Joint Bulk Purchasing of Essential Drugs
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I. Background

Following the meetings held in Abidjan and following the devaluation of the CFA franc the purchase and utilization of generic essential drugs rose very sharply. It then became necessary to improve sub regional organization in this area in others to properly address issues relating to drug prices and quality.

Therefore, in December 1995, the idea of creating an association of public structures for generic essential drug supply was born. The Constituent Assembly of three African association of central Medical Stores for generic essential Drugs (ACAME) was held by five founding member countries in July 1996 in Ouagadougou, Burkina-Faso. These countries were defined as Chad, Mali, Niger and Senegal. The objectives of ACAME were defined as follows.

* To promote the establishment of central stores for generic essential drugs in African countries which do not have them.
* To set up a data bank on suppliers, prices, etc. and promote the exchange of information among central medical stores for generic essential drugs.
* To progressively organize joint bulk purchasing.
* To protect the moral and material interests of members (i.e. central medical stores).

The first General Assembly of ACAME was held in Niamey, Niger, in June 1997. The following eleven countries attended that forum: Benin, Burkina Faso, Chad, Democratic Republic of Congo, Guinea, Madagascar, Mali, Niger, Rwanda, Senegal and Togo. That General Assembly decided to conduct a joint bulk purchasing test by group of countries and to report on the result to thee General Assembly that was to be held in Bamako from 28 September to 2 October 1998. That general Assembly was then to decide on the feasibility of the initiative. The *Pharmacie Populaire du Mali* (PPM) was responsible for coordinating that activity.

In order to ensure the success of the initiative, it was requested to make a joint bulk purchasing test after studying the bulk purchasing systems of countries of the Maghreb and the Gulf.

The study visit took place and the study team visited Morocco and Saudi Arabia.

Maghreb countries

The bulk purchasing of drugs was initiated by the UMA (Union of Arab Maghreb) ministers of health.

The first purchase stated in 1989. There is no permanent secretariat. The role of secretariat was assured, in turns, by the Directorate of Drugs and Pharmacy of the host country of the Ministerial Conference.

A committee made up of two from each country meets to prepare the special tendering procedure (drugs list of countries of the UMA , technical schedule of

specifications, legal matters, financial issues, processing of bids, award of contract). Each country sends its drug need to the secretariat which complies a list and invites tenders. The quantities of drugs are pooled together and harmonized in order to have the same supplier and the same price. This enables each county to sign a contract with the supplier chosen on the basis of the laws and regulations of the country.

Libya, Mauritania and Tunisia are still involved in bulk purchasing. Algeria withdrew in 1996 due to its own internal problems. Morocco has withdrawn since 1994 . It should however be noted that virtually the entire drug market in Morocco is controlled by local pharmaceutical industries in spite of competition from abroad.

The study team was unable to obtain statistical figures because of lack of permanent secretariat . However , the people we talked to affirmed that bulk purchasing enabled them to obtain price reductions ranging from 15% to 20ù. Morever, the fact that purchases were still being made despite the withdrawal of two of the Member States showed that the participating countries had a keen interest in the initiative.

Countries of the Gulf

The six-member Gulf Cooperation Council(Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates) started joint bulk purchasing in 1978 through their ministries of health. A permanent secretariat was set up by the ministers to examine all issues relating to the purchase of drugs and to serve as a data bank. Unlike the UMA secretariat , this one is a permanent secretariat The joint bulk purchasing conditions are the same as those prevailing in Maghreb countries except for the fact the secretariat coordinates joint bulk purchasing operations for the countries of the Gulf.

* Joint bulk purchasing started in 1978 with the procurement of drugs worth US$1 million. Purchases then rose to US$ 178 million in 1997, including electro medical equipment and vaccines.
* At least 80% of the public sector’s drug needs are met by each country through the joint bulk purchasing system (Saudi Arabia buys all its public sector’s drug needs using this system).
* On average, a 30% reduction in costs is realized through joint bulk purchasing , compared to purchasing by individual countries.
* Because of joint bulk purchasing , the Gulf countries have harmonized their drug regulations: drugs registered in one country are valid in the other countries, a common essential drug list is adopted, the same therapeutic formulation is used , the same curriculum in faculties of pharmacy, etc.
* Private hospitals are now taking part in the joint bulk purchasing system.

Lessons learned

The following conclusions can be draw from the review of joint bulk purchasing experiences in countries of the Maghreb and the Gulf:

* Joint bulk purchasing strengthens the bargaining position of buyers vis-à-vis suppliers as the latter can no longer exploit inter-country differences and as a supplier

who is accepted in one country is equally accepted by the other countries. A supplier rejected by one country in automatically rejected by the other countries. Moreover, the pooling of quantities of drugs to be bought strengthens the bargaining position of the countries.

* Joint bulk purchasing help to harmonize drug policies, thereby ensuring better use of drugs and improved care for patients.

* Joint bulk purchasing leads to a substantial reduction in costs, which allow for greater access of the population to drugs and enhanced promotion of generic essential drugs.

II. Joint bulk purchasing

These are elements indispensable for joint bulk purchasing and deserving special attention.

* The political agreement of ministers of health.

* The establishment of a (permanent) secretariat to act as a data bank disseminate information to all Member States.

* The signing of a framework agreement (rules of procedure) governing the joint bulk purchasing process and procedures.

* Joint bulk purchasing by a limited number of countries, preferably according to geographical or linguistic grouping.

* The setting up of a standing committee on tendering.

However, risk factors such as:

- political instability in countries and,
- lack of transparency in carrying out analyses and inviting tenders still exist.

Although these factors do not exist in the countries with experience in joint bulk purchasing , they need to be more closed addressed so as to minimize their impact.

The one-day meeting helped reach an agreement on the conditions for organizing, managing and awarding contracts. The meeting was aimed at adopting a common position on the following issues:

- type of invitation to tender,
- choice of drugs to be purchase and their technical specifications,
- method of assessing tenders,
- award of contracts and the articles and conditions of the contract.

* Owing to the multiplicity of suppliers and the difficulties involved in managing such a restricted tendering in which only the best ten suppliers of each central medical store could complete, all central medical stores that attended the Bamako meeting submitted a list of 10 suppliers. After analysis, a shortlist of 25 suppliers was authorized to bid.

* To produce the final list, the specifications and the quantity to be purchased, each central medical store was requested to provide information on 10 drugs in high demand. Five drugs have been selected.

* The type of contract agreed upon involved the pooling of drug purchases in order to have a single CIF price, with goods delivered to thee purchasers. Each purchaser signs a contract with the selected supplier.

These arrangements make it possible to adhere to the laws and regulations in force each country. The supplier is paid 30% upon the delivery of drugs and 70% after quality control is done.

* The Niamey laboratory in Niger (Regional quality control laboratory) was selected to conduct drug quality control. For communications and cost reasons, however, the *laboratoire National de la Santé du Mali* carried out the tests.

* A tender assessment commission comprising procurement managers of the central medical stores of participating countries was set up.

PPM was requested to prepare a schedule of specifications that took into account the key issues above and to start the tender invitation process.

The draft schedule of specifications was submitted to the central medical stores that approved them in January 1998. The cost of the schedule of specifications was fixed at 100 000 CFA francs.

The invitation to tender was launched in March 1998 and the processing and analysis of bids took place in July 1998.

III. Analysis and results

Out of the 25 suppliers invited to submit tenders, 20 tenders files were purchased and 12 bids were received. It should be noted that none of the four local suppliers invited submitted bids, for unknown reasons. It is considered necessary to know the reason(s) for this failure.

On the whole, three countries (Guinea, Mali, and Niger) participated in the test on the following five generic essential drugs:

1 Amoxycilin tablets 500 mg
2 Ampicilin injection 1g
3 Benzylpenicilin 1 MU
4 Chloroquine tablets 100mg Base
5 Cotrimoxazople tablets 400+80mg

At its August 1998 meeting the Committee based examined the bids in four no qualifying stages .

1- The first stage consisted in examining whether the submissions were done in conformity with the administrative rules in force . The tender documents of suppliers who had fulfilled this condition were examined for technical conformity.

2 - The second stage involved an assessment of the technical conformity of those bids which had met the set conditions in the previous stage. This stage entailed the examination (macroscopic and packaging) of samples is done by price of samples deemed to be of good quality.

3 - The provisional award of tender was based on the quality of the sample and their price.

4 - The final award was made after two conditions are fulfilled : the quality of the services of the supplier (delivery time) and result of the sample quality control.

The results obtained (annexes) were 7 to 27% lower than the lowest prices each of the participating countries had obtained for over 3 years for any of the five drugs.

Although some suppliers met the conditions in all the stages they were not awarded the contract due to delays in delivery (over 8 months) in one of the purchasing countries.

The preparation of tender documents and committee's expenses (accommodation, food and per diem) were covered by the costs of tender documents.

IV. RECOMMENDATIONS

For each central medical store, it would be worthwhile making a comparative assessment of the difference between the profit obtained from the joint bulk purchasing and the expenses incurred in organizing it. ACAME was charged to conduct this analysis at the beginning of 1999.

V. CONCLUSION

In conclusion one may state that the success of joint bulk purchasing depends on the following.

* a firm commitment will of managers of central medical stores backed by the support of ministers of health;
* the preparation and signing of an agreement defining the applicable rules during the entire tender period; this agreement must cover all matters concerning drug marketing;
* transparency in the implementation of the framework agreement in order to assure suppliers.

For the future, a study visit is planed to Scandinavian states with the WHO collaboration.