DRUG PROCUREMENT AND DISTRIBUTION IN THE PUBLIC SECTOR

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The Chairman, members of the high table, all protocols observed. I feel highly honoured to be given the opportunity to contribute to the on going debate on the challenges of hising health care cost in Nigeria - the Pharmaceutical input.

May God in His infinite mercies continue to bless all sincere efforts towards boldly engraving the name of our great profession PHARMACY on the health-care scene of Nigeria in particular and the world in general.

The National Health Policy and strategy, for the past five years, had been directed towards achieving Health for all Nigerians by the year 2000 in line with W. H. O 's Alma Alta declaration.

The provision of Essential Drugs is one of the pivots on which rest the health care programmes. In line with W. H. O. 's model list of Essential Drugs, the Federal Ministry of Health in Nigeria published the country's Essential Drugs list which had been further revised in 1991. The State Governments have patterned their own lists after the Federal Government's list.

In the past many methods have been employed for procuring drugs by various Governments at Federal, State and Local Levels in the country. The methods include:-

Open Tendering
Selective Tendering
Mini Tendering.

OPEN TENDERING

This involved advertising the tender in the national dailies i.e. "all comers welcome", as long as the conditions of the client are met.

These prices were then compared and most of the time lowest sensible tenderes would be awarded the supplies. This method was found to be very cumbersome and involving sometimes up to fifty companies. Most of the time too many non-performers would come out triumphant after the exercise, depending on how effective they were in manouvering their ways round members of the Tenders Board.This usually ends up side-tracking the serious minded straight forward professional with the resultant non-performance of and non-availability of the drug items in the public institutions

SELECTIVE TENDERING:

Involves hand-picking the favoured few (for whatever reasons) and comparing their prices. This also has its own problems which include a high degree of favouritism during awards and the untouchable sacred cows who are only interested in their personal gains rather than the patients' welfare.

THE MINI TENDER:

This is usually employed as an emergency measure, to provide urgently needed drug items, hence fewer contractors (3 to 5) were dealt with. All these three procuring methods were affected by the National sickness of corruption and economic mismanagement.

Another reason for the failure of the systems is the minimal positive contribution of the serving Pharmacists. The desired positive Pharmaceutical effect would only be achieved when Pharmacists with well defined goals find their ways into policy making levels in adequate numbers (i.e.the present apex should be flattened a bit.). The recent establishment of the agency at the federal level is a step in the right direction. It is hoped that the states will individually come up with solutions to the current impasse in carrier structures for civil service Pharmacists.

Having briefly mentioned the on-going drug procurement methods which had not been satisfactory so far, I would like us to examine possible areas of positive input by Nigerian Pharmacists.

In 1991 the International Conference on Harmonisation (I. C. H.) of Technical Requirements of Pharmaceuticals for Human Use was held in Brussels to harmonise the systems, for approving and monitoring new drugs, in operation in Japan, the U.S.A. and Europe.

The Japanese Pharmacist who presented a paper at that conference had this to say "Pharmaceutical products are world commodities; free and efficient trade of which can contribute to the health of people of the world

To show the seriousness attached to the conference (I. C. H.) the second conference was scheduled for this year 1993 in U.S.A. AND the third in Japan in 1995. The identified headings for these conferences were Quality, Safety and Efficacy.

Who will bell the cat for a Nigerian Conference that would involve the manufacturers, the distributors and end users of Pharmaceutical products where the free and efficient trading could be discussed as well as the quality, safety and efficacy of the products.

It would be a worthwhile venture in response to the economic dictates of the Nigerian environment, and a way of positively contributing to the health policies in the country.

The Good Post-Marketing surveillance Practice (GPMSP) code which governs the post - marketing collection of information on efficacy and safety came into effect in Japan in April 1993. This involves collection of data for 4 to 6 years after approval had been obtained for the marketing of a particular product. The collected data would then be used for proper administration of individual drugs especially drugs containing new active ingredients, new combined drugs, drugs with new directions and dosages.

If a highly developed country like Japan with a lot of stringent measures in place, is continously monitoring Pharmaceutical products in her market, as a positive contribution to the health of her people, what do you think should happen to the marketing of the products in Nigeria - an "all comers welcome" Market?

In November 1992, the International Pharmaceutical Federation (F.I.P) issued the document on guideline for drug Procurement earlier adopted in March 1992 by the F.I.P. Bureau.

The guidelines were offered as an aid to those responsible for the procurement of pharmaceuticals particularly in developing countries where drug expenditure constitute an important part of the total health budget of the countries.

Most of the points highlighted in the document are very well known to those involved in the procurement procedures in our public sector. The full benefit could only be derived when the operatives of the guidelines, who should be Pharmacists, are determined to tenaceously adhere to the spirit of the publication.

The Essential Drugs list published in 1991 by the Federal government contained 484 drugs and most of which are expected to feature in the various State Lists. With an average of three preparations per drug, it is expected that roughly one thousand four hundred and fifty two (1452) drug items at most should be on any tender list of a state. In 1993 one hundred and ninety-five contractors (195) registered as supplier of drugs and medical consumables for Lagos State

Ministry of Health. Whereas in a country like Finland with 3,200 registered medicaments, the Hospital Pharmacist buy from only two identified wholesalers in a country with two drug manufacturers (Orion-Farmos and Leiras) and representatives of 120 foreign pharmaceutical companies. Purchases from the identified two wholesalers, supplement production of different medicaments by the Hospital Pharmacies. When will the much - talked about pharmaceutical production in the Hospital in Nigeria see the light of the day!!!

DRUG DISTRIBUTION IN THE PUBLIC SECTOR

The traditional method of distributing drug items in the public sector in Nigeria consists of:-

i. A central depot or Central store which houses all the bulk purchases by the purchasing committee either at the federal or state Level.

ii. From (i) the items are distributed based on individual needs to various hospitals and health centres.

iii. From the Pharmacy stores the items are issued out into the main dispensaries and hospital wards from where outpatient and inpatient prescriptions are filled. To achieve the deliverance of appropriate, safe, effective and economic medication for the patients, Hospital Pharmacists must be prepared to operate on a 24 hours basis. in other words they must be ready to offer more services, change the current habits that are bedecked with apathy and some degree of indiscipline.

Pharmacists in government must be ready to re-present their profession to other members of the health team and national or State policy Makers - more Seriously And with Clear-cut objectives.

In August 1991 during the Commonwealth conference in Hamilton the role of Pharmacists in decreasing drugs cost to institutions i.e. cost containment in the Health Services, was discussed. Much emphasis was laid on utilising pharmacists to optimise therapy and reduce costs. The major point highlighted were:-

1. PHARMACOTHERAPY MONITORING

This is the area of Pharmacy practice which ensures safe, appropriate and economic use of drugs in patients through the application of specialised skills, knowledge and functions of patient care.

2. THERAPEUTIC INTERVENTION

This is defined as any change in drug therapy suggested by a Pharmacist and accepted by the prescriber, thus resulting in the change of the drug prescription in question.

The outcome of these interventions are optimisation of drug therapy, cost reduction of drug therapy, and reduced patient morbidity and mortality. Drug therapy monitoring are applicable at two levels in clinical pharmacy practice viz:

(i) MONITORING OF DRUG PRESCRIPTIONS PRIOR TO DISPENSING

It has been found many times that a correct diagnosis and treatment plan could be undermined by unintentionally writinng incorrect prescription,. Recent studies in USA. in three Hospitals documented the number of medicaton prescribing errors

From the Studies:-

(i) 48 - 57 of the errors were judged by Pharmacists and Physicians to have significant or potentially serious adverse consequencies.

(ii) One study documented that 0.2% of the errors were potentially lethal

(iii) Most common error in all the studies was that of DRUG overdose.

It should be noticed that in that presentation the most important factor is documentation of observations.

III. MEDICATION THERAPY

Can be further improved when Pharmacists supplement medication information with medical information with medical diagnoses laboratory data and other information derived from a review of medical charts.

This is the only way to identify inappropriate or contra-indicated therapy. Adequate patient counselling has always been useful in this regard.

A review of Pharmacists intervention in some British hospitals not only identified drug dosage error but overly prolonged use of drugs, inappropriate choice of drugs, and adverse reaction to medications.

In the same review, Physicians acceptance and implementation of the Pharmacists recommendations was 86% and reflects the increasing acceptance of the Pharmacists role in monitoring drug therapy. Since the Nigerian Medical history is patterned after the British system, it is hoped that the Nigerian Physicians like their British counterparts should terms with the reality of (T.I). Therapeutic Interventions once its usefulness comes to light.

The Ontario Hospital Association (O.H.A.) has recommended that the concept of Pharmacy-Based Intervention Programs utilising medication profiles be promoted as an essential component of the Pharmacists responsibility for drug therapy monitoring. The Australian Journal of Hospital Pharmacy Vol. 21 No. 4 1991 published clinical Pharmacists Interventions made over a six months period, during which patients' drug therapy charts were checked on 6641 occasions and a total of 556 interventions sheets were completed 315 (i.e 56.7%) were Pharmacist - initiated interventions and 241 (43.3%) were prescribing errors.

CONCLUSION

The International Pharmaceutical Federation (F.I.P.) guidelines for Drug Procurement should be adopted by Pharmacists responsible for procurement of Pharmaceutical products in the public sector.

The Direct purchases from Manufacturers and Limited number of reliable wholesalers with proven integrity should be encouraged.

Hospital Pharmacists should aggressively pursue the much-talked about in house Pharmaceutical production to emphasise their relevance in the drug world.

The documentation of Clinical Pharmacists intervention is very essential, as it is the only record which describes his imput to patients' drug therapy. The Pharmacist who wishes to take part in drug therapy monitoring and must be well armed with latest information on the drugs and treatment methods. In other words he must be professionally sound and alert.

The Public Health Units are fertile grounds for researchers, i.e. Academic Pharmacists, who wish to make positive imput into policies affecting drug distribution in the public sectors or even Non-Government health sectors where Pharmacists are involved.

The Pharmacist Council (PCN) and the Pharmaceutical Society of Nigeria (PSN) should monitor effectively drug policies and their operatives in both Federal and State Institutions; for the evil of one bad Pharmacist would be taken as a reflection of all Pharmacists.

Thank you for your attention and God bless you.