statutory community health councils rather than through choice of provider.

LHBs operate within a policy framework determined by the Welsh Government and plan services accordingly. Because of the country's small size and the absence of an organizational level between the local and national, political involvement in local decision-making is sometimes strong. Responsibility for social services lies with 22 local authorities, which are required to work in partnership with the NHS and the third (non-profit-making) sector. Separate regulatory bodies for health and social care work with the Wales Audit Office and others to report independently on service performance.

#### **4.1.2 Delivery of services**

Public health in England is primarily the responsibility of the Department of Health; the Chief Medical Officer leads on public health and is responsible for health improvement and protection as well as the nine regional public health groups. NHS-funded primary care is provided in various ways. The first point of contact for general medical needs is usually self-employed GPs and their practices, typically entering into contractual engagements with PCTs, although GPs may also be employed directly by alternative providers (e.g.

commercial sector). Community health services, NHS Direct, NHS walk-in centres, dentists, opticians and pharmacists are part of NHS primary care services. The primary care system also plays a gatekeeping role in determining access to more specialized, often hospital-based, acute health care services. NHS-funded secondary care is provided by salaried specialist doctors (consultants), nurses, and other health care professionals (e.g. physiotherapists and radiologists) working in government-owned hospitals (NHS trusts). A small private sector exists alongside the NHS, funded through private insurance, direct payments from patients, or publicly funded payments by PCTs and the Department of Health, and mainly provides acute elective care. To access NHS specialist care, patients require a referral for a consultation from a GP. Patients can also pay out of pocket for a private consultation or be referred through a PMI scheme if they are members of such a scheme. In addition to secondary care, a range of more specialized tertiary services are also provided by NHS trusts and deal with more complex or rare conditions. These trusts are usually also linked to medical schools or teaching hospitals, as well as being centres of research in their fields. Patients are mostly referred to a tertiary centre by a secondary care specialist, although direct referrals by GPs are also possible. In addition, most tertiary centres also provide some private health care services. Social care is the statutory responsibility of 152 councils with adult social services responsibilities (known as CASSRs). The organization of long-term care has shifted over time from residential (or institutional) care to care provided in the community, while the provision of care has shifted from the public sector to private- and voluntary-sector organizations. The mental health system in England has developed since 1948 from a system of asylum-based detention to

an emphasis on the provision of care in the community for people with mental health problems. The system is a mix of primary care and community-based services supported by specialist inpatient care. Services provided through the NHS are available free at the point of delivery. PCTs have responsibility for both commissioning and sometimes providing mental health services for their local populations. PCTs are responsible for the provision of NHS dental services in their geographically defined local areas and must ensure that NHS dentistry is available to anyone wishing to access services. Although individuals have these treatment entitlements under the NHS, they may choose to receive a mix of private and NHS treatment within the same episode of dental care.

Increasing emphasis has been given to NHS boards' lead role in improving population health, reflecting growing concern about Scotland's health problems. Key public health developments include a ban on smoking in public places, raising the age for purchasing tobacco from 16 to 18 and introducing a minimum unit price for alcohol (agreed in principle by the Scottish Parliament in 2012). Around 90% of patient contact is with primary care and most patient journeys begin and end in primary care, where GPs increasingly work as part of multidisciplinary teams involving nurses, midwives, health visitor, allied health professionals and managers. In recent years all the services provided by the NHS have been subject to change designed to improve their quality, effectiveness and efficiency. Common themes have been: improving health outcomes; improving access; providing services in the community in partnership with local authorities and the third and independent

sectors; strengthening anticipatory and preventive care; involving patients and carers in decisions; and increasing productivity.

Public health is the shared responsibility of all NHS bodies and more widely permeates all Welsh Government departments, which share a commitment to assess the health impact of policy developments. Leadership is provided by the NHS Trust Public Health Wales (PHW), which operates both nationally and through its staff located in each LHB. Primary care is mainly provided by independent contractors, as in the rest of the United Kingdom. Specialized ambulatory care is developing rapidly in Wales, as the NHS responds to an historical model generally perceived to be over dependent on hospitalization. Emergency care is currently located in district general hospitals, but this may change significantly during 2012–2014 as LHBs propose radical restructuring of hospital services. Pharmaceutical care is led by a network of community pharmacies, on which the government is relying for some of the extension of access to services, a current priority. Intermediate care is another priority area, and considerable work has focused on supporting self-care and managing long-term conditions more effectively in the community. Informal carers provide the vast majority of care for people living at home, and their entitlement to their own assessment of needs is enshrined in law. Palliative care receives less public funding in Wales than in England, but third sector providers remain the mainstay of such provision. Mental health care is another priority area, with clear action focused on the provision of services and attempts to reduce stigma. Dental care in Wales now relies heavily on private

provision, as parts of the country struggle to recruit NHS general dental practitioners.

#### **4.1.3 Health care expenditure in UK**

Health care expenditure in the United Kingdom has risen significantly in recent years. As Table 2 shows, total spending on health care as a proportion of GDP increased from 5.6% in 1980 to 8.7% in 2010. In particular, spending increased rapidly between 1997 and 2010, from 6.6% to 8.7% of GDP, corresponding to an increase in expenditure in cash terms from £55.1 billion to £125.4 billion (Haynes 2010). Health services remain predominantly publicly funded: in 2008, some 83% of expenditure derived from public sources. There was a decline in public expenditure as a proportion of total health expenditure between 1980 and 2000 from 89.4% to 79.3%. However, in the period since 2000, public expenditure almost doubled while private expenditure increased by just over 50%, resulting in a shift in the proportion of total spending back towards the public sector. This resulted from the Labour Government's desire to bring spending in the United Kingdom, as a proportion of GDP, closer to the European average. In 2002, the Chancellor of the Exchequer (United Kingdom Minister of Finance) announced plans for a sustained increase in NHS expenditure, with 7.4% annual real growth in the United Kingdom over the five years to 2007–2008, and 7.5% in England (HM Treasury 2002). In 2002–2003, 19.1% of projected government expenditure in the United Kingdom was on health care (HM Treasury 2002).

## **4.2 Medical standards in Benin**

### **4.2.1 Organisation and regulation**

The National health system in Benin is a pyramidal structure based on a cutting in territorial zoning and consists of the three levels which are named below. On the back of the public health office, Benin has a lot of private health office and actors of Traditional medicine.

#### ○ **CENTRAL LEVEL**

The Ministry of Health, in accordance with the Decree N°2010/060 of March 12, 2010 has for mission the conception, the implementation and the follow-up assessment of the politics of the state concerning Health. The Minister of Health is responsible for the sanitary promotion in Benin He is charged of:

- to conceive, to apply and to control the national and international sanitary politics of the state;
- to define and to suggest to the Government, if need be, of concert with other ministerial departments, the strategies, and programs of actions compliant to the sanitary politics;
- To develop and to execute, in collaboration with the other ministerial departments, the policies of training and setting to level of employees of health system.

The central level consists of: the Minister's cabinet, the services directly connected to the Minister; the General secretariat of the Ministry; the central

and technical directions, the great hospitals, the structures under protection, the national consultative organs and the agencies.

○ **Middle level**

To the number of six (06) at the rate of one by department according to the former territorial carving, the Departmental Directions of Health (DDH) represent the intermediate level of the health system and are the organs of programs, integration and coordination of all actions of health to the level of the department. They supervise the structures of health in intermediate and peripheral levels.

○ **PERIPHERAL LEVEL**

The peripheral level constitutes the basis of the sanitary pyramid and accounts 34 sanitary zones distributed on all the extent of the national territory.

The sanitary zone represents the operational entity, the more decentralized of the health system. It is organized under shape of a network of public services of first contact (Motherhoods and only clinics, Centers of Health) and of the private sanitary centers. The all are supported by a hospital of first rank or private reference center. They can keep between 100.000 and 200.000 inhabitants.

The fundamental mission but especially vital devolved to the ministry of health is to work decidedly and efficiently to the improvement of the socio - sanitary conditions of the populations. Consequently, it is charged notably of:

- To conceive, to apply and to control the national politics of the state concerning health;
- To suggest to the government the strategies and programs of actions compliant to the politics knew quoted.

The results gotten through the different activities led in this setting are yearly compiled in a document titled directory of the sanitary year book. It acts as reference mark to the national sanitary politics and must to meet the expectations of the population favorably.

#### **4.2.2 Delivery services**

Benin provides different health services. Primary care is delivered to any patient who comes to hospitals before any other care. Hospitals also provide specialized cares such as National Hospital and University Center; Ulcer's Burili Treatment Center; Leprosy Treatment Centre. Benin people do not come to hospitals because of lack of health centers throughout the country. Table 3 shows that for one thousand people, there are fifty-nine doctors and 25°/° of people use good equipments in urban area. In addition in rural zone 5°/° people use also good equipments for their health problems. Most of Benin people do not know how to teach, to read, and to write. That is the reason why they leave hospital to tradipracticians.

## **4.3 Similarities and differences**

### **4.3.1 Similarities**

Although Great Britain is a developed country and Benin, a developing country, both systems have some similarities in certain points.

First of all, both systems face structural organisations that have proved resistant to reforms for some time. Benin has a pyramidal structure based on zoning. Britain's health system is based on NHS structure.

Secondly, they deliver the same care services: Britain offers through private sector and NHS, primary care, secondary care, social care and other care services. Benin also delivers through private and public hospitals, primary care and others cares services.

Thirdly, Great Britain and Benin Republic present life expectancy problems which have continued to increase. The common diseases in the two countries are circulatory diseases: malignant neoplasms (cancer), diseases of the respiratory system, diseases of the digestive system, external causes, and infectious diseases.

Fourthly, Great Britain and Benin have free health services for poor people. The two governments provide support to deprived families. Next, both systems face also mental problems but it has been taken into account by the government. So, their policies and their plans toward the mental problems are to promote good mental well-being, reduce the prevalence of common mental health problems, suicide and self-harm and improve the quality of life of those experiencing mental health problems or mental illness.

Finally, both systems have the same deficiencies because there has been a striking consistency in the objectives of successive governments regarding the health system: improving population health, improving the quality and outcomes of health care, and improving the efficiency and productivity of spending on health.

In addition, problems of equipments and human resources exist not only in Great Britain but also in Benin Republic as far as health systems are concerned.

#### **4.3.2 Differences**

After having studied both systems as far as health services are concerned, we have some different points. Great Britain is a developed country which has enormous potentialities where as Benin is a developing country whose human resources are still in poor condition.

Firstly, the health system in Britain is better structured because it has good potentialities than in Benin Republic. Secondly, Britain has good equipments and a lot of specialists than Benin especially in case of surgery. Thirdly, as for researches in medicine Britain has great scientists than Benin. Fourthly, Britain sets up plenty reforms in order to make easy access to health system care than Benin. For instance, each NHS system has developed ways of offering access to non-emergency medical advice. People in England and Scotland can access these services by dialling the free-to-call 111 number.

As with other health services, there is a distinction between services provided in acute hospital settings and services provided in the community. But in Benin, reference's hospitals provide special cares apart from the general care done in the other sanitary centers.

# **Chapter five: Difficulties and perspectives**

## **5.1 Difficulties**

Britain and Benin encounter some difficulties while providing health services. In Britain the need to tackle inequalities in health has been recognized by government for many years. Yet health inequalities between socioeconomic groups have been increasing in England since the 1970s, both in terms of broad outcomes such as life expectancy and contributory factors such as obesity and smoking prevalence. The Health and Safety Executive and the Health and Safety Commission merged in 2008. As early as 1980, Black and colleagues (1980) had reported on the key health inequalities. Acheson's report in 1998 confirmed the persistence of these inequalities, noting that the solution did not lie with the health sector alone and recommending that the new Labour Government take action on a number of fronts, including education, employment, housing and the environment. A key recommendation was that, as part of a health impact assessment, all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities (Acheson 1998). In 2010, another report on the state of inequalities in health in England covered many of the same areas as its predecessors (Marmot 2010). The issue of health inequalities has been a key focus of government since at least 1998, with several clear national targets; in addition, local health bodies with responsibility for population health have set their own sometimes quite formidable targets. At the local level, PCTs, in partnership with local authorities and other bodies, were tasked with ensuring that these targets were met. The result has been a

number of local and national initiatives in different parts of the country throughout the last decade. Thus “health action zones” were introduced in 1998 in 26 local areas of England, with an aim to improve public health by developing partnerships across government and with other sectors. Sure Start was introduced in deprived areas in 1999 to provide support to disadvantaged families with young children by increasing availability of child care, improving health and emotional development for young children, and supporting parents as parents and in their aspirations towards employment. “Healthy living centres” were introduced into deprived areas in 1999, again with the aim of promoting health and improving access to mainstream services for those who may not currently use them; “healthy towns”, aimed at improving people’s food choices and encouraging healthy activity, were introduced in nine towns in 2008. These initiatives had mixed results (House of Commons Select Committee on Health 2009a; Secretary of State for Health 2009).

In Benin, people do not access easily to health services. They have also problems of pure water for drinking; the atmospheric pollution due to the non mastering of urbanization. They manage badly garbage which causes infectious and parasitic illness. They also face strong demographic pressure, problem of integration of traditional medicine in health system. Health providers careers a badly manage. Most of the hospitals are under - equipments

## **5.2 Their causes**

Nearly all health services in England are free at the point of delivery and have been so since the foundation of the NHS. The main exceptions are prescription drugs and some optical and dental services; however, the impact of charges for these has been mitigated by various forms of exemption and controls over their level. Nevertheless, some people, particularly those just above the exemption limit, are deterred from consulting a GP, from taking up a prescription if they do or from using it in line with the recommended frequency or dosage (House of Commons Select Committee on Health 2006a). The government acknowledged this and went on to change the rules governing the low income exemption and also to extend the exemption from charges to cancer patients, covering drugs administered in community settings. However, it never responded systematically to the core criticism made in a report from the House of Commons Select Committee on Health (2006a) that there was no underlying logic to the current system of exemptions.

Nevertheless, in 1997, the main obstacle to easy access was not charges but delay. By 1998, waiting lists for hospital treatment were at a record level and long waiting times were still common, although the longest waits –over two years –had been eliminated by measures taken by the previous government. Delays were also common when patients wanted to see a GP or went to an A&E department. The new government had pledged to reduce waiting lists in its manifesto but it went on, in the NHS Plan and subsequent policy statements, to set new targets for waiting times covering hospital inpatient treatment, A&E departments and GP consultations. Even where

services are free at the point of delivery, users may nevertheless incur costs, principally those related to transport, to gain access to them.

The new Labour Government had made an election pledge to reduce the numbers waiting for hospital treatment by 100 000. This reduction was achieved by March 2000 and further reductions followed. By 2008, the number waiting was as low as it had been in the 1970s when there was considerably less activity. However, there has been an increase since 2008 so that it now stands at over 620 000.

In principle, the NHS offers free transport services to hospital facilities for patients with severe medical problems, and some financial support is available for those able to travel but with low incomes. However, many patients were not aware of the support available (National Association of Citizens Advice Bureaux 2001) and the application process for repayment of travel costs was cumbersome. Subsequently, the government issued a revised scheme in 2008 and extended it to include patients travelling as a result of a GP or dentist referral. The House of Commons Select Committee on Health also found that parking charges at hospitals presented a problem for users requiring frequent visits for treatment (House of Commons Select Committee on Health 2006a).

The government announced in December 2009 that it intended to tackle this issue but no proposals were made before the general election in May 2010. As noted in Chapter 7, the White Paper, *Our Health, Our Care, Our Say* (Department of Health 2006c), proposed a number of initiatives designed to promote the transfer of some services from hospital sites to other settings such as GP premises or new specially built health centres, and the expansion of the

numbers of GPs and pharmacists with special interests capable of providing specialist advice. In 2008, a commitment was made that a new health centre (or polyclinic) should be established in each PCT area to provide a base for the transfer of hospital services. Despite these measures a report by the Audit Commission (2009) found no evidence to show that PCTs had been successful in moving care out of hospitals.

Waiting times for most NHS hospital and primary care services have been substantially reduced since the late 1990s. However, for some services based outside hospital, such as physiotherapy, waiting times can be very long as these were not included in the 18-week target. Some people are still not able to see their GP quickly and conveniently and some users are still deterred from using services by cost or other obstacles, although the proportion of the population affected is small and lower than in other comparable countries (Schoen et al. 2009). For the last 25 or so years, there has been a striking consistency in the objectives of successive Scottish governments regarding the health system: improving population health; improving the quality and outcomes of health care; and improving the efficiency and productivity of spending on health. Coupled with a relative lack of organizational turbulence, this stability in aims has provided a strong launching pad for achieving beneficial change. Progress has been made in relation to each of these aims. Health status has improved significantly, although a gap still persists between Scotland and other countries and among socioeconomic groups in Scotland. Scotland has led the way in taking forward many aspects of the quality agenda, with encouraging results, such as a reduction of over 9% in hospital standardized mortality ratios, and

this has been evident in specific indicators for each of the “standard” dimensions of health care quality: person-centred, safe, effective, efficient, equitable and timely. There have also been improvements in all the main indicators of allocative and technical efficiency, and financial balance has been maintained at the same time as these improvements have been achieved. Comprehensive and rigorous analysis of the performance of the health system, including comparison with performance in other countries, lies beyond the scope of this report. Various attempts have been made to do this, but many of their conclusions have been challenged, not least due to the lack of comparable data of high quality.

The health system in Wales continues to face structural weaknesses that have proved resistant to reform for some time. However, there has been substantial improvement in service quality and outcomes since the end of the 1990s, in large part facilitated by substantial real growth in health spending. The financial climate has now changed significantly, and in the short term Wales faces perhaps the severest reduction in expenditure it has seen since the foundation of the NHS, worse than that in other parts of the United Kingdom. Life expectancy has continued to increase, but health inequalities have proved stubbornly resistant to improvement.

During several decades, all over the world and more especially in the countries poor, hygiene and purification have often been disregarded, because not having an impact immediate in term of results. In the other African country like Benin we knew the international decade of water drinkable and of purification (DIEPA); but in spite of the efforts opened out by

the government and the partners to the development, 39% of the Beninese population don't have accesses to a drinking water and 67% don't have any adequate works of purification (EDSB 2).

In Benin, several ministries work in the sector of purification. The Ministry of Health defines the politics concerning hygiene, of purification and of prevention, the Ministries in charge of the environment, of the public Works elaborate, the environmental politics, the big works of purification and the politics of road security. The Ministry in charge some inside has the administrative tutelage of the townships loaded of the setting in setting of these different policies. The question of the quality of the environment is a dimension important of the prevention, made more at least sharp by the behavior of the individuals and communities some matter of hygiene and purification. Some public services has been set for the sensibilization and the helping of the individuals and the communities to have a healthy life setting; it is about essentially of the Direction of hygiene and the purification of basis and more especially of the service of the sanitary police. On an economic level, the economic growth stabilized to 3,9%, a rate slightly superior to the demographic growth rate. But this growth remains frail because that it is strongly dependent of the fluctuations of the world courses of cotton.

## **5.3 Perspectives**

### **5.3.1 Health reforms**

- **In Britain**

The period since 1997 has witnessed a series of organizational changes to the health care system in England designed to shift responsibility away from the Department of Health at the centre to regional and local levels.<sup>2</sup> Major reforms included the creation of PCTs, which are responsible for commissioning health services for geographically defined populations; the introduction of new types of NHS providers, FTs, with greater financial and managerial autonomy; and the greater use of private-sector capacity to deliver publicly funded health care. At the same time the Department of Health created a number of new semi-independent bodies to assist in setting priorities and monitoring standards for different parts of the health care system.

Responsibility for health policy has been fully devolved to Wales since 1999. In the first ten years of devolution, organizational change focused on aligning the boundaries of the NHS and local government and on other initiatives designed to foster joint working on a public health agenda. In 2009, the remaining vestiges of the internal market were removed with the creation of LHBs. Wales has developed many distinctive policy initiatives. Some have attracted considerable popular attention (the abolition of prescription charges). Others were more subtle and possibly more far reaching, such as the

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<sup>2</sup> In 2010, a Conservative and Liberal Democrat Coalition Government was elected and proposed changes to the structure of the NHS.

statutory commitment to sustainable development across all government policy areas. Public services in Wales now face significant resources pressures, particularly the NHS. Government has made implementation a priority, amid concerns that progress in implementing policy has been too slow in many areas of Wales's public services.

For the first few years after the election of a (United Kingdom) Labour government in 1997, broadly similar steps were taken in Scotland and England to dismantle the internal market that had been developed by the previous Conservative government. From 2000, however, the Labour/Liberal Democrat coalition in Scotland began to pursue an increasingly distinctive approach that stressed integration and partnership among all parts of the NHS, eschewing moves in England to revert to a market in health care delivery (particularly for elective care) involving both NHS and private sector providers. The election of a Scottish National Party (SNP) government in 2007 reaffirmed this policy and emphasized the continuation of a publicly provided service with a new focus on mutuality –involving patients and the public and NHS staff as “owners” and partners rather than just users and providers –and on quality as the driver of modernization and improvement.

- **In Benin**

Benin is a part of intertropical region of which the environmental and sanitary situation is characterized essentially by tropical pathologies such as malaria. In Africa and especially in the south of the Sahara, malaria is the most important illness. We estimate that the number of case of malaria decreased

from 244 million in 2005 to 225 millions in 2009. The number of death due to the malaria is estimated to have decreased 985 000 in 2000 to 781 000 in 2009. Roll back malaria is an essential problem of public health but also of development in Benin.

In Benin, in 2009, the impact of the malaria for 100 inhabitants was of 15, 2%. That rate is estimated to 49, 3% at the children of less than one year, and 26,9% of 1 to 4 years and 8,9% for the 5 at 14 years. The evolution of malaria presents itself irregular rate from 2002 to 2009 with an average of 8, 8%.

Fight against malaria will reduce 40% of the disease in the sector of health. If the cases of malaria constitute valid reasons of absenteeism in the school and of absence of the mothers of children to their station of work; then to fight against the malaria that is to fight against poverty as the objective N°6 of the OMDS stipulates it. This reality was very included by the government of Benin, that in May 2011, the chief of the state has enacted the exemption from payment of the hold cares in charge of the cases of malaria to the pregnant women and to the children of less than 5 years.

The exemption from payment of the cares consists in providing benefits of cares to the population targets without that they don't participate financially. The state as guarantor of the health of the population himself substitutes for the recipients to pay to their place for the official covered act tariffs. It is the principle of third paying where the state repays the well stocked benefits free. We have four types of packet as far as the nature of the patient and the levels of the disease are concerned.

**Packet A: Ordinary malaria for the child under 5 years**

- Fast diagnosis test
- CTA, PARACÉTAMOL,
- Consultation and notebook fees

**Packet B: Serious malaria for the child under 5 years**

- Microscopy / tests done to the level of the HZ and the CHDS and other exams of laboratory (NFS, glyceamia)
- Serious malaria Kit,
- Consultation fees included notebook cost
- Hospitalization charges (3 days)
- Blood group and transfusion.

**Packet C: Simple malaria for the pregnant woman**

- Fast diagnosis test
- CTA
- Paracétamol
- Consultation and notebook charges

**Packet D: Serious malaria for the pregnant woman**

- Microscopy / tests done to the level of the HZ and the CHD/HNS and other exams of laboratory (NFS, glyceamia)
- Serious malaria kit
- Consultation and notebook fees
- Hospitalization fees

○ **Universal Health Insurance Regime** (RAMU)

The mutual insurances of health exist in Benin since the years 1990. The strategic plan of development for the mutual of health 2009-2013 indicates that at least they exist one mutual of health by department, with a strong concentration in the department of Borgou. In 2010, the number of mutual was estimated to 201, in relation to 11 in 1997. In spite of this strong growth, they contribute in the lessening of the financial weight of the households. The majority only covers the small risks (primary and curative consultation, antenatal consultation, normal childbirth, etc) that are taken in charge to the level of the clinics, and local health centers. Whereas great risks as the surgical interventions, the complicate childbirths and the hospitalizations, that are more expensive, are not covered by the mutual insurance.

In order to improve the state of health and the life expectancy of the population especially vulnerable and to reach the OMDS objectives for health the Universal health insurance Regime (RAMU) was set up to alleviate the load of the households. The RAMU improves the financial accessibility of the populations to the cares of health. It is a system which covers social illness destined to protect the set of the Beninese populations against the consequences of the risk illness. All Beninese citizens, whatever their social condition, their sex or their religion can benefit this insurance. This means that rich, poor, young or aged, handicapped person can use it for health problems.

For this first stage are concerned the paupers, the craftsmen, the artists, small dealers, undeclared tradesmen, drivers of taxicab motorcycles or agricultural actor, pupils and students of more than 18 years.

To benefit from the RAMU, It is necessary to adhere, It is necessary to respect a period of observation of two (02) months; It is necessary to pay regularly your contributions. You must also carry the following documents: national identification card, or Passport, or Card Lepi, birth certificate, or additional Judgment, driver's license.

The vulnerable people identified like pauper won't pay for anything to adhere and won't also pay for contribution.

For the phase of starting, the adherences or affiliations are on opened in the 14 sanitary zones: Atlantic coastal Borgou-Alibori: Zone sanitary Cotonou 2 and 3 Zone Sanitary Tchaourou, Zone sanitary Cotonou 6, Zone Sanitary Nikki-Kalalé-Pèrèrè Zone sanitary Allada - Zè-Toffo, Zone Sanitary Parakou-N'dali, Zone Sanitary Ouidah-Kpomassè-Tori ,Zone Sanitary Kandi-Gogounou-Ségbana, Mono Couffo - Ouémè :Zone Sanitary Comè - Grand Popo –Bopa, Zone Sanitary Porto - Novo - Sèmè - Podji

Zone Sanitary Athiémè-Lokossa, Zone Sanitary Kétou-Adja-Ouèrè-Pobè, Zone Sanitary Aplahoué-Djakotomè-Dogbo, Zone Sanitary DangboAdjohoun-BonouAtacora-Donga Zoucollines: Zone Sanitary Bassila Zone Sanitary Covè-Zangnanado–Ouinhi ,Zone Sanitary Djougou - Ouaké -Copargo Zone Sanitary Abomey-Djidja–Agbangnizoun ,Zone Sanitary; Natitingou-Boukoumbé-Toucountouna: Zone Sanitary Savalou-Bantè. Progressively all thirty-four (34) sanitary zones of the country will be covered.

The Government sets up number of mechanisms aiming to reinforce the medical aids to the poor and to the groups vulnerable such as:

- ✓ the exemption from payment of the benefits of the Program Widened of Vaccination;
- ✓ the exemption from payment of the Caesarean;
- ✓ the exemption from payment of the treatments Anti Old-fashioned Viral
- ✓ the exemption from payment of the treatments of the Tuberculosis, the Leprosy and the ulcer of Buruli;

Traditional healers admit the big efficiency of modern medicine while mentioning the technical advantages.

In spite of strong companies, resources and the activities of the traditional medicine are very badly known. They are really not included to the preoccupations of the sector of health; reports of confidence don't exist between the agents of health and traditional healers.

The traditional healers have been encouraged by the public powers to gather in a national association. Some difficulties occur in internal coordination which reduces the efforts of dialogue undertaken by the authorities with the corporation.

The Ministry of Health adopted in March 2002 the politics of promotion and integration of the pharmacopeia and of the traditional medicine in the national system of health. It aims to codify the practice of the traditional medicine and to assure the availability, the accessibility and the use rational of the efficient traditional medicines in the national system of health. Among the activities that are achieved in this setting, there is the census between practitioners of the traditional medicine.

### **5.3.2 Suggestions and recommendations**

#### **▪ In Britain**

The government should take draconian measures in order:

- to continue to protect the most vulnerable people in our society through early intervention, by ensuring our children get the best start in life and by promoting equality;
- to achieve sustainable, world-leading quality in health care, ensuring that people are able to be in their own homes and communities when possible and appropriate, and that they have a safe and good experience of health care services;
- to maximize value by supporting the people delivering health and care services and through increased efficiency;
- improving efficiency and productivity by reducing waste, harm and variation;
- improving the coordination of policy across government departments;
- improving partnerships with citizens, patients, staff, other public services and suppliers;

#### **▪ In Benin Republic**

- To promote hygiene and purification of basis in urban and out-of-town environment,

- To reinforce capacities of intervention of the DHAB its structures decentralized,
- To promote communication activities on health to the communal level,
- To promote communication for the development of health through the behavior of the professionals,
- Struggle against the important illnesses (STD,HIV,AIDS,Malaria and Tuberculosis)
- Struggle against the other transferable illnesses,
- Struggle against the main non transferable illnesses,
- Improvement of the availability and the generic medicine quality to cost reducing
- Promotion of medicine and the pharmacopeia traditional.

# **CONCLUSION**

This work has studied the theme of health services in relation with the different aspects of its implementation in Benin. To make this study more scientific, we find worthy adding some data and specifics of the same matter from a western country. Rather than making a pure comparative study of health services in Benin and in Great Britain, we have conducted a study that reveals the positive parts of health system in Britain so as to help the development of the system in our country. In addition, we have shown the various sectors and the different conditions under which people in Benin can benefit from health care dispositions. In each developed paragraph we have explained and reveal both the weakness and the strength of the health system.

The overview of the health system in Scotland has identified a number of key developments in the last decade:

- a substantial increase in funding, which has resulted in significant growth in the clinical workforce;
- marked improvements in population health and in the quality and effectiveness of NHS care and treatment;
- increasing divergence from England, both in health policy and in health systems.

The health system in Wales is still very similar to those in the rest of the United Kingdom, with many of the original features of the NHS still present: universal registration with a GP, comprehensive care available to all mainly free at the point of use, and resources allocated within the system according to need. It also faces many of the same challenges, including long-term rising demand and the need to effect a strategic shift from hospital to community services. However, where England has explored the use of quasi-market and

other mechanisms to address these challenges, Wales has remained consistent in its belief that common direction of provision within a unified system is the best approach to effect change while ensuring maximum equity of provision. These differences are set to become more pronounced over the coming years, as policy in England increasingly diverges from that in Wales. The relatively recently acquired legislative competence of the National Assembly of Wales, and the political differences between the governing parties in Cardiff and London, are likely to fuel this growing divergence. In the next few years, health policy in Wales will be powerfully shaped by significant financial challenges. The decision of the government to allow real health expenditure to decline faster than that in the rest of the United Kingdom if maintained –will place LHBs and others under relentless pressure and may arouse political controversy. There is concern in Wales that the health care system is not financially sustainable in the longer term unless additional funds can be found to meet rising demands and unless this demand can be controlled. Public health measures will have an important part to play in this, as will strategic shifts in provision, but progress to date has been relatively modest, and much remains to be achieved.

In Benin, the setting of the primary cares through the initiative of Bamako, the Round table on the sector of the health in 1995 proposed the reorganization of the basis of the sanitary pyramid of it “sanitary zones”, with their hospitals and structures of management implying the communities. The decentralization of the credits allocated to the sanitary zones is now a reality in Benin, but it should be reinforced. The financing of health sector also glimpses itself through the tentative of mutualisation of health and the township

involvement in order to assure the setting of primary cares. This vision puts the accent on the welfare that rests among others on the following elements: efficient and effective education system, dispensation of good cares, supplying of drinking water, electricity and supply of healthy shelter for all, creation of a healthy life setting.

Benin possesses a good capacity concerning initial formation: Sciences of Health Faculties of Abomey-Calavi and Parakou, Schools of professional training (INMES) of Cotonou, national School of male nurses and nurses (ENIAB) of Parakou. Several institutes of formation and research also exist to regional vocation, among which we have the regional institute of public Health (IRSP) of Ouidah.

The outside help in the sector of health, that represented 12,5% of the outside help total to Benin in the year 2000, passed to 13,2%, and represent one of the sectors thus of concentration of help. The international help contribution rests on the partners multilateral and bilateral those lead some actions in the sector of health. They have the formal relations with the Ministry of Health and bring their support in priority to the gone governmental. Their actions are visible and they impulse to the sanitary system the movement toward the international norms and the international sanitary objectives.

The main domains concerned by the outside help are: the infrastructures of cares, the staff's formation, the backing of the capacities, the struggle against the illness, in particular the vaccination, the VIH/sida, the malaria, the tuberculosis, the health of the, reproduction, the survival the mother, the newborn and the child, the global support to the zones sanitary, the support to the development of the mutual of health and the support to the national

System of information and sanitary management (SNIGS), the quality of the cares, the technical support and the benefit of cares. During the last years, the outside help to health was characterized by a reorientation toward the budgetary help, instead of the classic support under shape of projects (European union, French Cooperation, GTZ, Denmark, Belgium, Swiss Cooperation, and World Bank) or the approach programs (WHO, UNICEF etc.). This support to the budget of the state is based on the follow-up of certain indicators as: the rate of cover's vaccines, the number of new contacts, the rate of company in hospitals, the rate of childbirths attended by the qualified staff. The capacity of absorption of the outside help stays however a recurrent problem, in spite of the recent well stocked efforts, by the State in the management. That why in our work we could not end the dissertation without giving some affordable solutions that could help development of health services. If those recommendations can be taken into account, many positive things would come out from the services that Benin Government will provide its citizens with.