Flawed Medicine Procurement and Distribution System for Public Health Facilities:The Case of Maharashtra

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Despite, huge developments in the field of production of medicines in India, essential medicines are still out of reach of millions of people in India; one important reason being shortage of essential medicines in Public Health Facilities (PHF). These shortages have been occasionally documented. For example, a survey published in 2007 of PHFs in six states revealed that the median availability of a core list of 30 essential medicines in these PHFs was 0% to 30%.[1] Recent surveys (see an example below) indicate that even after four years of NRHM, government has failed to keep its promise of ensuring availability of essential medicines in the rural PHFs.

Unavailability of medical officer or other staff, callous attitude of staff, lack of cleanliness, non-availability of basic diagnostic tests in the facility, etc have led to reduced utilization of PHF. Shortage of essential medicines has become an additional cause for people's reluctance to seek treatment from the PHF. There are many implications of this shortage of medicines. For example, people are forced into unwarranted out of pocket expenditure and consequent indebtedness. This tragedy of medicine-shortage is due to inadequate budgetary allocation towards medicines and inappropriate procedures for medicine procurement and distribution system etc. Like other states, Maharashtra also suffers from this problem. Several instances of corruption in tendering, delayed payments to suppliers, delayed distribution are directly linked with loopholes in the medicine purchase and distribution system. Hence, to understand this issue in depth, SATHI conducted an in depth study of Maharashtra's medicine procurement and distribution system. The present piece summarises the findings of this study and suggests possible solutions.

Shortage of Essential Medicines in Rural PHFs in Maharashtra

Shortage of essential medicines has been reported from different parts of Maharashtra. Findings from the data collected in 2009 during the 4th phase of the Community Based Monitoring (CBM) project from 72 PHCs in five districts of Maharashtra showed that, out of the 28 essential medicines that were studied, 15 had zero stock in 25% of these 72 PHCs (Primary Health Centre). In 40% of these PHCs, 18 medicines were deficient in stock. It was also found that in case of some medicines, which were deficient or completely out of stock in some PHCs, were present in excessive quantities in other PHCs in the same district![2] A similar smaller study conducted by Jan Arogya Abhiyaan in November 2010, in five districts of Maharashtra showed similar findings.[3] When medicines are not available in the facility, medical officer either prescribe medicines from outside or purchases from discretionary funds available with PHF. In tribal, hilly areas where pharmacy shops are not available, people remain deprived of medicines even if they are ready to buy medicines. Moreover, as seen in a study done by Jan Arogya Abhiyaan, the prices of local purchase of medicines by the Rural Hospital were 3 to 10 times higher than the prices under rate contract made by government.[4]

Inadequate Budgetary Allocations

In Maharashtra, medicine shortage is partly due to inadequate budget. Maharashtra spends 11% of the total health expenditure on medicines, while in Tamil Nadu and Kerala, this proportion is 15% and 17% respectively. As per NRHM guidelines, every PHC should have supply of medicines worth Rs. 3 lakhs. Other states including even a small state like Div Daman have budget allocation of Rs. 3 lakhs towards medicines for PHC. However, Maharashtra govt. has not done this even after NRHM. At present, Maharashtra spends only Rs. 1.2 lakhs per PHC per annum towards medicines.

Health expenditure as a percentage of NSDP (Net State Domestic Product) at current prices has declined from 1 % in the 1980s to 0.7 per cent in 2001-2002, and as a proportion to total government spending from over 6% in the 1980s to 4.6% in 2001-2002.[5] Out of this low health expenditure, expenditure towards medicines is even low. Hence, there is definite need to increase the budget and expenditure.

However, low budget is not solely responsible for medicine shortage. The issue is compounded with several missing linkages in present medicine procurement and distribution system in Maharashtra. We now turn to this problem.

Inefficient Medicine Procurement and Distribution System

The annual per capita government expenditure on

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medicines in Maharashtra and Tamil Nadu is almost same, i.e. about Rs. 28.[6] Within the same budget, Tamil Nadu provides all medicines free to outdoor patients in government health facilities and hence now 40% of patients seek care in these centers. Maharashtra's performance about supply of medicines to patients is not even one third of Tamil Nadu!! This arises from the following lacunae in the system -

- Most problematic aspect of the system in Maharashtra is that purchase of medicine is done at different levels by different agencies. Multiplicity of sources and level of purchase causes delays and makes it difficult to monitor the procurement process. For example, medicines are supplied to PHCs from three different routes - from Central govt. for national programmes, from Zilla Parishad and from DHS (Directorate of Health Services). This makes it difficult to track the flow of medicines. There is no provision for ensuring transparency or monitoring. Basic information such as name of medicine, it's rate and name of selected manufacturer is not available on the website. Obtaining data regarding procurement process was quite difficult as there is no standard manual available describing the process. Lack of monitoring encourages malpractices, delays in payment, bogus payments, fake bills, short expiry stock etc. and leads to poor control on bidding process. Further, there is no provision for quality check and pre or post dispatch inspection of stock. The health department does not have single manual to define the process of procurement. There is no computerized linkage among PHCs, between PHCs and DHOs office, between DHOs office and state level and further between PHCs and State level.
- In addition to the problem of general understaffing, there is also lack of trained, professional cadre for the procurement work. For the health officers involved in procurement of medicines procurement related activities become an additional. Secondly, they are not trained about procurement.
- Currently Rate Contract is done for around 1800 products whereas there are only 350 medicines in Ministry of Health's National List of Essential Medicines (NLEM). The Tamil Nadu Medical Service Corporation (TNMSC) renowned for its procurement work, has a list of 260 medicines for procurement.
- Finally the supply of medicines to PHFs is not demand responsive (i.e. not need based) partly because there is no provision for tracking stock of medicines in PHC. All PHCs get a standard quota of medicines irrespective of their needs. The indent sent by Medical Officers is more often ignored.

In view of these lacunae, Maharashtra's Medicine procurement and distribution requires complete overhaul. Today Tamil Nadu (TN) procurement model, operative since 1995 is the model in India for medicine procurement for PHFs. Kerala has adopted it and has improved the medicine availability in their state. TN model has been appreciated internationally also. The Jan Aarogya Abhiyaan has been demanding adoption of the TN model in Maharashtra. After the decision of employing e-tendering system in July2011, now the Maharashtra Government declared that from 1st December 2011, Directorate of Health Services and Directorate of Medical Education and Research (DMER) would procure medicines separately for the facilities under their control. Along with e-tendering, now other improvements like computerization of the distribution system, formation of eight district warehouses, quality testing after delivery of medicines in the warehouses will be done. Though welcome, these changes would not be sufficient to overcome the gross shortage of medicines and solve the other issues. Maharashtra needs to adopt wholly the TN model, with minor modifications if necessary.

The Tamil Nadu Model

A fully autonomous and transparent TNMSC (Tamil Nadu Medical Services Corporation) was established in 1995. Its main features are -

- **Full autonomy** - Once broader policy has been decided, no reference is made to the government; all decisions are taken by the board.
- **Transparency -** Name of medicine, price of purchase, name of manufacturer and report of quality testing etc. are posted on website to bring transparency in the system.
- **Demand responsive system -** Each PHC can choose the medicines and their quantity as per need within the budget of Rs. 1.2 lakhs by using a 'passbook' (instead of conventional indenting).
- **Updated and limited list of essential medicines -** TNMSC procures medicines from a limited list of medicines (260 Essential Medicines and 200 other 'Speciality Medicine' (compared to a big list of 1800 medicines in Maharashtra).
- **'Tamil Nadu Transparency in Tenders Act 1998' and Rules 2000[7] -** It is one of crucial component of TNMSC which has promoted lot of transparency in system.

Comparison of Medicines Procurement Prices in Maharashtra and Tamil Nadu (2008-09)

Medicine name	TNMSC rate, per 100 tablets (Rs)	Maharashtra RC rate, per 100 tablets (Rs)	Difference in Rs. per 100 tabs (Rs)	Maharashtra RC prices higher by (%)
Aluminium Hydroxide	5.85	13.4	7.5	128
Amoxycillin	93.96	123.5	29.5	31
Amylodipine	5.1	13.5	8.4	165
Calcium Lactate	6.3	11.5	5.2	83
Enalapril	6.15	12.0	5.9	95
Glybenclamide	3.9	8.0	4.1	105
Metformin	12.16	18.0	5.8	48
Metronidazole	14.72	19.0	4.3	29
Ranitidine	18.19	30.0	11.8	65
Salbutamol	4.45	7.0	2.6	57

It should be noted that success of TNMSC model is due to not only e-tendering, computerization or only quality checking but also due to other crucial features mentioned above. The Tamil Nadu model is advantageous in terms of systemic development and is also a cost effective. Out of 21 high expenditure drugs (volume wise) which account for 79% of the procurement of Essential Medicines in Tamil Nadu's government health facilities, SATHI compared procurement prices in Maharashtra and TN for the most commonly used 10 essential medicines.[8] It was found that for 2008-09, Maharashtra's Rate Contract prices were 29% to 57% higher.

The TNMSC model has resulted in 36% savings in the outlay on drugs. As per National Sample Survey Organization's survey in 2004, (NSSO 2004) in rural Maharashtra, for admitted patients in a PHF, out of pocket expenditure was Rs. 2243 per patient compared to only Rs. 667 in TN. It should be noted that more than 50% of these out of pocket expenses are on medicines. NSSO 2006 shows that the proportion of patients not receiving medicines from public health facilities is 12 times (12.2%) in Maharashtra compared to Tamil Nadu (1%).

It is clear from the above that to change the current dismal scenario in Maharashtra of gross shortage of essential medicines in PHFs, the Maharashtra government, instead of indulging in experiments, should adopt the well-established, renowned TNMSC model of medicine procurement and distribution.

References

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[3] *Findings from the report on 'Gross Shortage of Medicines in Selected PHCs and Rural Hospitals in Maharashtra', conducted Jan Arogya Abhiyaan in the month of November 2010. for more details: http://phm-india.org/*

[4] *Findings from the unpublished report on 'Situation of medicine availability in selected health facilities from Aajra Taluka of Kolhapur District' conducted by Jan Arogya Abhiyaan in the month of November 2010*

[5] *Duggal R, Dilip.T.R, Raymus P, 2005. Health and Healthcare in Maharashtra - a Status Report, CEHAT, Mumbai, pp:29*

[6] *http://www.indianexpress.com/news/etender-system-for-medicines-inadequate/828187/Accessed: 07/12/2011*

[7] *Drug Procurement Policy and Procedure, TNMSC, Tamil Nadu Medical Services Corporation Limited.*

[8] *Chokshi, Maulik. R., 2008. Tamil Nadu Public Drug Procurement Model, New Delhi: pp. 21.*

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