

# Why Tamil Nadu's drug supply is (and should be) the envy of all the other states

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**Behold a rare object. A system that works.**



*By Margot Cohen / Grist Media – Mon 9 Jun, 2014*

Udaya Suryan, Block Medical Officer for the PHC in Bargur, Krishnagiri district, Tamil Nadu. Photo by KT Gandhirajan.

Let's coin a new term: drug envy. This should not apply to dissipated individuals who covet another's stash of narcotics. Instead, the term could describe the mindset of frustrated pharmacists in Karnataka, Gujarat, Uttar Pradesh and other states who envy the way that Tamil Nadu ensures a steady supply of free medicines to patients at government-run clinics and hospitals.

At the moment, drug envy runs rampant on Bangalore's Magadi road. This is the site of the Karnataka State Drugs Logistics & Warehousing Society, the designated mother lode of free generic drugs for patients throughout the state. Behind the shelves, pharmacists Vasudev K and Beena HM reminisce about their recent visit to a warehouse in Chennai, where they got a close look at how their neighboring state takes care of business. What did they see? "It was full of stocks!" exclaims Vasudev. Yes, all those lovely cartons, containing no less than three months of buffer stocks. They also heard about Tamil Nadu's reliable system of bottom-up indenting, which allows primary health centers (PHCs) to request the drugs they need on a quarterly basis, with rolling stocks at the ready. Tenders are completed on time.

In most other states, stalled tenders, expired products and drug shortages known as "stock-outs" plague the system. It's generally a quiet plague, spreading behind the rusted bars of dispensaries at PHCs across India. Perhaps such nitty-gritty issues of drug procurement and distribution seem less dramatic than a story about a mysterious new virus called MERS, or a tale of a miraculous number of heart surgeries performed at a leading hospital. Logistics are for geeks. And generics might be perceived as a little unfashionable, a little old-school, with all the talk of breakthrough branded drugs.

But there is something very dramatic about the way that broken state procurement systems compel poor people to spend money on medicine that they are entitled to receive for free. And these are not small sums. One widely cited statistic is that medicine comprises 70 percent of household spending on health, a major out-of-pocket expense. “People are spending substantial portions of their meager disposable income on highly priced medicines from the private sector,” concludes a March 2014 study from the Public Health Foundation of India (PHFI). The economic and physical burdens of disease remain as closely intertwined as any strand of DNA.

The Bharatiya Janata Party’s (BJP) election manifesto spoke vaguely of making drugs more accessible and affordable. Now, post-election, it remains to be seen whether the notion of “affordable” will be augmented by the urgency of “free”. But the idea does seem to be back on the table. On May 30, newly appointed Health Minister Harsh Vardhan [announced a plan](#) to meet with ministers of health from various states to discuss the possibilities of streamlining procurement and distribution of generics. An honest assessment of problems would be a refreshing start.

In Karnataka, for example, follow the trail of Amlodipine, an essential medicine to treat high blood pressure and prevent angina chest pain. As of late May, only one warehouse in Belgaum had any remaining supply, with thirteen other warehouses bereft. At a clinic in Bethamangala village, pharmacist Shanta Kumari says the stock-out has persisted for three months. Her appeals to the nearby warehouse in Kolar went unheeded. In Bangalore, Vasudev explains that an unfortunate mix of personnel transfers and the recent elections delayed the tender for Amlodipine.

With health services vulnerable to the caprice of bureaucratic appointments and political events, reliability falls by the wayside. In fact, the overall procurement process for essential medicines in Karnataka was not finalized until December 2013, eight months behind schedule. Meanwhile, another bad combination of budget constraints and poor judgment in annual indenting is creating havoc at the grassroots. “We can’t predict, exactly, what drugs we need,” confesses Amarnath, the sole doctor on duty in Bethamangala’s crowded community health center, a facility meant to employ five doctors.

Down the road, at a PHC in Kysambhalli village, a whiteboard hoisted above the entrance displays a host of little x’s to mark various drugs that are unavailable from month to month.

There is supposed to be a safety net. Public clinics and hospitals are now empowered to use certain emergency funds to run out and buy drugs on the open market – notwithstanding prices that would be higher than the bulk purchases sanctioned in Bangalore. Common items like iron pills, vitamins and disposable syringes are often subject to such piecemeal sourcing. Yet the bureaucratic approvals for some “emergency” purchases, such as drugs to treat diabetes, can also languish in the files. As a result, patients are asked to purchase the drugs elsewhere. “People do get aggressive, but we try to convince them to buy outside,” says Surekha S, a pharmacist at the Bangarapet taluk hospital. Private pharmacies opposite the hospital confirm that they regularly fill prescriptions written at the government facility.

Less than 70km south of Bangarapet lies Bargur, a town across the border in the

boulder-strewn Krishnagiri district of Tamil Nadu. Udaya Suryan, the doctor in charge of Bargur's local clinic, says that he never buys items on the open market. The clinic handled 1,38,000 patients last year, and everyone got free medicine. "We have everything available. Why should we purchase outside?" he asks. For example, when he ran low on lignocaine injections recently, the doctor dispatched the pharmacist in a van to the Dharmapuri warehouse (part of an extensive network of decentralized storage facilities). The pharmacist left in the morning and returned with the item by the end of the day.

Drug distribution did not always run so smoothly in Tamil Nadu. Fifty-three year-old Suryan can still remember the horrors of the old system in place 15 years ago, when top-down planning prevailed and waste was endemic. "They just dumped the drugs and left, whether we needed them or not," recounts the doctor. These days, his clinic attracts loyalists like 35-year old Vijaya, who supports her disabled husband by selling saris. This time she has come to remedy a persistent pain in her heel. "Even if I had more money, I would prefer to get medicine here," she says. "I feel I will get cured."

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For years, health activists across India have tried to transform drug procurement into a political issue. Well-aware of the Tamil Nadu model, they have campaigned for its widespread adoption, often rebuffed in the process. "It's very, very frustrating," reports Anant Phadke, a doctor and public health activist based in Maharashtra. "I am at a loss as to why the politicians have not done this. It's very unfortunate, and a little enigmatic." S Srinivasan, Gujarat-based joint convener of the All-India Drug Action Network, chalks it up to a lack of imagination. "Health is not a big priority with most state governments. They do not see the political impact it can have," he says.

There are exceptions. Both Kerala and Rajasthan, for example, have made significant strides in installing new software to ease procurement and provide more generics in public health centers. In 2011, the UPA government held a Delhi meeting with health secretaries from various states and urged them to move in the direction of the Tamil Nadu model. Such prodding did seem to shake up Gujarat, a state that is still plagued by daily stock-outs, according to a government official who requested anonymity. In August 2013, Gujarat formed an autonomous drug procurement agency and plans to install the same software that has helped Rajasthan track its supplies. **In Bihar, too, a more transparent website augurs positive change.**

### **Private Players**

Some big players in the private sector also admire the systemic transparency, quality control and prompt delivery achieved in Tamil Nadu. When asked for suggestions to fix the system in Karnataka, the response comes without hesitation. "They don't have to reinvent the wheel. They can benchmark Tamil Nadu," urges Premnath Shenoy, director of Patient Safety & Regulatory Affairs at AstraZeneca Pharma India Ltd. That advice is echoed by Rani Desai, head of the Biocon Foundation, the nonprofit linked to

the pharmaceutical firm founded by Kiran Mazumdar-Shaw. The foundation currently runs nine community health centers, choosing to independently source generic drugs rather than rely on the erratic government supply.

The issue strikes at the heart of India's prospects for overcoming the disturbing inequality that has left the country looking "more and more like islands of California in a sea of Sub-Saharan Africa," as starkly described by economists Jean Dreze and Amartya Sen in *An Uncertain Glory: India and its Contradictions*. India's healthcare system is now skewed toward the private sector, with only an estimated 35 percent of the population relying primarily on the government healthcare system. That trend is fuelled by the paucity of doctors who accept rural postings, along with the shortage of quality drugs in the public sector. It's hard to miss the irony here, given India's leading role in providing low-cost drugs to developing countries worldwide.

According to pharma industry insiders, generic drug procurement for government clinics was not a topic parsed by the group of 12 private pharmaceutical companies that advised the BJP on its health plank in the run-up to the elections. These companies were more concerned about setting up a universal insurance scheme that would allow for massive new purchases of their branded products. They also discussed the use of Corporate Social Responsibility funds to offer discounts to the government.

On a rhetorical level, however, generic hand-outs tick a host of boxes identified as priorities by Vardhan's boss, Prime Minister Narendra Modi. Broadening access to free medicine is intimately linked to transparency, efficiency, and delivering tangible gains. Its fate is wedded to updated software that allows for effective monitoring. (In Bangalore, for example, the drug logistics chief currently has no way of knowing about the stock-outs occurring in a clinic in Bethamangala village, since his antiquated software only reaches the district warehouse level.) It makes good economic sense, since more bulk purchases would save money squandered on piecemeal sourcing. An initiative supporting generics could also mesh with Modi's stated intention of rallying the states to coordinated action on the country's development needs.

And if states led by the Congress or regional parties wish to grab back the "development" mantle, providing a more reliable supply of generic medicines is one way to do that.

But curing drug envy (to return to our new phrase) is not so easy. Health experts point out that Tamil Nadu's superior system was borne of a 1994 drug scam that turned the public's stomach. Historically, Tamil leaders have perceived health as a politically sensitive subject, and exerted both political will and budgetary support to craft a system that works. In particular, the Tamil Nadu Medical Services Corporation was granted the gift of autonomy and dynamic leadership, which have given rise to fast-track decisions. Autonomy, leadership, money, and information management – such is the bouquet of prerequisites to success.

Sadly, many states will have to struggle to achieve such boons. "There's always a tug-of-war going on between different stakeholders," says Maulik Chokshi, an associate professor at the Indian Institute of Public Health-Delhi, affiliated with the PHFI. The line of resistance comes from those who are loath to relinquish their decision-making powers and priorities, Chokshi explains. In Odisha, for example, the formation of a

new State Drug Management Unit was not a panacea for the state's difficulties in distributing generics, as documented in a 2012 [article](#) published in the Economic and Political Weekly. New tenders were stalled for a shocking two years.

Health is a state subject, and each state draws up its own essential medicines list. Not surprisingly, the composition of that list is subject to lobbying by various pharmaceutical firms. Opportunities for corruption can arise when a decision is made to add an item, or just keep it on the list. "Ultimately, it is vendor-driven management," notes a retired health department insider in Bangalore. Clearly, some bureaucrats stand to benefit if the system in their state remains opaque. And patients lose. "There is a disparity between what is actually needed and what is actually stocked," says Sham Kashyap, senior research officer at Grassroots Research And Advocacy Movement (GRAAM), a Mysore-based NGO.

A boost in transparency can also pose a sudden strain. Consider the case in Rajasthan, where the comprehensive drug-management software called "e-Aushadhi," developed by the Center for Development of Advanced Computing (C-DAC), made its debut in 2011. The software allows officials to trace supplies all the way down to the PHC level, and even tracks individual prescriptions handed out by doctors. Colored alerts pop up if a particular stock runs low, or a drug approaches its expiry date. The improved flow of medicines led to a dramatic increase in clinic footfalls last year, according to Malini Aisola, senior research associate at PHFI.

But these developments also exposed the shortfall of rural doctors and pharmacists in Rajasthan. It's a puzzle replayed across the country. India has over a thousand pharmacy colleges, which churn out about 1 lakh graduates annually, according to Atul Kumar Nasa, president of the Indian Pharmacy Graduates' Association. Yet many states have not managed to recruit the required number of pharmacists for government jobs. In Karnataka, for example, there are still 760 vacancies even though the state boasts the highest number of pharmacy colleges nationwide. Some candidates shun rural postings, Nasa observes. But others simply can't figure out where the jobs are available.

Still, it's a positive sign that more governments are turning to better IT management of their drug stocks. According to C-DAC, states that are already in the process of adopting e-Aushadhi include Maharashtra, Odisha and Punjab. Additional requests have come in from Jammu & Kashmir and Nagaland.

Change also appears to be underway in Karnataka. Prabhuling Kavalikatti, appointed last August as the additional director for the Karnataka State Drugs Logistics & Warehousing Society, has set his sights on replicating the gains in Rajasthan and Tamil Nadu. "If others are doing much better than me, I will follow them or think of overtaking them," says the Karnataka Administrative Service officer. Having put in a request for new software to the National Informatics Centre (NIC), he expects to have access to stock reports from PHCs later this year, and wants to stick to a firm tendering timetable after the "procedural hiccups" of last year. Meanwhile, a government committee has pruned the list of approved items from 570 drugs and equipment down to 377 items, to focus on the most essential and fast-moving medicines.

Kavalikatti has also engaged in fresh consultations with vendors to iron out contractual

issues, according to the Karnataka Drugs & Pharmaceuticals Manufacturers' Association. In the first week of June, he dispatched his chief drugs supervisor on a fresh study tour of Tamil Nadu. And he will go ahead and procure bulk supplies for the state's medical colleges, a turnaround from the practice of yesteryear, when the colleges fended for themselves with problematic tenders.

"We want a system that is totally above board," insists Sharan Prakash Patil, Karnataka's Minister of Medical Education. "This is an important issue."

Since the start of the year, officials from Kerala, Himachal Pradesh, and Jammu & Kashmir have all trekked to Tamil Nadu to pick up more tips on generic distribution. Meanwhile, Tamil Nadu has its own plans. As other states work to catch up, Tamil Nadu is busy upgrading its own computer system for an even more comprehensive picture of the realities on the ground. States can learn from each other, but only if they cultivate their own stash of reliable data.

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