Aidspan
Independent observer of the Global Fund

GLOBAL FUND DECISIONS THREATEN CENTRAL MEDICAL PROCUREMENT AGENCIES

The role of national central procurement agencies

National central procurement agencies for essential drugs fulfill a public service with a social purpose, in accordance with their national pharmaceutical policies. Those institutions, called CAMEG (La Centrale d'Achat des Médicaments Essentiels Génériques et des consommables médicaux) for Central Agencies for Essential and Generic Medicines, are autonomous government institutions that purchase quality medications, laboratory reagents and other health commodities in bulk from manufacturers, warehouse them and sell them to public and private not-for-profit health facilities at affordable prices. Most of these procurement agencies in francophone West and Central Africa are members of the ACAME (African Association of Central Procurement Agencies for Essential Drugs).

The central procurement agencies' financial and economic model was based on cost recovery regulations advocated by the 1987 Bamako Initiative (BI). According to this financial model, central procurement agencies need to reach a financial break-even point in order to fulfill their mission. They make revenue by applying ad valorem margins to, and including operating expenses in, purchase prices. These operating expenses can be facility costs, direct and indirect operational costs (purchases, transportation, storage and distribution), financial expenses and funds for working capital requirements.

The operating costs and volume of sales of each central procurement agency determine margin rates. According to ACAME's 2016–2020 data, average margin rates can vary from 20% to 35%, depending on the specific central procurement agency and the year in question.

Over the last ten years, governments and their partners have more frequently required central

procurement agencies to store and distribute subsidized products that partners have purchased for priority health programs. The value of the procurement of these pharmaceutical products by the Global Fund to Fight AIDS, Tuberculosis and Malaria and other partners, including the US President Emergency Plan for AIDS Relief (PEPFAR); the President's Malaria Initiative (PMI); United States Agency for International Development (USAID); the Clinton Health Access Initiative (CHAI); the United Nations Population Fund (UNFPA); the United Nations Children's Fund (UNICEF); and Gavi, The Vaccine Alliance, has increased exponentially.

Central procurement agencies often do not have enough funding to purchase additional stock of essential medicines because they are unable to recover debt from public health institutions. Suppliers frequently require central procurement agencies to pre-finance stock, but they are unable to do so due to this lack of funding, which leads to stock-outs.

Multi-national procurement mechanisms rise at the expense of national agencies

The Global Fund Secretariat now carries out most of the procurement of "key health products" for countries receiving its grants, via its pooled procurement mechanism (PPM) and not a national central procurement agency. (In Africa, only a handful of countries such as Ethiopia, Kenya, Rwanda, and South Africa use their national institutions for procurement.) Key health products include antiretrovirals (ARVs), antimalarial medication, long-lasting insecticidal nets (LLINs), and rapid diagnostic tests for HIV and malaria. The Secretariat added the wambo.org platform as an additional system to allow countries to purchase health commodities with domestic and other funds. According to the Global Fund, establishing this multi-national mechanism is justified by:

- a greater capacity to negotiate prices and the potential to achieve economies of scale when acquiring health products, which account for the greatest expenditure within grant budgets (the average was 40% according to the BIG annual report in 2017 but is now around 60%, with peaks of up to 55% in Guinea-Bissau, 67% in Congo-Brazzaville or 68% in Togo
- difficulties encountered by certain countries in complying with tendering regulations or the Global Fund's policy on health product quality.

Depending on the country, health commodities purchased by the Global Fund and other partners represent between 30% and 40% of the value of the health products purchased by central procurement agencies, according to ACAME members' calculations. These figures confirm the trend to transform "procurement agencies" into "logistics platforms" focused on distributing, and no longer on purchasing, pharmaceutical products as initially intended.

When the central procurement agencies' purchasing role is replaced:

- It decreases countries' capacity to acquire health products for their populations.
- It does not encourage national ownership of the purchasing process since:
    - countries are not involved in the procurement and tender processes
    - tendering procedures and contracts between the partner (PPM/the Global Fund in particular) and its suppliers lack transparency. This makes it difficult to ensure that delivery times or technical specifications of the products are adhered to
    - fragmented acquisition processes result in longer order and delivery periods, and increase transaction costs and management fees due to the various intermediaries in the chain
    - there is little control over pharmaceutical quality assurance.
- It decreases the market share of the public pharmaceutical sector that central procurement agencies have in favor of specific disease programs financed by partners such as PEPFAR; PMI; UNICEF; Gavi and the Global Fund.

A reduction in the central procurement agencies' sales volume reduces their revenue. Consequently, the agencies increase their margins on unsubsidized health products to maintain a financial balance. This increases the price of products for non-communicable diseases and creates equity issues: for example, drugs for diabetes or hypertension cost more because antiretrovirals for AIDS, or drugs for tuberculosis, are subsidized and therefore cost less or are free for patients.

This issue is evident between people living with different illnesses or conditions. It is also becoming more important as people living with HIV age and develop other non-communicable diseases, which are not subsidized. The significant investment made in fighting such diseases is threatened because instrumental institutions have become obsolete due to the unintended consequences of organizational policies.

Pharmaceutical logistics costs are only partially covered

Currently, most of the products subsidized by the Global Fund and other partners are managed by central procurement agencies. Their pharmaceutical logistical operations include transportation or customs clearance and storage and distribution at the decentralized health facility level. The use of a national agency indicates that there has been real progress since 2006 when there were multiple distribution channels for health products within a country. The ACAME criticized the fragmentation of the procurement and distribution process caused by partners purchasing health commodities for their programs and distributing them to facilities in the Dakar Declaration of 2006.

Central procurement agencies either operate as sub-recipients or service providers for the Global Fund. They are then partly compensated, rather than fully paid for their logistics and pharmaceutical services, under varying conditions. For each grant, the Global Fund negotiates "management fees" with the Principal Recipient (PR) and the central procurement agency for the logistics services provided. ACAME identified a considerable difference when the national stakeholders were able to negotiate fees. However, thanks to a logistics cost calculation tool developed by ACAME, some central procurement agencies have been able to request that their management costs be increased to up to 10% of the customs value or the cost, insurance and freight (CIF) value of subsidized health products. Other central procurement agencies still receive between 2% and 5% of management fees. Two recent studies, one carried out by Dr. Zakariya Yabre on the logistics cost of the CAMEG Burkina Faso, and the other by the New Public Health Pharmacy in Côte d'Ivoire, have estimated that the direct and indirect costs of storing and distributing health products from the Global Fund are between 12% and 15% of the cost, insurance and freight value (CIF), although they only received between 2% and 4.75% of management fees depending on the grants (HIV, malaria or tuberculosis). This means that management fees cover only one third of the actual costs incurred by central procurement agencies and that the other two thirds are financed by the margin applied on the sale of other health products.

Increasing the prices of non-subsidized drugs to partially compensate for management costs of subsidized products for priority diseases again raises equity issues in terms of people being able to financially access essential drugs. In other words, the Global Fund's partnership forces people who live with or are affected by other diseases to subsidize those who live with or are affected by HIV, TB or malaria. Medicines for other diseases cost more than they would have if the Global Fund fully covered the costs of managing and distributing medicines and other supplies for the three diseases, or if these costs were co-financed by governments.

It is important to note that other donors use the same model for the diseases or conditions they care about. This situation compounds the problem of equity for those who live with or are affected by diseases that are not a concern for any donor.

Is the Global Fund jeopardizing central procurement agencies?

Substituting central procurement agencies at national level for multi-national mechanisms to procure pharmaceutical products goes against the ownership and alignment principles of the Paris Declaration and the Accra Agenda for Action (see the preamble), which both result from decades of development experience.

Notably, recent audits of the Global Fund Office of the Inspector General (OIG) on the PPM and on the wambo.org platform reveal a failure to achieve the expected economies of scale, long order timeframes but also non-compliance with tendering regulations since the PPM lacks rigorous procedures for developing and monitoring contracts. Some countries, like Ethiopia or Kenya, that do not use the Global Fund system buy certain medicines for a lower price than those obtained by the Global Fund. The OIG's audit of Kenyan grants found that some ARVs cost 21% less at Kenya's central procurement agency, Kenya Medical Supplies Authority (KEMSA), than within the Global Fund's PPM. (Aidspan described earlier how Kenya successfully procures health commodities without using the Global Fund's pooled procurement.)

This lack of alignment between countries and a partner as important as the Global Fund is regressive. By placing countries that have effective central procurement agencies for essential health products "under supervision" hampers the development of national facilities.

According to the OIG/Global Fund audit report on country-level Global Fund supply chain processes: "National ownership is essential for the efficiency of in-country supply chains and underpins the strengthening of supply chain systems."

In addition, the underestimated cost of storing and distributing health products subsidized by the Global Fund, and other partners, compromises the financial viability of central procurement agencies. Their ability to fulfilL their mission is severely disrupted as governments rely on central procurement agencies to implement policies and programs to achieve universal health coverage (SDG 3.8). Central procurement agencies must commit to establishing an analytical accounting system to enable them to better control their operating costs and plan for the investments required to expand their work.

Conclusion

In light of the new funding cycle, as well as this period of intense reflection to develop a new strategy, it is important to raise these issues, particularly as the proportion of health products in grants continues to increase (depending on the country, health products represent between 60% and 90% of expenditure).

It is vital to:

- ensure that the main global health donors, in particular the Global Fund, fully cover the costs of the services provided by central procurement agencies. In-country teams and ministries of health need to ensure that the logistics calculation tool is used, and that the cost of managing health products is adequately budgeted for during the grant-making process.
- acknowledge costs paid by central procurement agencies so that they can be co-financed by ministries and the Global Fund as part of national activities. Central procurement agencies have up-to-date figures on the management costs they incur, and these must be taken into account.
- provide substantial support to the most vulnerable central procurement agencies through grant funding in order to ultimately avoid resorting to external service providers (as occasionally done by agencies like Gavi; PEPFAR and the Global Fund) that are costly, sometimes ineffective and often unsustainable. This is a recommendation from the OIG, which has observed difficulties with supply and stock shortages despite substantial expenditure and the engagement of external partners. At a

time when health system strengthening is a priority for the Global Fund strategy, its health product strategy must be clearly oriented towards building national skills.
- assess procurement agencies' whose economic models are not viable and weaken them, in order to identify priorities and strategic actions to unite the efforts of the main health donors.

Further reading:

- OIG audit of Global Fund's In-country Supply Chain Processes, 28 April 2017
- OIG audit of Global Fund grants to Kenya, 12 November 2018

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