OVERVIEW

Substantial investments are made by the Ministry of Health & Family Welfare on the purchases of medicines and medical equipment. These investments are a significant part of the overall strategy of the ministry for improving quality of health services. Inadequate management of the pharmaceutical procurement procedures and operational principles for acquisition of medical equipment result in financial losses and more importantly affect the objective of providing diagnostic and therapeutic services to the public. During the years 2002-07 expenditure on purchase of supply and materials including medicines and medical equipment constituted about 13 to 16 *per cent* of total expenditure of the Ministry.

Performance audit of the procurement policy, procedures and practices in the Department of Health & Family Welfare, DGHS and Central Government hospitals and other subordinate/attached offices revealed that standard good pharmaceutical practices were by and large not followed and procurement process was characterised by ad-hoc and arbitrary decisions. The basic requirement of developing formal written procedures, using explicit criteria or key performance indicators for making procurement decisions was not met. Similarly, a Management Information System for tracking demand and supply of medicines and medical equipment has not been set-up either in manual or computerized environment for planning and managing procurement.

Instead of having a common essential drug list or a local formulary list for DGHS and Central Government hospitals, separate formulary lists had been prepared by DGHS, AIIMS, LHMC hospital and JIPMER**.** RML and Safdarjung hospital did not have any formulary list. Large scale purchases of medicines which were not included in the approved lists had been made by most of the organizations. The essential drug lists were, thus, unreliable. Wide variations in the medicines actually included under various groups in the essential drug lists, across different institutions, were observed. Techniques adopted for making accurate quantification of procurement requirements were not reliable as while on the one hand a large quantity of medicines remained in stock until the expiry of their life, on the other hand requirements could not be met in a large number of cases from supplies received through MSO. This had necessitated purchase of medicine from local chemists/suppliers on a very large scale.

The basic objective of making procurement in the large quantities both under centralized and decentralized systems in order to achieve economies of scale was to a large extent not achieved. Various studies including a study made by the Internal audit of the ministry had brought out serious irregularities in the scheme of purchase of medicines from local chemists under CGHS. The quality assurance procedures were also not reliable as pre and post qualification procedures for eliminating sub-standard suppliers and performing targeted quality control testing had not been established. The practice of purchasing pretested medicines had become inoperative owing to bulk local purchases.

The procedure adopted for acquisition of medical equipment suffered from improper planning, non-evaluation of full lifetime costs before the acquisition of equipment, non-standardization of medical equipment, excessive provision or under provision of medical equipment across hospitals and absence of medical equipment libraries.

Standard bidding documents had not been prepared for ensuring comprehensiveness and clarity of bid documents and non-standard bidding documents were used across departments. Cases were observed where important provisions relating to "liquidated damages", "document establishing bidder eligibility and qualification", "Force Majeure" and "packing" etc. were left out in bid documents.