

REPORT SUBMITTED TO
INDIAN COUNCIL FOR SOCIAL SCIENCES RESEARCH

Competition and Public Procurement

The Case of Health and Primary Education Sectors

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This report assesses the regulatory and competition issues in public procurement. In the development context of India, public procurement continues to play a critical role and require greater efficiency as well as effectiveness, and infusing competition can be a principal policy tool to achieve this goal. The report looks at two sectors – health and primary education – which impact lower strata of population more directly.

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Contents

S.No.	Chapter Name	Page Number
1	Introduction and Methodology	3
2	Regulatory Framework Governing Public Procurement	12
3	Public Procurement in Health Sector	19
4	Public Procurement in Primary Education Sector	52
5	Conclusions and Recommendations	60
	Bibliography	64
	Annexures	
	1. List of Persons whom the study team interacted	66

Chapter 1 Introduction and Methodology

1. Background of the Study:

1.1 Public procurement is the purchase of goods or services by the public sector and it generally accounts for a large share of public expenditure in a domestic economy. Public procurement¹ may be defined as, “the purchase of goods and services by governments and state-owned enterprises. It encompasses a sequence of related activities starting with the assessment of needs through awards to contract management and final payment.”²

1.2 Existing statistics suggest that public procurement accounts, on an average, for 15% of Gross Domestic Product (GDP) worldwide, and is even higher in OECD countries where that figure is estimated at approximately 20% of GDP. Public Procurement in India constitutes 30% of the GDP. Departments like Defence, Railways and Telecom devote about 50% of their budget to procurement, which happens to be higher than the expenditure of most state governments. About 26% of the health budget is devoted to procurement. By some estimates, the annual public procurement in India would be of the order of 8 lac crore while a rough estimate of direct procurement is between Rs. 2.5 lac crore to Rs.3 lac crore.. Thus total procurement figure for India is pegged at around Rs.11 lac crore per year. Considering such huge volumes of purchase, a sound procurement system is therefore crucial for ensuring national security, safety of passengers, health of the citizen and quality of infrastructure and services.³

1.3 There is a threefold approach to the objectives that are envisaged as being fulfilled by public procurement: maximize public welfare by providing quality services and products, maximize growth opportunities for the private sector and ensure efficient spending of government money. The primary goal of public procurement policy is to ensure that they achieve “value for money,” i.e. to procure best goods and services at the lowest price. Further, public

¹ As defined by OECD

² OECD Procurement Tool box. Available at: http://www.oecd.org/document/10/0,3746,en_21571361_44258691_44879818_1_1_1_1,00.html

³“Enhancing value in public procurement,” special address by Shri Pratyush Sinha, CVC, ‘Conference on Competition, Public Policy and Common men.’ Available at: www.cci.gov.in/menu/speechesbypratyushsinhacvc.pdf

sector being large purchaser of goods and services can impact and influence the overall resource allocation in the domestic economy. Therefore, procurement policies and procedures in the public sector have a deep impact on the overall competitiveness, economic efficiency and the pace of technological innovation. Further, given the magnitude of funds involved, the public perception of integrity and competence of the government is largely influenced by the performance and integrity in public procurement. Thus, in view of the fact that public procurement constitutes a significant proportion of the GDP of the government and government at all levels undertake large scale procurements, coupled with the absence of a clearly laid down regulatory framework for procurement makes it susceptible to competition issues⁴.

1.4 The impact of collusion, bid-rigging and corruption is more dampening in the public sector than in private because of the important nature of social services that are being provided by the public sector. Apart from the loss of public funds, inefficient procurements have a detrimental impact on public infrastructure and services, therefore directly hurts the interests of the most disadvantaged in society, who rely on public provision to a great extent. In light of the aforementioned background, it is reasonable to say that effective regulation and competition will bring in greater efficiency, value for money for goods and services procured, and transparency in the public procurement processes and systems.

1.5 The study has aimed to identify and analyse the regulatory and competition issues adversely affecting the public procurement in the health and primary education sectors both at the central and state levels with a focus on the State of Rajasthan. It highlights the regulatory and competition concerns along with possible remedies to address the identified issues in public procurement systems. The outcome of study in turn would help the government agencies to procure goods and services in efficient, effective and transparent manner.

⁴ Globally as well as in India, studies are being carried out to examine ways to infuse competition in public procurement. In view of the importance of public procurement, various international organizations like the World Bank, UNCITRAL, ADB, OECD, WTO etc. have provided guidelines governing public procurement which are followed by countries apart from their own procurement regulations.

2. Methodology

(a) Coverage:

2.1 This study has covered the legal and regulatory framework governing public procurement in India with particular emphasis on public procurement related to:

- Public Health Sector and
- Primary Education Sector

2.2 To cover these two sectors, the study has considered central as well as state level procurements. The focus state in this regard has been Rajasthan. Legal and policy framework of these two jurisdictions has been studied. Then the sectoral policy-framework and laws related to public procurement have been reviewed, alongside studying tendering process through available information for the previous three years.

2.3 Three most high value tenders of each sector in State and Central Government, during the previous three years were requested. Researchers could not get all the desired information; therefore, the conclusions presented in the chapters are based either on the limited information available in the public domain or what could be procured through filing RTI applications. Alongside, attempt was made to study three most frequently occurring tenders (irrespective of value) in terms of procurement of nature of goods and services, along the time horizon of last three years for each sector in state and centre.

2.3.1 The tender documents mentioned above were analysed in the light of the well-recognised principles of public procurement, which evaluate each stage of the procurement process. The matrices below, some indicators along with their impact on competition have been presented:

Pre- tendering phase	<ul style="list-style-type: none">• Needs assessment• Planning and budgeting• Definition of Requirements• Choice of Procedure
Tendering Phase	<ul style="list-style-type: none">• Invitation to tender• Evaluation• Award
Post-tendering phase	<ul style="list-style-type: none">• Contract Management• Order and Payment

Main Indicators	Sub-indicators	Competition Impact
1. Legislative and Regulatory Framework	<ul style="list-style-type: none"> i. Uniformity and universality of coverage ii. Procurement Method iii. Advertising Rules and Time Limits iv. Rules on participation v. Price preferences for domestic firms. vi. Registration vii. Participation of state owned enterprises viii. Tender documentation and technical specifications ix. Tender evaluation and award criteria x. Complaints xi. Model tender documents for goods, works, and services. xii. Procedures for pre-qualification 	<ul style="list-style-type: none"> i. Results in greater transparency in procurement ii. The choice of the procurement method determines the degree of competition in the tendering process. iii. The law and regulations should establish the criteria for setting the minimum time between advertisement and submission of proposals. This has an important bearing on the degree of competition in the tendering process. iv. Firms, including qualified foreign firms, should not be excluded from participating in a tendering process for reasons other than lack of qualifications. Exclusions from tendering that are not based on the qualifications of the firm may arbitrarily limit competition and may result in inefficient procurement and higher prices. v. Excessive price preferences or other concessions for certain groups of bidders can deter effective competition and reduce gains in efficiency. vi. Registration as a condition to participate in a bid may become an entry barrier unless registration is open all the time and can be completed in a simple way any time prior to contract award. The registration system should not constitute a barrier to participation and should not discriminate. Registration should not substitute publicity in wide circulation media. vii. Participation of state owned enterprises should be governed by rules that create a level playing field for all competitors and should not be subject to preferential treatment on account of subsidies or tax exemptions, etc.

		<ul style="list-style-type: none"> viii. Specifications included in the tender documents must be neutral and refer to international standards where possible or other officially recognized standards that are essentially equivalent to the ones specified. ix. Pre disclosed and objective criteria are essential for efficiency, fairness and transparency in the evaluation of tenders. It is desirable that evaluation criteria be quantifiable as far as possible, or stated in pass/fail terms. The decision criteria for award should be based on awarding to the lowest price evaluated tender. Vague criteria (e.g. award to the tender most convenient to the interest of the state) should not be acceptable. Confidentiality and regulated communications with the bidders during the evaluation period are necessary to avoid abuse and undue interference in the process. x. Confidence in a procurement system is a powerful incentive to competition. A fundamental part of this is the establishment of the right to review procurement decisions by an efficient and functionally independent process. xi. Model documents of good quality promote competition and increases confidence in the system. xii. Pre-qualification should be defined by procedures in order to ensure that it is not abused and used as a method for limiting competition by overstating the qualification requirements.
<p>2. Procurement Operations and Market Practices</p>	<ul style="list-style-type: none"> i. Effective mechanisms for partnerships between the public and private sector. ii. Private sector 	<ul style="list-style-type: none"> i. The voice of the private sector needs to be heard with regard to practices by the government that may undermine the competitive effectiveness of the private sector. There must be forums for dialog

	<p>institutions are well organized and able to facilitate access to the market.</p> <p>iii. There are no major systemic constraints (e.g. inadequate access to credit, contracting practices, etc.) inhibiting the private sector's capacity to access the procurement market.</p> <p>iv. Degree of access to information.</p> <p>v. Choice of Procurement Method</p>	<p>between the government and the private sector.</p> <p>ii. A well organized and competitive private sector should result in keen competition, better prices and an equitable distribution of business.</p> <p>iii. Participation in competition for public contracts depends on many conditions, including some that are controlled or within the control of the government. Access to credit, reasonable contracting provisions that are seen to fairly distribute risks associated with performance of contracts, fair payment provisions that help offset the cost of doing business with the government are examples which can improve access by the private sector to the government marketplace. Alternatively, when the conditions are difficult for the private sector, the degree of competition will suffer.</p> <p>iv. Public access to procurement information is essential to transparency and creates a basis for social audit by interested stakeholders. The system should also include provisions to protect the disclosure of proprietary, commercial, personal or financial information of a confidential or sensitive nature.</p> <p>v. Although open tendering is generally considered as the best method of procurement, it may not be so always. Open tendering might not be an efficient method for smaller contracts. One would expect that a large volume of procurement in value is grouped in a relatively low percentage of contracts. A high number of contracts procured under open tender can result in high administrative costs or it might</p>
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		<p>indicate that the contracts are kept intentionally small even though grouping of requirements into larger contracts could result in wider competition and improve economies of scale. A low percentage of open tenders can indicate fractioning of procurement to avoid open tendering.</p>
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(b) Data Collection:

2.4 The required data for the study has been collected from primary as well as secondary data sources. The nature of data is quantitative as well as qualitative. A checklist prepared to collect data. The parameters considering while collecting data for the report included:

- What is the basis of making any procurement? How is the needs assessment for making any procurement done?
- What is the timeframe for the preparation of the tender and is it sufficient? What are the cases in which there are inconsistencies in the application of this timeframe?
- What are the possible evidences a procuring officer keeps in mind about informal agreement on a contract?
- Are there any signs of procurements not being aligned with the overall policy of the organisation?
- How far are the selection and award criteria clearly and objectively defined?
- What conditions could result in inconsistencies in access to information for tendering i.e. in the invitation to tender? How are such inconsistencies dealt with?
- Are the award and evaluation criteria announced in advance of the closing of the bid or not?
- Are the records on the procedure followed for procurement easily accessible?
- How is it ensured that the specifications of requirements for the procurement are clear and comprehensive but not discriminatory?
- What are the other things borne in mind while writing specification of requirements for any procurement?
- Does the department concerned have a draw-down contract or framework agreement in place for the product/service?

- If such an arrangement exists but is not being used, what are the reasons for it?
- What are the steps followed in conducting an appropriate competitive tendering procedure?
- What are the contents of the 'Request for Tender' document of the concerned department?
- How is commercial sensitivity ensured and that the competitive situation of other tenderers is not compromised?
- How are instances of possible collusion between contractors and supervising officials detected and dealt with?
- Are standard terms and conditions for different types of tendering processes in place so as to maintain consistency?
- Is there a grievance redressal mechanism in place in a case particular bidder is not satisfied with the outcome of the contract finalized?
- What is the procedure for registration of suppliers? What is the timeframe and calendar for registration of suppliers/manufacturers?
- What is the system in place for training and enhancing awareness of procuring officials as procurement has emerged as a highly specialized discipline?
- What is the concentration of suppliers like in the given sector?

2.5 Information on the legal and policy framework on the focus sector and jurisdictions were collected for further analysis.

2.6 Data was collected from the tender documents mentioned above to be studied in respect of:

- Criteria of different public procurements (whether discriminatory or not)
- Nature of goods and services
- Objectives of procurements
- Clarity of definitions and conditions of the goods and services to be procured.
- Time limit of delivery
- Payment schedule
- The difference between prescribed and purchased.

2.7 In order to successfully achieve the research objectives, personal interviews were conducted with various categories of procurement officers in focus sectors and jurisdictions to gain insight into how the procurement function is performed.

(c) Data Analysis:

2.8 Identification of ‘regulatory issues’ including competition concerns was undertaken. Then regulatory issues including the competition concerns were analysed from two angles- policy/legal and their implementation/management aspects.

2.9 Furthermore, the data was analysed in light of competition issues and anti-competitive practices harming the overall benefit of public procurement along with the intention to answer the research questions. For example, data was mapped on the scales of time, geography and sector specificity.

2.10 Simultaneous to the analysis, best practices of cross geography comparison have been documented.

2.11 As an outcome of the project, recommendation for regulatory reforms related to public procurement system have been prepared for each sector keeping in view the best practices.

Chapter 2 Regulatory Framework Governing Public Procurement

Macro Regulatory Framework Governing Public Procurement in India

3.1 At the apex of the Indian legal framework governing public procurement is Article 299 of the Constitution of India, which stipulates that all contracts made in the exercise of the executive power of the Union of India, or by a State Government, shall be made in the name of the President of India or by the Governor of the State, as the case may be, and be executed on behalf of the President or the Governor by such person as he may direct. The Indian Contract Act, 1872 and the Sale of Goods Act, 1930 are the major Legislations governing contracts of sale/purchase of goods and services in general.

3.2 At the federal level in India, there is no legislation exclusively governing public procurement of goods, though at the state level certain state legislatures (like Tamil Nadu) have enacted such laws (whether these laws are really capable or laws on procurement still a separate question for analysis). These are “The Tamil Nadu Transparency in Tenders Act, 1998” and “The Tamil Nadu Transparency in Tender Rules, 2000” and the Karnataka Government has legislated “The Karnataka Transparency in Public Procurement Act, 1999”.

3.3 However, comprehensive rules and directives have been put in place at the federal level in terms of (i) the General Financial Rules (GFR), 2005, (ii) the Delegation of Financial Powers Rules (DFPR), (iii) the Manual on Policies and Procedures for Purchase of Goods issued by the Ministry of Finance (Manual), (iv) similar Manual governing Procedures for Purchase of goods/services issued by individual ministries/departments like Defence, (v) Government orders regarding price or purchase preference or other facilities to sellers in the Handloom Sector, Cottage and Small Scale Industries and to Central Public Sector Undertakings, etc. and (vi) the guidelines issued by the Central Vigilance Commission to increase transparency and objectivity in public procurement. These provide the regulatory framework for public procurement by governmental instrumentalities. **Further, vide notification dated November 2, 2010 issued by the Department of Expenditure, Ministry of Finance,** the Central Government has made the GFR Rules applicable to autonomous bodies’ as well, except in those cases where the bye laws of an autonomous body provides for separate financial rules which have been approved by the Government.

3.4 General Financial Rules were first issued in 1947 and were in the form of executive instructions. These were subsequently modified and issued as

General Financial Rules, 1963. Over the last four decades, these GFRs had to be amplified and supplemented by various decisions of the Government of India. Many of the rules had also become redundant. These developments including a rapid growth of alternative service delivery systems, developments in information technology, outsourcing of services and liberalization of the system of procurement, accounting and disposal of goods in line with the international practices necessitated an overall review of the General Financial Rules, 1963. A Task Force was set up for this purpose. The report submitted by the Task Force was widely circulated to all the Departments and Ministries and their suggestions were duly considered for making appropriate changes.

3.5 The General Financial Rules 1963 were amended with effect from July 1, 2005 to reflect the provisions of supra-national regimes like the GPA and the EC Rules which have been amended from time to time. General Financial Rules, 2005 have evolved as a result of the wide consultations and extensive review. The rules have been simplified and put in a logical sequence for easy comprehension. The appendices and forms of General Financial Rules, 1963 have also been comprehensively reviewed. Provisions regulating advances to government servants have been excluded from GFRs as these are distinct from direct government expenditure. These provisions have been issued separately as a compendium.⁵

3.6 As far as the administration of the regulatory regime for public procurement in India is concerned, there are a number of agencies which ensure effective implementation of the legal framework for government procurement in India. The constitutionally appointed Comptroller and Auditor General (CAG) oversees the accounts of the Union and the States (Chapter V, Articles 148-151, Constitution of India). The reports of the CAG relating to the accounts of the Union are laid before each house of the Parliament and those relating to the accounts of the State are laid before the Legislature of the State. These reports also cover procurement. The Parliamentary Accounts Committee (PAC), the Standing Committees and the Legislative Accounts Committees in the States oversee the functioning of the executive, conduct detailed examination and hearings and can call for all documents related to any decision or procedure. A system of checks and balances is built in at each level of Government to ensure transparency in the process. There is local fund audit for local bodies and these reports are also laid before the State Legislative Assemblies.

⁵ Preface to the General Financial Rules 2005, Department of Expenditure, Ministry of Finance, Government of India. Available at: http://finmin.nic.in/the_ministry/dept_expenditure/GFRS/GFR2005.pdf

3.7 The judicial process through the structure of Civil courts, High Courts and the Apex level Supreme Court provide an alternate channel of redressal for matters related to corruption in procurement. There is active participation of Civil Society and NGOs in the process through the channel of Public Interest Litigation where the High Courts and the Apex Court can hear writ petitions on matters relating to public interest even when the litigant may not be directly affected by the subject matter. Courts can direct investigative agencies to investigate any matter and also supervise the investigations.

3.8 The Central Vigilance Commission (CVC) is now a statutory body subsequent to the Central Vigilance Commission Act, 2003 and supervises investigations under the Prevention of Corruption Act, 1988 and the vigilance administration of the central Government. The CVC has also issued guidelines and instructions to curb corruption in procurement (www.cvc.nic.in). State Vigilance Commissions have also been set up in some states. Lokayuktas or ombudsmen have also been set up in some states to investigate charges of corruption against public servants, politicians, and officers. Any complaint regarding officials or the companies/firms involved in procurement is inquired into and action taken swiftly.

3.9 Recognising the benefits of competition, government constituted a High Level Committee in 1999 to review MRTP Act 1969 for shifting focus of the law from curbing monopolies to promoting competition. Following the recommendations of the Committee, the Competition Act 2002 was enacted. The Act prohibits any agreement which causes or is likely to cause appreciable adverse effect on competition in markets in India. Any such agreement is punishable. Bid rigging or collusive bidding is one of the horizontal agreements that shall be presumed to have appreciable adverse effect on competition under Section 3 of the Act.

3.10 The Right to Information Act, 2005 marks a benchmark in transparency and accountability with its objective of an informed citizenry for effective democracy. The active involvement of civil society organizations, jansunwais (public hearings) and social audit leading to greater awareness is at the heart of the process. Any information relating to any decision taken regarding procurement, among other things, can be accessed by the citizens within the prescribed time frame.

3.11 Sectoral procurement procedures have been developed within the general framework keeping in mind the specific requirements of the sector. Defence Procurement Manual (DPM) 2005 and Defence Procurement

Procedures, 2005 provide a comprehensive guideline including an offsets policy, an integrity pact and timetable for procurement. The aim is to increase transparency, to provide clear guidelines and remove ambiguities and to speed up the process of procurement.

3.12 As far as the legal framework governing public procurement in the health and primary education sectors is concerned, there is no central procurement authority though central purchase organisations like the Directorate General of Supplies and Disposal (DGS&D) and state level purchase organisations are active for rate contracts with registered suppliers for goods and items of standard purchase in the government under the provisions of the General Financial Rules (2005) and State Financial Rules. This has been dealt with in greater detail in chapters three and four.

3.13 In case of health sector procurement at the Central Level, there is an Empowered Procurement Wing which is a development initiative of the Ministry of Health and Family Welfare (MoHFW) under National Rural Health Mission (NRHM). EPW was initiated in the year 2005 to professionalise procurement of health sector goods and thereby promote conditions leading to better competition and transparency in procurement of health sector goods, drugs and services in India ensuring quality and timely delivery. Similarly in Rajasthan, health sector procurement is looked after by the Rajasthan Medical Services Corporation Limited, which has been established under the Companies Act 1956, to undertake procurement of drugs and medical equipments in the state.

3.14 In case of Primary Education sector, under the Sarva Shiksha Abhiyan, it is mandatory to follow the procurement procedure prescribed in the Financial Management and Procurement Manual for all the procurement under the SSA scheme. The states may follow the financial ceiling prescribed by each state for various methods of procurement. MHRD may prescribe financial ceilings for different methods of procurement from time to time. In such cases, the financial ceilings prescribed by MHRD shall prevail and should be adhered to.

3.15 Public Procurement Bill, 2011

3.15.1 In 2011, a Public Procurement Bill was presented. Various sections of the Bill cover almost the entire gamut of public procurement in sufficient details. However, time permitted for different stages is such that the total time taken for the procurement process may prolong the time period up to double of the present day situation. There is a need for tradeoff between conflicting issues keeping in view the ultimate

objective of timely procurement in the competitive markets to fetch best value for money.

- 3.15.2 In the Bill, certificate of ‘Independent Determination of Bid’ was not permitted, which is a good practice, observed in many countries. This measure alone has the potential of curbing anti-competitive practices like formation of cartels and bid-rigging etc. and obtaining best value for money.
- 3.15.3 Subject of Registration of Vendors/ Bidders should cover clauses pertaining to high technology and complex items where it should lay down guidelines covering different stages of registration so that the process as is existing today becomes more transparent, time bound and does not act as a deterrent for prospective vendors which if registered can bring about competition and fetch best value for money in public procurement.
- 3.15.4 It is observed through the contents of the draft Bill that there is an attempt to introduce greater transparency at each stage of the procurement cycle. Although ensuring transparency in procurement procedures is essential, flow of competition sensitive information could facilitate the formation of cartels and hamper competition as the potential bidders would be in a position to come together and manipulate the bidding process on the basis of information officially provided to them. Thus, there is a need for a trade-off between the degree of transparency and ensuring effective competition to obtain best value for money.
- 3.15.5 Comments on Specific Sections of the Bill - An attempt has been made as described hereunder to reflect the contents of Sections of various Chapters of the draft Public Procurement Bill 2011 against the essential principles of Transparency, Efficiency, Economy, Accountability, Professionalism and other relevant parameters that promote effective Competition.

S.No.	Section No.	Subject of the Section	Comments
Chapter IV			
1.	41(2)(b)	That they meet the relevant and other ethical standards.	It is not clear that how the procuring authority is going to satisfy itself that the bidders meet ethical and other standards’.
2.	43(2)(a)	The evaluation criteria may include the price.	Evaluation criteria do not include the certificate of Independent Determination of Bid as one of the criteria which is considered very important to avoid formation of cartels.

S.No.	Section No.	Subject of the Section	Comments
3.	54(1)	Acceptance of successful bid and award of contract	Criteria for acceptance of successful bid do not include the certificate of Independent Determination of Bid as one of the criteria which is considered very important to avoid formation of cartels.
4.	54(12)	Acceptance of successful bid shall be communicated to all the bidders within a reasonable time but not later than 120 days from the bid date.	The Section is silent on action to be taken by procuring authority in case one or more of the unsuccessful bidders raise a grievance against the decision of the procuring authority regarding acceptance of the bid from the successful tenderer.
5.	58(7)	Registration of qualified bidders-- situation when number of prequalified bidders is less than three.	Relevant section stipulates action of publishing notice at least once a year in newspapers in case the number of prequalified bidders is less than three. But what happens in the interim has not been explicitly specified. Should procurement continue with less than three prequalified bidders?
6.	77(1)(e)	Conditions for use of a single source procurement	Relevant Section stipulates that subject to approval by the Department of Public Procurement and following public notice and adequate opportunity to comment on the single source procurement. Section is silent on the mode of communication and time frame for adequate opportunity through public notice. Since single source procurement is the most restrictive form of procurement sufficient safeguards should be in-built in the section in a non-discriminatory manner to avoid complication at a later stage.
Chapter VI			
7.	90(1)	Period of effectiveness, modification and withdrawal of bids- Stipulates that period of effectiveness of bid	Against 60/90 days of period of effectiveness as of now, this is proposed to be enhanced to 120/240 days. Under such a situation period of finalization of open bids will correspondingly increase to almost

S.No.	Section No.	Subject of the Section	Comments
		shall not ordinarily exceed 120 days from the bid date and in no case beyond 240 days from the bid date.	double thereby affecting process of procurement adversely.
8.	90(1)(b)	Extension of effectiveness of bids by the bidders.	What happens in a situation when a bidder refuses to extend effectiveness of its bid beyond 120 days? Will this bid be also considered along with other bids whose effectiveness has been extended by the bidders?
Chapter VII			
9.	96(8)	Request for proposal without negotiation- “The procuring entity shall promptly communicate to each bidder the score of the technical, quality and performance characteristics of its respective proposal”.	The procuring entity should intimate the bidders in advance about the procedure to be followed and criteria for determination of the ‘score’ of technical, quality and performance characteristics.
Chapter VIII			
10.	97(6)	Two Stage Bidding- ‘the request for proposals with bid prices shall be issued not later than 120 days from the deadline specified for submission of the proposal for the first stage of the two stage bidding process.’	Permitting 120 days for submission of second stage price bid after deadline for submission of first stage of the two stage bidding process would prolong the time taken for finalisation of the bid which in turn would delay the entire procurement. It would be better if a model time frame for each type of bidding process is laid down covering each stage for compliance /guidance.
11.	98(5)(g)	Clause g of sub-section (5) of section 98 stipulates that, ‘where the procuring entity intends to limit the numbers of bidders which shall not be lower than three, if possible.’	The section states that the number of bidders shall not be lower than three. There are some obvious contradictions in limiting the number of vendors in restrictive bidding to three. There may be a need to revisit the relevant clauses to address this.

Chapter 3 Public Procurement in Health Sector

4 Health sector in India- An Overview

4.1 In the Indian perspective the provision of health care by the public sector is a responsibility shared by the State Governments, Central Government and local governments. General health services are the primary responsibility of the states with the Central Government focusing on medical education, drugs, population stabilisation and disease control. The National Health Programmes of the Central Government related to reproductive and child health and to the control of major communicable diseases like malaria and tuberculosis have always contributed significantly to state health programmes⁶.

Public Spending on Health

4.1.1 It is estimated that between 20-50% of the government health budget is used to procure drugs. Preventing and controlling corruption in procurement is, therefore, a determining factor in policy and project efficiency⁷. In Indian context about 26% of the health budget is devoted to procurement. A sound procurement system is therefore crucial for ensuring national security, safety of passengers, health of the citizen and the quality of infrastructure and services.⁸

4.1.2 Currently the public health system in India spends about Rs. 6000 crores (0.1% of GDP) for procuring drugs. In the event of India providing Universal Health Coverage, an additional medicine purchase of amount Rs. 24,000 crores would be required by the public health system. That means India need to spend 0.5% of its GDP on procuring medicines alone in the event of universal health coverage (total spending on healthcare at present is 1.2% of GDP). This makes public health procurement a crucial exercise. It is now well accepted that competitive bids for procuring bulk drugs complemented by streamlining the rational use of drugs can result in enormous amount of saving of the public money.

⁶ See annual report of Ministry of Health and Family Welfare, Government of India, available at <http://www.mohfw.nic.in/showfile.php?lid=121>

⁷ Corruption in Public Procurement, available at <http://www.u4.no/themes/procurement/procurementintro.cfm>

⁸ Enhancing value in public procurement: Special address by Shri Pratyush Sinha, CVC, Conference on Competition, Public Policy and Common Men. Available at <http://www.cci.gov.in/menu/speechesbypratyushsinhacvc.pdf>

- 4.1.3 Apart from drugs, public health procurements also include health devices and other materials required for public hospitals. Furthermore, present line of thinking in the government is to shift 'from supplier to procurer' of health services for part of secondary level and whole of tertiary level healthcare by 'contracting-in' private sector. This can happen either by procuring such services directly or indirectly by procuring requisite health insurance. It is believed that health insurance route would be more transparent, cost-effective and accountable, than that done through direct procurement of health services. However, the Report of the High Level Committee on Universal Health Coverage recommends not using insurance companies or any other independent agents to purchase healthcare services on behalf of the government. It has cited many reasons for this in the Report inferring that in the long run it would be in public and national interest when states procure healthcare services directly.
- 4.1.4 Government health care services are organised at different levels. Primary health care is provided through a network of over 146,036 health sub-centres, 23,458 PHCs and 4,276 CHCs. At the district level on an average there is a 150-bedded civil/district hospital in the main district town and a few smaller hospitals and dispensaries spread over other towns and larger villages. At the time of independence only about 8 per cent of all qualified modern medical care was provided by the private sector. But over the years the share of the private sector in the provision of health care has at about 80 per cent of all outpatient care and about 60 per cent of all in-patient care.
- 4.1.5 At the central level, Directorate of Procurement, under Ministry of Health and family Welfare is in charge for procurement and supply of the drugs for the vertical program. The directorate is supported by technical support unit. Along with assisting the Government of India in procurement supply chain management of drugs and equipments for the vertical program, they also have a mandate of enhancing the capacity of the central and state government on the supply chain management and bringing transparency in the process.

5 Health Indicators of Rajasthan

5.1 The Total Fertility Rate of the State is 3.21. The Infant Mortality Rate is 63 and Maternal Mortality Ratio is 388 (SRS 2004 - 2006) which are higher than the National average. The Sex Ratio in the State is 909 (as compared to

the goal of 917 for the XIth five year plan period for the state). Comparative figures of major health and demographic indicators are as follows: ⁹

Table I: Status of Major health and demographic indicators in Rajasthan

SN	Health Indicator	XI Plan Goal	Current level
1.	IMR (SRS-Oct, 2009)	32	63
2.	MMR (SRS-Oct, 2004-06)	148	388
3.	TFR (NFHS-3,2005-06)	2.1	3.21
4.	Crude birth rate	21	27.5
5.	Institutional Delivery		32.2 (46 DLHS3)
6.	Institutional Delivery U/R		68/41
7.	Sex Ratio (0-6 years, 2001- Census of India)	917	909
8.	Total Literacy-2001 Census of India	79.57	60.4
9.	Anemia among women (15-49 years) (NPHS-2005-06)	24.3	53.1
10.	Malnutrition in children (0-3 years) (NPHS-3,2005-06)	25.3	44.0
11.	Decadal Growth (Census 2001) (%)		28.41
12.	Population below Poverty line (<%)		26.10
13.	Couple protection rate	65	57.0 (DLHS 3)

5.2 The data given in the above table reveals that practically in respect of every indicator, the State is much behind the target to be achieved by the end

⁹ Available at: http://mohfw.nic.in/NRHM/Health_Profile.htm#raj

of the XI Five Year Plan. The ratio of the rural and urban population is 77:23 and the growth rate of population, being 20%, is higher than the rate of growth of population for the country.

5.3 If the targets of the indicators have to be achieved, among other things, the infrastructure of the Medical and Health Department emerges an important factor helpful for the achievement of the targets. This underscores the importance of judicious government spending and timely and effective procurement of the required goods and services, failing which the performance of this sector would be a casualty. The following table gives details of existing Health Infrastructure in the state.

Table II: Health Infrastructure of Rajasthan

Particulars	Required	In position	Shortfall
Sub-centre	9554	10742	-
Primary Health Centre	1555	1503	52
Community Health Centre	388	349	39
Multipurpose worker (Female)/ANM at Sub Centres & PHCs	12245	12271	-
Health Worker (Male) MPW(M) at Sub Centres	10742	2528	8214
Health Assistant (Female)/LHV at PHCs	1503	1358	145
Health Assistant (Male) at PHCs	1503	714	789
Doctor at PHCs	1503	1542	-
Obstetricians & Gynaecologists at CHCs	349	110	239
Physicians at CHCs	349	241	108
Paediatricians at CHCs	349	71	278
Total specialists at CHCs	1396	651	745
Radiographers	349	269	80
Pharmacist	1852	2355	-
Laboratory Technicians	1852	2065	-
Nurse/Midwife	3946	8425	-

(Source: RHS Bulletin, March 2008, M/O Health & F.W., GOI)

The other Health Institution in the State are detailed as under:

Health Institution	Number
Medical College	8
District Hospitals	33
Referral Hospitals	
City Family Welfare Centre	

Rural Dispensaries	
Ayurvedic Hospitals	100
Ayurvedic Dispensaries	3539
Unani Hospitals	3
Unani Dispensaries	102
Homeopathic Hospitals	9
Homeopathic Dispensary	178

6 Achievement of Financial Targets at State Level

6.1 Medical Sector, from the point of view of allocation of funds and fixing targets, can be divided into modern medical system (allopathic) and traditional medical system (Ayurved). As far as Ayurved system is concerned, initially the outlay of Rs.12496.45 lakhs for the XI Plan was made but was subsequently raised substantially. Budgeted amount for the first three years was Rs.13048.53 lakhs which was more than the initial allocation for the entire plan period. However, the Department could not utilise the funds made available. The expenditure incurred was only Rs.9546.73 lakhs which was only 73.16%.¹⁰

6.2 XI Plan outlay for the Medical and Health for a period of five years (2007-12) being Rs.78137.45 lakhs, proportionately three year outlay works out to Rs.46882.47 lakhs. However, the budget allocation of Rs.39003.55 lakhs was made which is Rs.7878.92 lakhs less than the allocation. Actual expenditure in the three years under review was only Rs.37915.59 which works out to 97.21%. Once the budget allocation was made of a lower order, effort should have been to utilise this fully which was not the case. The following table highlights instances where funds not utilized for the following important activities:

Table III

No	Activities	Allotted fund, Not utilized (Rs in lacs)
1	Strengthening of rural institutions selected by NRHM-	3905.19
2	State share for NKHM construction of SC building	5000.00
3	Construction and opening of food testing Lab	855.0 and 2162.10
4	Construction of residential quarters at selected institutions (NRHM)	1310

¹⁰ Available at:

<http://www.planning.rajasthan.gov.in/Mid%20Term%20Apraisal%20Book.pdf>

5	Opening of city dispensaries/ urban PHCs	857.90
6	Strengthening of general nursing training centres	783.9
7	Creation of staff at institutions selected by NRHM	3906
8	Zonal office at Bharatpur	1415

6.3 Repeated instances of lack of utilization of funds allocated for the important sector of Medical and Health clearly establish absence of fool proof and streamlined procurement regime in place leading to repeated failures, delays and subsequent non procurement of quality material on time and thereby non utilization of funds allocated which in any case is scarce.

7 Regulatory and Policy Framework of Public Procurement in the Health Sector in India

7.1 Timely supply of drugs, medical supplies and equipment of good quality, which involves procurement as well as logistics management, is of critical importance in any health system. Legal, policy and regulatory environment are recognized as providing an important foundation for public procurement in the health sector. An efficient procurement policy would have an integrated approach starting from (i) preparation of an essential drugs list, (ii) assessment of the quantity of drugs needed, (iii) quality assurance from suppliers, (iv) procurement process, (v) supply chain management, and (vi) prompt payment to suppliers.

7.2 The regulatory system as far as public procurement in the health sector is concerned has been relatively weak. In India, Central and State Government institutions follow one or more of these arrangements for public procurement:

- Central Rate Contract System,
- Pooled Procurement either by the government or through an autonomous corporation,
- decentralized procurement, and
- local purchase.¹¹

- (i) Central Rate Contract System: In Central Rate Contract System, drugs are financed, procured and distributed by the government,

¹¹ Sakthivel S, 'Access to Essential Drugs and Medicines- WHO India.' Available at: http://whoindia.org/LinkFiles/Commission_on_Macroeconomic_and_Health_Access_to_Essential_Drugs_and_Medicine.pdf

which is the owner, funder and manager of the entire system. Selection, procurement and distribution are all handled by a unit within the health ministry. In India, Central Government works with multiple agencies for procuring and distributing drugs to its various health schemes/programmes. It is preferred drug procurement and distribution system by central government for MoHFW.¹² Similarly, under different National Health Programmes (NHPs), each of the six NHPs has its own procurement procedures resulting in duplication of effort with no attendant benefits of lower prices that a bulk purchase would entail.¹³ The system does experience problems with financial management, quantification of requirements, management of tenders, warehouse management, transport and security of drugs. These problems have been exacerbated by political or administrative influences and weak financial discipline.¹⁴

- (ii) Pooled Procurement: Autonomous corporations are constituted as parastatals, either under the ministry of health or as independent organization with a board of directors including representation from other (than health) government ministries. The board is autonomous in running the agency but reports to a higher official from the ministry of health who may be involved in the appointment of the chairman of the board or the executive officer. The purpose of establishing an autonomous supply agency is to achieve the efficiency, flexibility, transparency and accountability in the system.

The pooled procurement system uses a two-stage tender system. This ensures that only those companies that are capable of supplying products of adequate quality receive orders. The tender process is limited to companies that fulfill the technical criteria. Through a two-envelope system (technical bid and price bid), the drug purchase committee of the society is able to ensure that the purchases are made from companies complying with the Good Manufacturing Practices. A company which does not fulfill the technical criteria of a minimum annual turnover of Rs 12 crore and adherence to prescribed Good Manufacturing Practices (GMP), is automatically disqualified for making a price bid. The companies are required to undergo GMP inspections and random testing of

¹² A country level report on the pharmaceutical sector in India Part One: Institutions involved in pharmaceutical regulation. April 2008. A report commissioned by DFID, UK

¹³ Ibid

¹⁴ Chaudhury R Roy et.al. Quality Medicines for the poor; experience of Delhi programme on rational use of drugs. Health Policy and Planning; 20(2) 124-136. Oxford University Press. 2005.

products. There are instances of companies being blacklisted for want of proper compliance with GMP and poor quality of products. Doctors are asked to prescribe only products on the procurement list, although hospitals are allowed to use up to 10% of their drug budget on unlisted products.

The Tamil Nadu Medical Services Corporation (TNMSC) is set up by government of Tamil Nadu as autonomous corporation in July 1994 under the Companies Act of 1956, for the purpose of supplying the essential drugs and services. The success of the TNMSC lies in its centralized drug procurement and distribution system supported by a computerized system of drug management. The TNMSC has adopted a 'two envelope system' (technical bid and price bid being sent in separate envelopes) which ensures a speedy and transparent mechanism in procurement of drugs. Contracts are awarded to only those manufacturing units, which have a Good Manufacturing Practices (GMP) certificate of the WHO and should ideally have a minimum ceiling of annual turnover. Tenders are invited only for those drugs not supplied by Public Sector Undertakings and Small Scale Industries. The direct benefits flowing from the TNMSC model seem to support lower prices contributed by competitive bidding and bargaining power.

Another successful centralized procurement model is Delhi's model. Delhi was the only Indian state to have a comprehensive Drug Policy in 1994. The Delhi Society for the Promotion of Rational Use of Drugs (DSPRUD) in close collaboration with Delhi Government facilitated the implementation of various components of the policy. In 1997, the Delhi Programme was designated the INDIA-WHO Essential Drugs Programme by the World Health Organization. The pooled procurement system, including the rigorous selection of suppliers with a minimum annual threshold turnover and the introduction of Good Manufacturing Practice inspections, resulted in the supply of good quality drugs and in holding down the procurement costs of several drugs. Bulk purchasing of carefully selected essential drugs was estimated to save nearly 30% of the annual drugs bill for Delhi Government and improved availability of drugs (more than 80%) at health facilities. Further, training programmes for prescribers led to a positive change in prescribing behaviour, with more than 80% of prescriptions being from the EDL. These changes were achieved by transforming managerial systems with minimal additional expenditure.

Although such pooled procurement efforts are laudable, a question from competition policy point of view, however, does arise, with

respect to technical criteria regarding annual turnover, as it does tend to create some sort of entry barrier to new enterprises. One can understand the criteria regarding GMP viewing the safety of consumers, but that related with turnover can be reviewed. (Even though the threshold of Rs.12 crore is low in case of Delhi, in present case, it is the concept of putting such criteria that can be problematic from competition policy angle.) Technically there can be a good manufacturer meeting the GMP criteria, but failing on account of 'market standing' and 'turnover'. Should such firms be out of consideration per se? In case of TN, it is said that this is done with the assumption that smaller firms may fail in supplying the requisite drugs in right amount. Such assumption require a considered approach and not a per se approach.

- (iii) Decentralized Procurement: Decentralized system is followed by Karnataka and Rajasthan. In the former, a major part of drug procurement, accounting for 60%, is sourced by zila panchayats (local governments) at the district level while the remaining 40% is sourced by government medical stores. In Rajasthan, the procurement of drugs, equipments and supplies are carried out by the Store Purchase Organization (SPO) under the Directorate of Medical and Health Services (Center for Pharmaceutical Management, 2003). The SPOs are entrusted with the responsibility of finalizing the rate contract for the majority of drugs and equipments. The rate contracts are finalized as per the General Finance and Accounting Rules for the State. Also, preferential treatment is also provided to drugs manufactured by the State's Small Scale Industries/Other Local Units of the State. Tenders are invited only for those drugs not supplied by Public Sector Undertakings and Small Scale Industries. The state government negotiates drug prices for the entire state through a rate contract with manufacturers. Health facilities and district warehouses can then order these drugs as needed throughout the contract cycle directly from the manufacturer. The ESIS and the cooperative pharmacy system do not participate in the state pooled procurement approach but have independent procurement mechanisms. In addition to state government drug supply warehouses, vertical programs maintain independent separate warehouses. The vertical programs that have warehouses include Family Welfare, immunizations, malaria, and communicable diseases. These parallel systems lead to operational and financial inefficiencies.¹⁵

¹⁵ The World Medicines Situation 2004. World Health Organization.

7.3 Drug Procurement Mechanism by HSCC

7.3.1 The Ministry of Health and Family Welfare, government of India usually assigns the procurement of drugs and pharmaceuticals to an agency called Hospital Services Consultancy Corporation (HSCC). HSCC is a multi-disciplinary consultancy organization which was established to provide quality consultancy services in healthcare and other social sectors. HSCC has been dedicatedly involved in providing a complete range of services in the fields of:

- a. Construction of Hospitals, Laboratories, Research Centres etc.
- b. Procurement of drugs and medicines
- c. Procurement & commissioning of medical equipments
- d. Solid & medical waste management systems
- e. IT-based management systems in health care

7.3.2 HSCC undertakes procurement of drugs and pharmaceuticals including formulation of specifications, tendering, order placement, expediting and follow-up, inspection and dispatch. A number of World Bank supported programmes for procurement of drugs and pharmaceuticals have been undertaken by the HSCC viz. Malaria, TB, Reproductive Child Health etc. The procurement services are in accordance with the guidelines and norms of the World Bank.¹⁶

7.4 Under different National Health Programmes (NHPs), the Central Government either provides financial aid or supplies drugs to States through centrally procured arrangements. Each of the six NHPs has its own procurement procedures resulting in duplication of effort with no attendant benefits of lower prices that a bulk purchase would entail. Currently, the NHPs are (i) Revised National Tuberculosis Programme, (ii) National Leprosy Elimination Programme, (iii) Reproductive and Child Health (RCH), (iv) National Malaria Control Programme, (v) National AIDS Control Programme, and (vi) National Blindness Control Programme.

¹⁶ Ibid

Twelve guiding principles of good pharmaceutical procurement

According to a study by NIPER,¹ there are twelve guiding principles of good pharmaceutical procurement, which can be said to be important from competition policy point of view. These principles are grouped in four categories, and are given below. Twelve Guiding principles of good pharmaceutical procurement

A. Efficient and Transparent Management

1. Different procurement functions and responsibilities (selection, quantification, product specification, pre-selection of suppliers and adjudication of tenders) should be divided among different offices, committees and individuals, each with the appropriate expertise and resources for the specific function.
2. Procurement procedures should be transparent, following formal written procedures throughout the process and using explicit criteria to award contracts.
3. Procurement should be planned properly and procurement performance should be monitored regularly; monitoring should include an annual external audit.

B. Drug Selection and Quantification

1. Public sector procurement should be limited to an essential drugs list of national/local formulary list.
2. Procurement and tender documents should list drugs by their International Nonproprietary Name (INN), or generic name.
3. Order quantities should be based on a reliable estimate of actual need.

C. Financing and Competition

1. Mechanisms should be put in place to ensure reliable financing for procurement. Good financial management procedures should be followed to maximize the use of financial resources.
2. Procurement should be effected in the largest possible quantities in order to achieve economies of scale; this applies to both centralized and decentralized systems.
3. Procurement in the public health sector should be based on competitive procurement methods, except for very small or emergency orders.
4. Members of the purchasing groups should purchase all contracted items from the supplier(s) which hold(s) the contract.

D. Suppliers Selection and Quality Assurance

1. Prospective suppliers should be pre-qualified, and selected suppliers should be monitored through a process, which considers product quality, service reliability delivery time and financial viability.
2. Procurement procedures/systems should include all assurance that the drugs purchased are of high quality, according to international standards.

7.5 Empowered Procurement Wing

7.5.1 The Ministry had set up an Empowered Procurement Wing (EPW) in October 2005 to consolidate, streamline, strengthen and professionalize the procurement of health sector goods under the NRHM, which were made by the various programme divisions in a fragmented and disjointed manner. There were to be three functional units of EPW, viz. Health, Family Welfare and Universal Immunisation Programme, under three Directors headed by a Joint Secretary. Seven Deputy Directors oversee procurement activities under the disease control programmes (DCPs) and IDSP.

7.5.2 However, the desired structure did not physically exist under one wing. ~~The EPW had been only~~ directly handling the procurement of vaccines and contraceptives and supervising the procurement undertaken by RNTCP. The EPW was not overseeing the procurements made by various programme divisions by monitoring their procurement plan. Thus, the intended purpose of having a centralised procurement unit so as to generate cohesiveness and efficiency remained unfulfilled.

8 Findings on the Public procurement System in the Health Sector in the Central Government and in the State of Rajasthan

8.1 Public procurement in health sector under review and analysis in this chapter has a unique system, which has already been explained in the preceding chapters. In this section a number of tenders have been analysed to reach a conclusion on the competitive aspects involved in the procurement of products and services in this sector.

8.2 **Analysis of Tender documents:** As per scheme of the present research proposal, a number of tender documents have been procured from the concerned department and analysed for their competitive impact. Tenders have been analysed on the basis of the way procurements have been made under these tenders. These tenders have been mentioned below in terms of cases.

8.3 **Case No. 1:** Tender No.UIP-11011/149/2009-10/TOPV/T.E/VPC Dated: 18.09.2008 Conclusion of Rate Contract and Purchase of 1663 lakh

doses of Trivalent Oral Polio Vaccine (TOPV) for Immunization Programme 2009-10.

- i. In Terms of Tender No. referred to above, bids were invited by Deputy Director (UIP) of Vaccine Procurement Cell of Ministry of Health & Family Welfare Government of India for and on behalf of President of India for supply of 1663 lakh doses of TOPV for Immunization Programme 2009-10 from manufacturers who possess manufacturing licenses and Good Manufacturing Practices (GMP) certificate complying to the revised schedule 'M' of Drugs and Cosmetics Act 1940.
- ii. Accordingly, a reference was made to DCG(I) on 05.08.2008 to advise such manufacturers who comply with the relevant stipulations. DCG(I) in turn intimated list of five approved manufacturers duly licensed under the provision of the Drugs and Cosmetic Act 1940.(See Page 18 i.e. Agenda for TOPV).
- iii. It was decided with the approval of Competent Authority i.e.AS&FA to invite Limited Tender Enquiry instead of Advertised Tender Enquiry since in any case the procurement was to be limited to the eligible Sources who comply with the GMP requirement as per revised schedule 'M' of Drugs and Cosmetics Act 1940.Further it was proposed that since the sources of supply were known and the possibility of fresh sources being tapped was considered remote, the limited Tender Enquiry route will not only save considerable time, unnecessary expenditure involved in giving advertisements through DAVP and ITJ in terms of provisions under rule 151 of GFR will also be saved.(See Page 18 i.e. Agenda for TOPV).
- iv. The Conditions of Contract were to be governed by DGS&D - 1001,"General Terms and Conditions of Contract governing Rate Contract" and those contained in Pamphlet No.DGS&D-229 containing various instructions to tenderers quoting against tender enquiries issued by DGS&D.
- v. Pre-Bid Meeting was scheduled to be held on 29.09.2008 at 11 AM in Committee Room No.249'A 'Wing, Nirman Bhawan.
- vi. Time &Date of Receipt of Tenders was scheduled at 3PM on 15.10.2008. Date of opening of Tenders was fixed at 4PM on 15.10.2008.
- vii. Description of Stores was advised as,"ORAL POLIO VACCINE-Trivalent (t-OPV) in Vial of 20 Doses with VVM as per Vaccine Specifications EPW 2008 enclosed as per Annexure A. Temperature Monitoring Device as per Annexure II was not required.
- viii. In Addition to the General Conditions of Contract in form DGS&D-1001,Certain Special Conditions of Contract in respect of Performance Criteria, Inspection, Warranty, Packing & Marking and Payment Terms were made applicable which were to have an

- overriding effect over the General Conditions in case of any conflict between the two.(Pl see page 64) .
- ix. Period of Rate Contract and Delivery Schedule was specified from 1.04.2009 to 31.03.2010.
 - x. Following documents were to be enclosed with the offers:
 - a. Drugs License for manufacture and sales of the item &GMP.
 - b. Firms should have two years marketing and manufacturing experience of the item on the date of tender opening with documentary evidence.
 - c. Supply/Dispatch position of various items already ordered.
 - xi. During Pre-Bid Meeting the vaccine manufacturers requested not to include Temperature Monitoring Device due to its complex features and to continue with the payment Terms as 98% against dispatch by Air by enclosing the original copy of the airways bill of National Carrier along with the Inspection Note and for supplies by Train with attendant or refrigerated van, 98% after delivery of goods and provisional receipt recorded on copy no.1 of I/Note and balance 2% after consignee confirms receipt of stores in good condition on copies 2&5 of the Inspection Note.
 - xii. Thereafter indenting officer of the Programme Division recommended change in the specifications of the Temperature Monitoring Device and asked for a simpler device in respect of three very sensitive vaccines (DPT,TT and Hep.B) .There was no change in specifications in respect of tOPV and payment terms & delivery schedule .Tender opening date was extended up to 10.11.2008 enabling firms to quote.
 - xiii. A Bid evaluation committee comprising of Director (UIP), DD (UIP), AC (UIP) an Officer from IFD and Consultant EPW was formed to evaluate the bids.
 - xiv. The Committee recommended all five offers as techno-commercially responsive and acceptable after ascertaining Technical Compliance, Compliance to the Eligibility Criteria and Compliance to Commercial Terms and Conditions.
 - xv. The committee then proceeded to consider, Prices Quoted, Performance of Orders placed during 2007-08 and 2008-09 & Last Purchase Prices. It arrived to the conclusion that performance of BIBCOL , which is a Central Govt. PSU based at Bulandshahar, had not been satisfactory as the firm against an ordered quantity of 684 lakh doses could supply only 190 lakh doses and therefore balance ordered quantity of 484 lakh doses had to be repurchased due to failure of BIBCOL to supply the ordered quantity.
 - xvi. Accordingly based on the Past Performance, Total Capacity versus the available capacity and quoted Prices & Last Purchase Prices, the Committee proposed to distribute total indented quantity of 1663 lakh doses as under:
 - a. M/S Bharat Bio Tech International Limited, Hyderabad: 415 lakh doses @Rs.74, 75 per Vial all inclusive.

- b. M/S Haffkine Bio Pharmaceutical Corporation Ltd, Parel, Mumbai: 1248 lakh doses @ R s.74.75 per Vial all inclusive.
- xvii. Thus Rate Contract vide no. UIP/11011/149/09-10/VPC/RC/t-OPV/BBL (&HBPCL) Dated:12.03.09 based on above recommendations duly approved by competent authority was concluded and addressed to the two firms as above on whom Orders were also placed.

8.4 **Case No. 2: TENDER ENQUIRY NO.S 12012/2/2011-VPC/0.5ml ADS/BD** Dated 30.03.11.Date of Tender opening : 29.04.11. (Procurement of 0.5ml & 0.1 ml AD Syringes for Routine Immunization Programme for 2011-12 and tOPV for Pulse Polio Programme.)

A) 0.5 ml AD Syringes:

- i. An advertised tender enquiry no. S 12012/2/2011-VPC/0.5ml ADS/BD Dated 30.03.11 with date of Tender opening as 29.04.11 was issued for procurement of 4653.35 lakh pieces in 28 schedules prepared on geographical locations & delivery schedule.
- ii. Pre-Bid meeting was held on 11.04.11 and as per discussions held in Pre-Bid meeting, necessary clarifications were provided. Thereafter the tenders were opened on 29.04.11 in the presence of firms ' representatives by the tender opening Committee.
- iii. In response to the advertised tender, the bids from following 6 bidders were received:
 - a) M/S Hindustan Syringes & Medical Devices (HMD)
 - b) M/S Sisco Medical Devices Pvt. Ltd.
 - c) M/S Abu Dhabi Medical Devices.
 - d) M/S Wuxi Yushou Med. Appliances.
 - e) M/s BD India Pvt. Ltd.
 - f) M/S Iscon Surgicals Ltd.
- iv. The Quoted Schedules and the Rates for each schedule by the above bidders have been tabulated for the purpose of comparison and for decision making process.
- v. A Bid Evaluation Committee comprising of DC(CH&I), DD(Proc.), DGHS, Dir.(UIP/S),DS (IFD).Rep. of DCG(I) and Consultant, EPW was constituted with the approval of competent authority. The Meeting of Bid Evaluation Committee was held on 25.08.11, 06.09.11 and 13.10.2011.Recommendations of the Bid Evaluation committee were as under:
 - a) Two Bidders namely M/S Wuxi and Abu Dhabi quoted directly as Independent bidders and were found to be non-compliant to the tender conditions requiring International Bidders to have licensed premises of their own and appointed Indian Agents.
 - b) The Bid of M/S Iscon Surgical was also found to be non compliant with respect to the bid condition for possessing manufacturing and marketing experience for last two years

from bid opening for the for the specific goods (0.5 AD Syringes) .

c) The Bidder M/S SISCO did not submit EMD and requested exemption from submission of EMD on the basis of NSIS Registration. Since the bidder was not registered for the specific goods required as per tender enquiry, accordingly, their bid was rejected in terms of clause 19 of GIT of bid document.

d) The Bids of M/S BD India and M/S HMD were found to be eligible for four and all quoted (21) twenty one schedules respectively. For remaining six schedules (I, II, IV, IX, X and XII) there was no eligible bidder.

e) A representation was received from M/S Wuxi vide letter dated 17.10.2011 against their rejection which was examined by the Bid Evaluation Committee in consultation with DCG (I). DCG (I) vide his letter dated 09.11.2011 stated that although M/S Wuxi Yushou China is a registered manufacturer under Drugs and Cosmetics Act 1940, but for the import of AD Syringes, in addition to registration certificate, an import License is also necessary for which M/S Wuxi Yushou has so far not applied. The Committee therefore did not find any merit in the representation of M/S Wuxi Yushou, China.

f) Subsequently case was put up for holding IPC meeting on 09.11.2011 which could not be held. Further meeting could not also be held on 14.11.2011, 17.11.2011, 18.11.2011, 21.11.2011 & 22.11.2011 when it could not be held due to non-availability of one or the other members. Finally, the meeting was held on 24.11.2011.

g) Meanwhile another application was received from M/S Wuxi Yushou (Dated 22.11.2011) which was deliberated in the IPC .M/S Wuxi Yushou reiterated that their company meets all statutory and regulatory requirements of DCG(I) to export AD Syringes to MOH&FW against the said tender as these Syringes are being imported by MOH&FW and as such the import license is not required by the foreign supplier. The firm also stated that MOH&FW have purchased these syringes in the past on the same basis. Programme Division expressed urgency for this item as the stock of available syringes will not last beyond Dec.2011 and it would upset both RI and Catch-up campaigns for 2nd dose of measles.

- vi. Thereafter, IPC further considered representation of M/S Wuxi with respect to their offer for supply of AD Syringes in consultation with the representatives of DCG (I). The Committee observed that M/S Wuxi is a registered foreign manufacturer under Drugs and Cosmetics Act and in their bid they had referred M/S Carewell as their Indian Agent who was holding a valid import license to import the Syringes from M/S Wuxi on the date of bid opening and as such M/S Wuxi meets statutory requirements of Drugs and Cosmetics Act.

- vii. It was further observed by IPC that the quoted prices of M/S Wuxi are L1 and very competitive vis-à-vis other bidders. On the basis of their overall considerations regarding their price competitiveness, past performance, urgency of requirement and their Indian Agent meeting all the regulatory requirements and after detailed deliberations, IPC considered the bid of M/S Wuxi as responsive. IPC also noted that there would be substantial savings to the Government Exchequer if the L1 bid of M/S Wuxi is considered responsive. On the same grounds, IPC also recommended for acceptance of the bid of M/S Abu Dhabi.
- viii. Thereafter the IPC noted that on the basis of qualification criteria, M/S Wuxi is qualifying only for seven schedules as the average turnover for last five years of M/S Wuxi is Rs.56.64 Crore which is able to meet the requirement of turnover of seven schedules only. Similarly, M/S Abu Dhabi is qualifying for two schedules as they have submitted details of four supply orders of equivalent quantity executed during last five years only. The overall responsiveness for number of schedules on the basis of eligibility criteria of tender enquiry and considering the allocation of quantity to L1 bidder where the difference between L2 & L1 is maximum was worked out as under:

Name of the Bidder	No. of Schedules quoted	Responsiveness for no. of schedules on the basis of eligibility conditions of T/E
M/S Abu Dhabi	4	Qualified for 2 schedules(I&IX)
M/S Wuxi	15	Qualified for 7 Schedules(II,IV,X,XVIII, XX,XXII and XVI)
M/S BD India Pvt. Ltd.	15	Qualified for 4 Schedules(V,XIII,XIV and XXI)
M/S HMD	21	Qualified for all the quoted Schedules)

- ix. IPC further recommended the Prices to be allowed as per following criteria while making coverage of demands against various schedules of T/E:
- For individual schedule at the first place, the coverage be made on the L1 bid basis.
 - After exhausting the coverage with available L1 bid, the remaining schedules be covered by way of counteroffer of the L1 bid price for individual schedules to the next individual bidder. In case L1 price is in US \$, Counter offer to a bidder

who quoted in Indian Rs. shall be in US\$ subject to payment in Indian Rupees as on the date of supply. However, such payment in equivalent Indian Rupees on the date of supply, in no case will exceed the price quoted by the Indian Bidder in Indian Rupees.

B) 0.1ml AD Syringes:

- i. An Advertised Tender Enquiry was issued on 30.03.2011 for procurement of 367.879 lakh pieces of 24 schedules prepared on geographical locations and delivery schedules.
- ii. Pre-Bid meeting was held on 11.04.11 and as per discussion held in Pre-Bid meeting, necessary clarifications were provided. Thereafter the tenders were opened on 29.04.11 in the presence of firms' representatives by the tender opening Committee.
- iii. In response to the advertised tender, the bids from the following 4 bidders were received:
 - a) M/S Hindustan Syringes & Medical Devices (HMD).
 - b) M/S Sisco Medical Devices Pvt. Ltd.
 - c) M/S Abu Dhabi Medical Devices, UAE.
 - d) M/S Wuxi Yushou Medical Appliances, China.
- iv. The Quoted Schedules and the rate for each schedule by the above bidders were tabulated in a tabular form for the sake of comparison.
- v. A Bid Evaluation Committee comprising of DC (CH&I), DD(Proc.), DGHS, Dir.(UIP/S), DS(IFD), Rep. of DCG (I) and Consultant EPW was constituted with the approval of Competent Authority. Recommendations of Bid Evaluation Committee were as under:
- vi. The Two bidders namely M/S Wuxi and Abu Dhabi quoted directly as international bidders and were found to be non-compliant to the tender conditions requiring international bidders to have licensed premises' of their own and appointed Indian Agents.
- vii. The bidder M/S Sisco did not submit EMD on the basis of NSIS registration. Since the bidder was not registered for the specific goods required as per tender enquiry, their bid was rejected in terms of clause 19 of GIT of bid document.
- viii. The offer of M/S HMD was found eligible for all schedules.
- ix. IPC noted that the bid evaluation committee had rejected the bid of M/S Wuxi (L1 for all schedules) on the same grounds as in the case of 0.5ml AD Syringes. IPC recommended that in this case

also the bid of M/S Wuxi may be accepted who is eligible for all the schedules and is L1.

- x. **Notification of Award:** Based on the discussion and decisions taken in the IPC, notifications for award of the contract for procurement of 0.5ml AD Syringes and 0.1 ml AD Syringes were issued.

8.5 **Case No. 3:** Tender Enquiry no.S.12012/12/2010-Supply/RC/Condoms, Ministry of health and Family welfare, Department of Family Welfare, Government of India.

- i. 1. The tender file contains photocopies of 44 pages including covering letter and most high value tender covering estimated drawl of four different qualities of Nirodh of estimated value Rs. 1000/-crore.
- ii. Notice inviting Tender including Terms and Conditions and Special Terms and Conditions is placed from SN1 to SN 43.
- iii. The conditions of contract which will govern any contract are contained in booklet no. DGS&D 1001.
- iv. The tender contains two parts. Part A consists of technical and commercial terms and conditions and Part B form for submitting the price offered by the tenderer. The Part A and the Part B must be sealed in separate covers clearly marked as Part A containing the techno commercial bid and Part B containing the price bid respectively. The two covers must then be enclosed in one cover and sealed again and the name and address of the tenderer, the tender number and the date and time of opening must be clearly marked on the cover and put in the tender box placed in Room no 112 D Wing of Nirman Bhawan, New Delhi.
- v. The Technical and the commercial offer of the firm contained in Part A shall be first evaluated. The offers from only those tenderers' who satisfy the eligibility criteria given in the tender part A shall be evaluated. The offers from only those tenderers who satisfy the eligibility criteria given in the tender shall qualify for further consideration. The envelope containing prices (Part B) of only those firms who become qualified for further consideration as above shall be opened after giving suitable notice to such qualifying tenderers.
- vi. Schedule of tender Enquiry No. S.12012/12/2010-Supply/RC/Condoms
- vii. Price per Tender SET-(Rs.1000/-)
- viii. Estimated drawal-(rs.100.00crore)
- ix. Time and date of receipt of tenders: by 10.30a.m on 23/03/2010
- x. Time and date of opening of tenders: 11a.m.of 23 /03/2010

- xi. The tender shall remain open for acceptance-up to 120 days from the date of opening of techno commercial bid.
- xii. Technical Specifications should conform to the schedule R of Drugs and Cosmetics Rules as per page 5.
- xiii. Part B contains details of the terms and conditions of the invitation to bid and should be filled and signed and enclosed in a sealed envelope and it must be clearly and boldly mentioned on the envelope that it contains the price Bid. The Envelope should also clearly mention the tender no. and date and time of opening. The failure of the tenderer to do so may result in a mix up with the Techno-commercial bid and in that event the offer will be liable to be ignored summarily.
- xiv. In addition to the General conditions of Contract given in Form-1001,as amended to date, there are special conditions of Contract (available from Page 11 to Page 15) which are applicable and would have over-riding effect over the general conditions in case of any conflict between the two.
- xv. Purchase preference will be allowed to PSUs subject to the purchase preference policy of the Government of India applicable for the Public Sector Undertakings of the Government of India.
- xvi. Specifications of the packing material for different qualities of Condoms is given from Annexure I to Annexure IV. Specifications for Latex Rubber Condoms are available at Annexure V.
- xvii. Sampling Plan for quality control of Condoms at manufacturers' level/Purchasers' level is available from Appendix 1 to Appendix 3.
- xviii. Tenderers should furnish specific answers to all the questions given from page 37 to Page 43. Tenderers should further note that if the answer so furnished are not clear or are evasive, the tender will be liable to be ignored.
- xix. Letter from the firm on the format DGS&D 69A is enclosed confirming that the offer of the Tenderer will not be retracted or withdrawn from the date the tender is opened but may be bound by a communication of acceptance dispatched within the reasonable time.
- xx. Letter from the firm on the format DGS&D 68A is enclosed confirming that the firm offers to supply the stores detailed in the schedule as may be specified in the Acceptance of Tender at the price given in the said schedule and shall be bound by the communication of acceptance within the prescribed time.

8.6 **Case No. 4:** TENDER NO.SPO/D&M/PSU/NIT/2010-2012/10/2026 DATED 26/07/2010 (Rajasthan Drugs and Pharmaceuticals Limited)

- i. TENDER NO.SPO/D&M/PSU/NIT/2010-2012/10/2026 WAS FLOATED ON DATED 26/07/2010 for concluding Rate Contract for Drugs and Medicines manufactured by Public Sector undertakings for medical and Health Department, Rajasthan , Jaipur for a period of two years 2010-12 ending on 31-03-2012- due for submission on 18-08-2010.
- ii. Terms and Conditions of the Rate Contract for Drugs and Medicines for Public Sector undertakings is placed at Annexure B/SN8.It contains a total of 42 documents to be enclosed and lists 7 certificates and Declarations duly attested/ notarized as the case may be.
- iii. Offer of Rajasthan Drugs and Pharmaceuticals Ltd,(A Govt. of India Enterprise) based at Jaipur appears from 1 to 131 pages. The firm has quoted for 43 Drugs and Medicines (A=26,B=4 &C=13).Summarized position is available at SN 132.
- iv. TOTAL SIX PSUs have quoted against this tender as under:
 - a. M/S RDPL
 - b.M/S IDPL
 - c.M/S BPCL
 - d.M/S KAPL
 - e.M/S HAL
 - f .M/S HLL Life Care
- v. Meeting of Stores Purchase Committee was held on 03/05/2011 in which based on technical scrutiny,37 items were found suitable in favour of M/S RDPL out of 43 quoted. Score for other firms based on technical Suitability is also available on file. On the basis of technical scrutiny, SPO approved rates of drugs and medicines after negotiations or otherwise as recorded in each case.
- vi. During deliberations, it was noted by the SPO that one of the PSUs namely M/S HLL Life Care has requested for extending currency of the contract for supply of Soochers expired on 31st March 2011, The committee noted that M/S HLL Life Care is the only PSU Manufacturing Soochers and that last contract for supply of Soochers was awarded to the firm M/S HLL Life CARE after negotiations ,It was decided to extend currency of contract expired on 31st march 2011 be extended for another year i.e. Till 31st March 2012.
- vii. Based on the decisions taken in SPO,the firms were advised vide SN 194 of the acceptance of their rates and asked to sign the agreements on the judicial stamp paper of Rs.5000/- thus concluding the rate contract.
- viii. Finally, Director Public Health. Government of Rajasthan advised all Administrative Officers and Purchase Authorities vide SN 206 the details of rate Contract with Public Sector Units such as name of the units, name of the approved PSU and the rates etc approved for the Rate Contract Period ending 31/03/2012.

8.7 Case No. 5: Brief of Tender No. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/1147

- i. Notice inviting tender no. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/1147 was issued on 30/03/09 from Manufacturers and direct importers for the supply of the items listed at Part A (Drugs and Medicines) covering Sections A to E to various institutions of Govt. of Rajasthan for the Rate Contract period 2008-10(ending 30.11.2010)
- ii. Last date of receipt of tender is 11.05.09 up to 1.30PM. Date and time of opening of technical bids are as under:
Section A: 13/05/09 at 2.30PM.
Section B: 15/05/09 at 2.30PM
Section C: 20/05/09 at 2.30PM
Section D: 25/05/09 at 2.30PM
Section E: 29/05/09 at 2.30PM
- iii. As per Purchase preference Rules 1995 of Government of Rajasthan, Purchase Preference will be given to SSI Units of Rajasthan.
- iv. The Pre-Bid Meeting will be held on 20/04/2009 at 11AM in the Conference hall of Directorate of medical and Health Services, Rajasthan, Jaipur.
- v. Corrigendum to original tender No. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/1147 date 30/03/09 was issued on 30/04/09 vide no SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/1497 revising last date of sale of tender form, last date of receipt of tender and dates and time of opening of technical bids.(SN12)
- vi. Further in terms of tender no. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/1583 dated 11/05/09, last date of sale of tender form, last date of receipt of tender and dates and time of opening of technical bids were further revised.(SN 13)
- vii. Again vide tender no. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/1816 dated 09/06/09, last date of sale of tender form, last date of receipt of tender and dates and time of opening of technical bids were further revised.(SN14)
- viii. Yet again corrigendum to notice inviting tender was issued vide no. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/2009 dated 07/07/09, last date of sale of tender form, last date of receipt of tender and dates and time of opening of technical bids were further revised.(SN15)
- ix. Once Again, corrigendum was issued vide Tender No. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/2218 dated 04/08/09 due to change in terms and condition of Tenders and revision of technical catalogue of section A,B&C.(SN16).
- x. This is a tender case for finalization of Rate contract for Drugs & Medicines and Chemicals & Regents for 2008-10 ending on 30.11.2010 against finally revised tender no SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/2218 dated 04/08/09.

- xi. Bid received from M/S Medipol Pharmaceuticals India Pvt. Ltd, Vishwas Nagar, Delhi-32 offering drug no C-267,Chlordiazepoxide tabs (Pl. see SN46 of the offer)covered in Section C of the tender has been filed in this case from SN 1 to SN 71 IN 23 DOCUMENTS AS PER CHECK-LIST (COVER A) at SN 1.
- xii. Terms and Conditions of the Rate Contract for Drugs & Medicines and Chemicals & Regents for Pvt. Sector issued by Directorate of Medical and health Services are available from SN.23 to SN 35 vide Annexure B.
- xiii. As per ITEM NO.3 of the amended terms and Conditions of Tenders and Contract available at SN 24, "Sealed Tenders Super scribed," "Tenders for Rate Contract for two years," containing Cover A & Cover B as prescribed hereafter should be submitted to the Secretary, Store Purchase Organization ,Directorate of Medical and health Services, Rajasthan, Jaipur".
- xiv. Checklists of Tender Documents (Rate Contract for Drugs & Medicines and Chemical & Regents for Period 2008-10), Part-I, II &III are available at SN.75, 77 &79 respectively.
- xv. As per comments of the competent authority on Part III of the check list at SN 79,"Tender for Part A Section submitted by M/S Medipol Pharmaceuticals India Pvt. Ltd, Vishwas Nagar, Delhi-32 may be considered for opening of Cover B (Price Bid)".
- xvi. Further in terms of Office Order at SN 81, The committee nominated for opening of Price Bid was directed to open the Price bid at 11AM on 14/10/2010.
- xvii. Subsequently, price bid was opened by the nominated committee at the time, date and place fixed. Rate of the ZEPEx1 POL-10, in 10x10 Tabs in Strip pack was found as Rs.24.40 excluding 1% CST against form C/D otherwise 4%.This Rate was put up to Stores Purchase Committee for decision.
- xviii. Stores Purchase Committee met on 14/12/2011and 15/12/2011 and decided to call the firm M/S Medipol Pharmaceuticals India Pvt. Ltd for negotiation on account of higher rate quoted by the firm compared to the market prices.
- xix. The firm after negotiation reduced the rates to Rs 24/-excluding CST/VAT @ 4% or as applicable from corresponding originally quoted price of Rs24.40. per strip of 10x10 tabs.
- xx. Stores Purchase Committee in their Subsequent meeting held at 11AM on 07/03/2011took a decision to give a counter offer of Rs 20/-per packing unit to the firm after declining to accept the negotiated rates.It was further stipulated that if the firm does not accept the counter offer, the bid of the firm should be rejected. It is on record that this was a single offer of this item from this firm only.

- xxi. However, the counter offer was accepted by M/S Medipol Pharmaceuticals India Pvt. Ltd, Vishwas Nagar, Delhi-32 vide SN 101 with the stipulation that the terms of the CST be revised to 1% against form C otherwise 5% or as applicable at the time of supply.
- xxii. Based on acceptance of the counter offer by the firm, Letter of Acceptance of tender Part A Cat No C/267 (Chlordiazepoxide Tabs. IP 10 mg for rate contract period 2008-10 for a period of two years from the date of issuance of rate Contract was issued in terms of SPO/D&M/Pvt Sec/2008-10/11/686 dated 07/04/2011.

8.8 Case No. 6: Tender No. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/1147

- i. Notice inviting tender no. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/1147 was issued on 30/03/09 from Manufacturers and direct importers for the supply of the items listed at Part A (Drugs and Medicines) covering Sections A to E to various institutions of Govt. of Rajasthan for the Rate Contract period 2008-10(ending 30.11.2010)
- ii. Last date of receipt of tender is 11.05.09 up to 1.30PM. Date and time of opening of technical bids are as under:
Section A: 13/05/09 at 2.30PM.
Section B: 15/05/09 at 2.30PM
Section C: 20/05/09 at 2.30PM
Section D: 25/05/09 at 2.30PM
Section E: 29/05/09 at 2.30PM
- iii. As per Purchase preference Rules 1995 of Government of Rajasthan, Purchase Preference will be given to SSI Units of Rajasthan.
- iv. The Pre-Bid Meeting will be held on 20/04/2009 at 11AM in the Conference hall of Directorate of medical and Health Services, Rajasthan, Jaipur.
- v. Corrigendum to original tender No. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/1147 date 30/03/09 was issued on 30/04/09 vide no SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/1497 revising last date of sale of tender form, last date of receipt of tender and dates and time of opening of technical bids.(SN12)
- vi. Further in terms of tender no. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/1583 dated 11/05/09, last date of sale of tender form, last date of receipt of tender and dates and time of opening of technical bids were further revised.(SN 13)
- vii. Again vide tender no. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/1816 dated 09/06/09, last date of sale of tender form,

- last date of receipt of tender and dates and time of opening of technical bids were further revised.(SN14)
- viii. Yet again corrigendum to notice inviting tender was issued vide no. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/2009 dated 07/07/09, last date of sale of tender form, last date of receipt of tender and dates and time of opening of technical bids were further revised.(SN15)
- ix. Once Again, corrigendum was issued vide Tender No. SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/2218 dated 04/08/09 due to change in terms and condition of Tenders and revision of technical catalogue of section A,B&C.(SN16).
- x. This is a tender case for finalization of Rate contract for Drugs & Medicines and Chemicals & Regents for 2008-10 ending on 30.11.2010 against finally revised tender no SPO/D&M/Pvt. Sec./NIT-3/2008-10/09/2218 dated 04/08/09.
- xi. Bid received from M/S Medipol Pharmaceuticals India Pvt. Ltd, Vishwas Nagar, Delhi-32 offering drug no C-267,Chlordiazepoxide tabs (Pl. see SN46 of the offer)covered in Section C of the tender has been filed in this case from SN 1 to SN 71 IN 23 DOCUMENTS AS PER CHECK-LIST (COVER A) at SN 1.
- xii. Terms and Conditions of the Rate Contract for Drugs & Medicines and Chemicals & Regents for Pvt. Sector issued by Directorate of Medical and health Services are available from SN.23 to SN 35 vide Annexure B.
- xiii. As per ITEM NO.3 of the amended terms and Conditions of Tenders and Contract available at SN 24, "Sealed Tenders Super scribed, "Tenders for Rate Contract for two years," containing Cover A & Cover B as prescribed hereafter should be submitted to the Secretary, Store Purchase Organization ,Directorate of Medical and health Services, Rajasthan, Jaipur".
- xiv. Checklists of Tender Documents (Rate Contract for Drugs & Medicines and Chemical & Regents for Period 2008-10), Part-I, II &III are available at SN.75, 77 &79 respectively.
- xv. As per comments of the competent authority on Part III of the check list at SN 79, "Tender for Part A Section submitted by M/S Medipol Pharmaceuticals India Pvt. Ltd, Vishwas Nagar, Delhi-32 may be considered for opening of Cover B (Price Bid)".
- xvi. Further in terms of Office Order at SN 81, The committee nominated for opening of Price Bid was directed to open the Price bid at 11AM on 14/10/2010.
- xvii. Subsequently, price bid was opened by the nominated committee at the time, date and place fixed. Rate of the ZEPEx1 POL-10, in 10x10 Tabs in Strip pack was found as Rs.24.40 excluding 1% CST against form C/D otherwise 4%.This Rate was put up to Stores Purchase Committee for decision.

- xviii. Stores Purchase Committee met on 14/12/2011 and 15/12/2011 and decided to call the firm M/S Medipol Pharmaceuticals India Pvt. Ltd for negotiation on account of higher rate quoted by the firm compared to the market prices.
- xix. The firm after negotiation reduced the rates to Rs. 24/- excluding CST/VAT @ 4% or as applicable from corresponding originally quoted price of Rs24.40. per strip of 10x10 tabs.
- xx. Stores Purchase Committee in their Subsequent meeting held at 11AM on 07/03/2011 took a decision to give a counter offer of Rs 20/-per packing unit to the firm after declining to accept the negotiated rates. It was further stipulated that if the firm does not accept the counter offer, the bid of the firm should be rejected. It is on record that this was a single offer of this item from this firm only.
- xxi. However the counter offer was accepted by M/S Medipol Pharmaceuticals India Pvt. Ltd, Vishwas Nagar, Delhi-32 vide SN 101 with the stipulation that the terms of the CST be revised to 1% against form C otherwise 5% or as applicable at the time of supply.
- xxii. Based on acceptance of the counter offer by the firm, Letter of Acceptance of tender Part A Cat No C/267 (Chlordiazepoxide Tabs. IP 10 mg for rate contract period 2008-10 for a period of two years from the date of issuance of rate Contract was issued in terms of SPO/D&M/Pvt Sec/2008-10/11/686 dated 07/04/2011.

8.9 Other Reported Cases

- 8.9.1 **Case 1:** One of the reported competition issue in the sector relates with the procurement of medical devices by CGHS and ESIC which amounts to disincentive for local manufacturers as well as competition distortion in the relevant market. Recently CGHS and ESIC issued a notification in which they prescribed three different ceiling of prices for medical devices on the basis of country of registration - lowest for Indian approved devices and highest for US-approved and in between that for EU-approved. For instance, in the CGHS notification, a drug eluting stent with the US approval had a ceiling price of Rs 65,000 a piece, the limit for Europe-approved stent was Rs 50,000 and Indian one was Rs 40,000. Similarly, a higher price was allowed in ESIC tenders for supply of devices such as electrosurgical generators and diathermy that had the USFDA approval, than products with Indian registration or any other European registration¹⁷.

¹⁷ Business Standard, 23rd December 2011

- 8.9.2 These government agencies need to desist from such discriminatory practices because this would not only adversely affect increasing domestic base of medical device manufacturer, but also tend to reduce the incentive of suppliers to compete. Firstly it undermines the domestic drug regulatory regime by implying that the DCGI approval is not optimal. Secondly, in the absence of a clear rationale and justification for favouring foreign regulatory approvals it seems prima facie discriminatory and a regulatory barrier against the domestic medical device manufacturers. Thirdly, if without basis and justification, it influences consumer minds that are victims of asymmetrical information in the relevant market to choose foreign medical devices over purely domestic medical devices on baseless grounds¹⁸.
- 8.9.3 Therefore, the present piecemeal regulatory approach for medical devices in India results in application of redundant rules. In certain cases, product registration and manufacturing standards intended for drugs are applied to the manufacture of devices - e.g. it is insisted that an expiry date be given on certain medical devices, whereas this is not required for such products. This also results in lack of clarity and transparency about regulation. There are also problems pertaining to multiple levels of government authority involved in enforcing the guidelines, as well as inconsistent interpretation and application of the regulatory guidelines by customs officials at the ports, state drug controllers, and officials within CDSCO. This results in a prolonged and cumbersome regulatory pathway, especially for new product.
- 8.9.4 The Health Ministry recognises the above-said inadequacies of the present regulatory regime of medical devices and is endeavouring to rectify the problems. The Ministry is in the process of drafting a new Bill especially for the regulation of medical devices, which would have separate definition for medical devices and there would be provisions for separate manpower for its regulation and separate standards for clinical trials of a medical device. Then there would not be any need to notify all the time for a device let it into regulatory control.
- 8.9.5 While General Financial Rules, 2005 seems to be the principal regulation with respect to government procurement, there are other departmental orders (Office Memorandums) with respect to purchase of drugs and other medical devices. In addition, different states (and also different programmes) seem to have their own procedures of public health procurement. This makes the analysis complex as to which rule(s) would apply on a particular procurement.
- 8.9.6 **Case 2:** One Central Government order that merits mention is the Department of Chemicals & Petrochemicals OM No.

¹⁸ Competition Distortion in India; No. 14, October-December 2011; CUTS International

50013/1/2006-SO(PI-IV) dated 7th August, 2006, which grant purchase preference exclusively to Pharma CPSEs and their subsidiaries in respect of 102 specified medicines manufactured by them. The salient features of this Purchase Preference Policy (PPP) are as under:

- PPP in respect of a maximum of 102 medicines would be applicable to purchases made by Ministries / Departments, PSUs, Autonomous Bodies, etc. of the Central Government It would be valid for a period of five years.
- This would also be applicable to purchase of 102 drugs made by State Governments under health programmes which are funded by Government of India. (e.g. purchases under National Rural Health Mission etc)
- PPP will extend only to Pharma CPSEs and their subsidiaries (i.e. where Pharma CPSEs own 51 % or above shareholding).
- It would be applicable to a maximum of 102 medicines, The list of 102 medicines would be reviewed and revised by Department of Chemicals & Petrochemicals as and when required taking care not to include any item reserved for SSI units.
- The Purchasing Departments / PSUs / autonomous bodies etc. of the Central Government may invite limited tenders from Pharma CPSEs and their subsidiaries or purchase directly from them at NPPA certified/notified price with a discount upto 35%. The purchasing departments would purchase from Pharma CPSEs and their subsidiaries subject to their meeting Good Manufacturing Practices.
- (GMP) norms as per Schedule 'M' of the Drugs & Cosmetic Rules. If no Pharma CPSE is forthcoming to supply these 102 medicines, the purchasing departments would be at liberty to purchase from other manufacturers.
- If the Pharma CPSEs or their subsidiaries which have the benefit of PPP, fail to perform as per the purchase order, they would be subject to payment of liquidated damages or any other penalty included in the contract.
- The medicines covered under Drug & Price Control Order (DPCO) would be supplied at the rates fixed by National Pharmaceuticals Pricing Authority (NPPA) rates minus discount up to 35 per cent.
- In case of medicines not covered under DPCO, prices would be got certified from NPPA, only for the limited purpose of supply to Central Government Departments and their Public Sector Undertakings, autonomous bodies etc. On the certified price, Pharma CPSEs and their subsidiaries would provide discount up to 35%.
- The Purchase Preference Policy (PPP) as contained in Department of Public Enterprises O.M. No. DPE.13(12)/2003-Fin.Vol.II dated 18.7.2005 would not be applicable to Pharma CPSEs.

8.9.7 On the face of it, such preferential purchasing policy goes against the principles of competition policy - competition neutrality. However, this

may be justified if it is needed to keep such central public sector enterprises alive, to which government can turn to in cases of public health emergency. This particularly assumes importance because of closure of public pharmaceutical manufacturing units, on the one hand, and acquisition of major domestic pharmaceutical companies, on the other hand. The way the two phenomena are happening side by side, the very tool of ‘compulsory license’ could become redundant, with adverse consequences for competition in pharmaceutical sector, and hence on consumers who pay for it out-of-pocket.

8.10 Credibility of drug regulation and impact on competition in procurement of drugs

8.10.1 Drug regulation covers many functions, namely:

- Marketing approval of new medicines based on safety and efficacy studies,
- Licensing and monitoring of manufacturing facilities and distribution channels,
- Post-marketing adverse drug reaction (ADR) monitoring,
- Quality control (QC),
- Periodic review and re-evaluation of approved drugs,
- Control of drug promotion
- Regulation of drug trials.

8.10.2 While most functions pertaining to drug regulation come under the jurisdiction of Central Government and are carried out by the Central Drug Standards Control Organization (CDSCO), others viz. licensing and monitoring of manufacturing units and distribution channels; quality control etc. are carried on by state level drugs authorities under the administrative control of state governments.

8.10.3 Drugs and Cosmetics Act 1940 and Rules 1945, Drugs & Magic Remedies (Objectionable Advertisements) Act 1954 as amended from time to time are the principal legislations that govern the functioning of CDSCO and state drug authorities.

8.10.4 A main problem in effective execution of regulatory functions as noted by the Parliamentary Committee¹⁹ is lack of staff. Notably, the pharmaceutical industry is growing at the rate of approximately 10% per year. However, the workload of CDSCO is increasing at the rate of approximately 20% per year while there is no corresponding rise in the manpower and infrastructure to meet the demand of the industry and

¹⁹ Department Related Parliamentary Standing Committee on Health and Family Welfare (2012), Fifty Ninth Report on the Functioning of the Central Drugs Standard Control Organisation (CDSCO)

discharge mandatory functions. As per the Report of the Parliamentary Committee, there are four Deputy Drugs Controllers and five Assistant Drugs Controllers in Headquarters. These nine officers have to handle each year the work load of approximately 20,000 applications, over 200 meetings, attending to 11,000 public/industry representatives, responding to 700 parliament questions, around 150 court cases etc. Further, these nine officers also attend the meetings of DTAB and its sub-committees, Drugs Consultative Committee, National List of Essential Medicines (NELM), prepare the guidance documents on various subjects, provide inputs for amendments of Drugs and Cosmetics Act and Rules, build up pharmacovigilance programme, train the newly recruited staff and attend any other tasks assigned by Director-General of Health Services or Ministry of Health and Family Welfare, from time to time.

- 8.10.5 Further, the Report of the Parliamentary Committee mentions that condition of state drugs regulatory systems is a matter of serious concern. This issue has to be seen from the quantity as well as quality of personnel points of views. The Mashelkar Committee in 2003 had recommended one drugs inspector per 50 manufacturing units and one drugs inspector per 200 sales/distribution outlets for effective implementation of functions assigned to them. It was also informed that there were approximately 600,000 retail sales outlets and around 10,500 manufacturing units in the country, which, require just over 3,200 Drugs Inspectors. However, in reality, there were only 846 Drugs Inspectors in place against 1,349 sanctioned posts in States. Secondly, current professional skills of the available drug inspectors also call for consistent capacity building. It may be added here that main problems faced by the States Drug Authorities are: inadequate infrastructure, shortage of drugs inspectors, non-existence of data bank and accurate information, non-uniformity of enforcement among the states and lack of pro-active interaction between the States particularly, in connection with investigations relating to drugs found 'Not of Standard Quality'. All these factors may have resulted in adverse public perception about the credibility of regulatory mechanism.

Impact of Good Manufacturing Practices (GMP) on Competition in Procurement

A **good manufacturing practice (GMP)** is a production and testing practice that helps to ensure a quality product. Many countries, including India, have legislated that pharmaceutical and medical device companies must follow GMP procedures, and have created their own GMP guidelines that correspond with their legislation. Basic concepts of all of these guidelines remain more or less similar to the ultimate goals of safeguarding the health of the patient as well as producing good quality medicine, medical devices or active pharmaceutical products.

As of now, reportedly, there are 20,000 companies which manufacture drugs. This also includes the multinationals companies having operations in India. Initially, the government sought to ensure quality of drugs through the Patent Act of 1970. This Act aimed to oversee the quality of pharmaceutical products and to protect the consumers from adulterated products. Prior to the Patent Act of 1970, there was a Schedule M of India's Drug & Cosmetics Act. This Act covered guidelines and regulations only on the pharmaceutical company's location, buildings, equipment, safety and sanitation. Not covered in this Act were personnel's qualifications, proper documentation and processes. The advent of GMP requirements covered the gaps in India's Drug & Cosmetic Act. These regulations are more comprehensive and cover in details personnel requirements and liabilities. The current version of GMP guidelines were adopted in 2005. As per the Central Drugs Standard Control Organization record, there are already more than 800 pharmaceutical companies registered. The high percentage of Schedule M-GMP compliant is mostly from Gujarat, Karnataka, Maharashtra and Andhra Pradesh.

The amendment of Schedule M which is in consolidation with GMP is relatively lenient compared with what the US and EU regimes require. An issue for debate in this regard has been the compliance of small drug companies with the GMP. Although it has been some years from the time that this harmonization was implemented, the small and medium size enterprises are still in the process of adopting GMPs. There have been demands to relax the GMP. Given the sensitivities, a committee headed by Dr Najma Heptulla looked into the impact of Schedule M regulations on small players in the pharmaceutical industry. After 2 years of thorough deliberation, the committee recommended that the Indian administration should be considerate of the plight of the small and medium size enterprises. The committee noted that small pharmaceutical units might be shutdown in some states and it recognized the possibility that the amendment might favor the multinational companies and the big players in the industry. The Health Ministry of India contends that there are many small enterprises that adhere to the GMP requirement and many more are coming into compliance. From the competition perspective, GMP requirements need to achieve a balance between product safety and restricting effects of the compliance. GMP requirements which may be more restrictive than required may foreclose competition and adversely impact drug availability and prices.

From discussion with various experts it emerged that good manufacturing practices (GMP) play an important role in procurement market of pharmaceuticals products. It is evident that having GMP is seen as a critical prerequisite for winning a procurement tender. However, it also emerged that there is lack of credibility in administration of the GMPs. A particular reference to lack of faith in the credibility of state drug inspectors adversely affects successful participation of various companies in procurement market. It is important to note that there seems to be no lacunae in the extant legislations but in the practice or in the administration. Therefore, procedural improvement of the GMP administration can be considered as a possible remedy.

8.11 Conclusion:

8.11.1 Three Tender Cases each were received from Ministry of Health and Family Welfare, Government of India and Public Health and Elementary Education Department of Rajasthan Government through RTI for the purpose of scrutiny. As may be seen above details of procurement proposed under said tender has been provided along with processes followed. Detailed analysis of all the tender case has been done to ascertain competition concerns. It is found that:

- i. Procedure of Rate Contract as laid down in DGS&D manual has been followed for procurement of Drugs and Medicines, Vaccines and Medical Equipment.
- ii. Pre-Bid Meetings have been conducted to clarify doubts and issues and incorporate changes in the Tender documents wherever considered necessary.
- iii. Advertised Tenders with Two Bid System to ward off unresponsive and technically unsuitable bids have been invited in all the cases to ensure maximum participation of prospective bidders.
- iv. Last Purchase rates and Rates obtained in the current Tenders have been analyzed to detect cases of Bid rigging and cartel formation and other malpractices.

As may appear from above four points that design of tender documents have been as per existing norms of public procurement and procuring entities seem to aware about competitive process and they claim to have taken safeguards to cut down any attempt of anticompetitive conduct such as bid rigging etc.

Specifically looking into cases some issues may be highlighted from the competition assessment aspect. In Tender Enquiry no.S.12012/12/2010-Supply/RC/Condoms, procurement of condoms worth Rs.1000 Cr. is proposed by a two bid system. As per details there is only one competition concern which requires consideration i.e. whether system proposed by tender document thwarts competition and creates an entry barrier or disallows bidders to fairly participate in the bidding process or technical specifications are designed to favour few suppliers etc. on prima facie assessment what may be stated that no apparent anomaly vis-à-vis competition may be seen, however, if procurement system does not have a global appearance it may be concluded that global competitive bidding could have provided better competitive prices. It may also be noted that the tender document provided for Purchase preference, in terms that procurement shall be

subject to the purchase preference policy of the Government of India applicable for the Public Sector Undertakings of the Government of India. Such clear preferences may not be considered in consonance with competition mandate for the reason that preferences in procurement would definitely dilute competition and create an entry barrier for a number of private producers.

Such approach has been consistently seen by and large in all the high value procurement tenders, which shows that procurement processes have not become competition compliant, however, they aim to be transparent and competitive.

Chapter 4 Public Procurement in Primary Education Sector

9 Primary Education System in India- An Overview

9.1 In recent past, India has made a huge progress in terms of increasing primary education enrolment, retention, regular attendance rate and expanding literacy to approximately two thirds of the population. Free and compulsory education to all children up to the age fourteen is constitutional commitment in India. The Parliament of India has recently passed Right to Education Act through which education has become fundamental right of all children of age group 6-14 years. This has been done in pursuance of The 86th Constitutional Amendment Act, 2002 which made education a Fundamental Right for children in the age group of 6-14 years by providing that “*the State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine.*” The country is yet to achieve the elusive goal of Universalisation of Elementary education (UEE), which means 100 percent enrolment and retention of children with schooling facilities in all habitations. It is to fill this gap that the Government has launched the Sarva Shiksha Abhiyan in 2001, one of the largest such programmes in the world.

9.2 Public Expenditure on Education in India has been 3.77% of GDP in the year 1999-2000 and 3.74% in the year 2003-04, this may suggest that the total amount spent on procurement in primary education is not so high. Furthermore, the given focus on Primary Education by the government allows huge procurement by the state of various goods and services for ensuring reach and outcome of elementary education. It suggests that any inefficiency in public procurement system would not only bring in sub-standard quality of goods and services but also derail the policy objective of primary education.

10 Primary Education in Rajasthan

10.1 The elementary education sector has been given prime importance in the XIth Five Year Plan with stress on the successful implementation of Sarva Shiksha Abhiyan. Continuing the trend of the tenth plan the eleventh plan also proposes an outlay of about 28.33% of the total plan outlay to the social and community service sector. In the eleventh five year plan the state government spells the importance of education as the most critical element for empowerment of people and expresses the focus on expansion of educational facilities/ quality in teaching and learning and improvement in access, coverage and retention ratio in schools as a major task for the plan. In this regard, emphasis on result-oriented training of teachers along with an expansion in the infrastructural and institutional facilities would be crucial to creating a

favourable environment to give a boost to universalisation of elementary education.

10.2 However, a review of the existing infrastructure facilities in the state for elementary education does not present a very encouraging picture. The number of primary schools with classrooms in good condition has gone down because many of them have been upgraded to upper primary school. Hence the schools with good classrooms at upper primary level now stands at 136535 (in the year 2008-09) as compared to 22892 in the year 2005-06. Classrooms requiring major repairs are 28575 (both in PS and UPS). This is quite a large number considering the availability of enough funds for this purpose. What, however, is distressing to note is the fact that 1988 schools still do not have either the rented or own building. One can visualize the plight of children studying in such non-building schools. Only 30021 (37.20%) schools have pucca boundary wall and 17.66% schools do have broken ones. 2.41% schools have wire fencing. What, however, is amazing is the fact that 34471 (42.71%) schools have no building wall at all, thus exposing the school children both to man-made and natural hazards. Coming to facilities directly affecting school children, one finds that toilets exclusively for girls have not been provided in 15050 (18.64%) of schools, while drinking water facility is non-existent in 7917 schools. 15050 schools do not have any kind of toilets. The absence of electricity in a vast majority of schools is a serious matter, since this has an adverse impact on children's attendance in summers. Computers, though now considered to be a symbol of technological progress and an asset for innovative teaching learning processes, are available only in a miniscule number of schools. It may be stated that computers do not operate in the absence of electricity, and this unfortunately is available only in 16.83% schools. In terms of facilities, although, one may state, that there has been considerable progress, yet large gaps exist particularly in providing toilets for girls, electricity and computers.²⁰

10.3 Lack of proper and adequate infrastructure facilities at the elementary education level in the state acts as a limiting factor in moving towards the goal of universalization of elementary education. This necessitates a well laid out procurement strategy which could facilitate the provision of infrastructure facilities and services which are necessary for giving impetus to universalization of elementary education in the state.

²⁰ Available at:

<http://www.planning.rajasthan.gov.in/Mid%20Term%20Apraisal%20Book.pdf>

11 Regulatory and Policy Framework

11.1 The role of universal Elementary Education (UEE) for strengthening the social fabric of democracy through provision of equal opportunities to all has been accepted since the inception of our Republic. With the formulation of NPE, India initiated a wide range of programmes for achieving the goal of UEE through several schematic and programme interventions, such as Operation Blackboard, Shiksha Karmi Project, Lok Jumbish Programme, Mahila Samakhya, District Primary Education Programme etc.

11.2 Currently, Sarva Shiksha Abhiyan (SSA) is implemented as India's main programme for universalising elementary education. SSA interventions include opening of new schools and alternate schooling facilities, construction of schools and additional classrooms, toilets and drinking water, provisioning for teachers, periodic teacher training and academic resource support, text books and support for learning achievement.

11.3 **Sarva Shiksha Abhiyan (SSA)** - The SSA (education for all) is the prime initiative undertaken by the Central Government of India to improve the overall literacy levels and quality of education in the country. SSA was undertaken in the Eleventh Five-year Plan. SSA is an action plan whereby the government would incorporate the following:

- Increase the availability of schools (capacity creation) through opening of new schools and construction of new classes;
- Improve the standards of education (quality of learning) by enhancing the skill levels of teachers, recruiting more teachers, providing better courseware and syllabus;
- Attract more students to schools by implementation of the Mid-day meal scheme, which will help provide better nutrition levels to children, and
- Create an environment more conducive to imparting better education to every one who needs to be educated.

11.4 **Procurement in SSA:** The implementation of the national programme of Sarva Shiksha Abhiyan (SSA) entails procurement of textbooks, teaching learning equipment, teaching learning materials, furniture, school equipment, materials required for teacher's training, office equipment, computers and their accessories, improvement of school facilities, construction of primary and upper primary school buildings, additional class rooms, toilets, drinking water facilities, boundary walls, separation walls, electrification, construction of BRCs/CRCs, maintenance and repair of school buildings, construction of SIEMAT, hiring of experts for specific tasks etc. While the village/school-

based structures shall decide the best way of procurement in connection with up-gradation, repair and maintenance of schools and teaching learning equipment, the SSA framework has not specified the methods for procurement at school, CRC, BRC, district and State level. It was decided by the EE Bureau that procurement under SSA may be carried out as per the respective State Government procedures/Rules. However, in case the State Implementation Society is already following a procedure under DPEP, the same may be adopted by it for procurement under SSA also. The choice of the procurement procedure i.e., whether State guidelines or the existing DPEP procedures, may be decided by the Executive Committee of the State Implementation Society. This choice may be exercised by the Executive Committee either for the entire procurement to be done by the Society in toto or for each item of procurement on a case-to-case basis.

- 11.4.1 In SSA, goods, works and services required for the implementation of the programme will be procured at (a) school/community level, (b) CRC/BRC level, (c) district level, and (d) State level. The procurement procedures as laid down in the State Government Rules or the Panchayati Raj Institutions Rules as applicable at each level shall be normally followed for the procurement of civil works, goods and services in SSA.
- 11.4.2 While resorting to procurement under SSA, it should be kept in mind by the programme implementing authorities that specific budget provision should be available for meeting the expenditure in the financial year in which it is to be incurred. Bulk requirement of stores for State Society office and district level offices should be assessed at the beginning of the financial year and action for procurement should be initiated in accordance with the purchase procedure applicable under SSA. Purchase of office equipment and furniture should be in economic lots keeping in view the annual requirements. Purchases must be made to the best advantage of the programme after comparison of competitive prices.
- 11.4.3 The preparation of a procurement plan is an essential requirement. The procurement plan covering civil works, equipment, goods, vehicles and consultancy services and resource support shall be prepared on a firm basis for first year of the programme, and on a tentative basis for the subsequent years. Procurement plan shall be prepared every year by the State / UT. The procurement plan schedule shall be prepared contract wise. The method of procurement shall be based on the value of the contract.
- 11.4.4 The limit applicable to the particular procurement procedure shall be strictly adhered to. In case the procurement activity could not be completed in a year as per the plan and the same is to be carried over

to the next year, a reference to this effect should be made to the EE Bureau, GOI stating the reasons for not procuring the items in the particular year. It should also be mentioned to the Bureau that except for the carry forward of the procurement, all other procedures remain unchanged.

11.5 SSA- Performance Round Up - There has been significant growth in infrastructure, but the implementation process has been slow and a huge gap still remains. The very nature of this mission is to complete the task of improving the literacy levels of India in a time-bound manner. SSA has succeeded in helping the states in largely achieving the basic task of providing infrastructure and creating systems and processes for improved educational attainments. As quality and equity are two main thrust areas of SSA, the process improvements effected by SSA need to be maintained in the future to continue the improvement process of education in India. As per SSA estimates, there is a shortfall of approximately 1.25lakh upper primary schools in India. The demand for upper primary school would be greater than the demand for primary schools.

11.5.1 School Infrastructure – Information collected through the District Information System for Education (DISE) suggests that 3% of the primary schools and 2.4% of upper primary schools did not have any building in 2005-06. Further, there is a severe shortage of classrooms in schools where the school building is present. There was a shortage of over 6 lakh class rooms during 2006-07. In 2005-06, a significant 44.6% of primary schools and 15.3% of upper primary schools did not have any toilet at all. Similar proportion of schools, both in the primary and upper primary stages, did not have any boundary wall. Drinking water facilities were not available in 15.1% primary and 4.8% upper primary schools. These are very important issues and call for adequate attention to ensure availability of the required physical infrastructure in the schooling system. Such lack of facilities would consequently hamper both enrolments as well as the quality of education.

11.5.2 The physical infrastructure at primary and upper primary schools still requires significant improvement. Some requirements—e.g., blackboards, electricity, and playgrounds—are critical support in achieving quality education. The school building program requires a proactive building maintenance and management program to continuously maintain performance standards. This report recommends that central education authorities develop standard specifications for school infrastructure.

11.5.3 In order to assess the level of competition, few contracts have been analyzed with respect to processes and systems of procurement. The analysis significantly reveals the level of competition in SSA in the State of Rajasthan.

12 Findings on the Public procurement System in the Primary Education Sector in the Central Government and in the State of Rajasthan

12.1 Case 1: Procurement of Civil Works

- i. The tender relates to procurement of civil works at a school level contract of an upper primary school in Chirota Village in Rajasthan, dating back to July 2006, carried out under the Sarva Shiksha Abhiyan.
- ii. The sanctioned quantum of work was the construction of three rooms, sanctioned by the District Implementation Agency. The total amount sanctioned by the Government for the work was INR 4,00,000 and the amount actually spent was INR 4,07,408.

Methodology of Procurement:

- iii. **Analysis:** It was observed that no formal list of suppliers was maintained. Thus, the method chosen for selection was not formal, it was a random selection process based on general knowledge. The analysis reveals that no proper market assessment was carried out to identify potential tenderers, whereas an ad-hoc random process of selecting the tenderers was chosen based on convenience. This may have important bearing on the quality of work and the competitiveness of rates, ultimately compromising on competition, since no proper market survey was carried out to identify potential tenderers based on their capabilities to carry out the assigned task.

12.2 Bid Reference No: F-7/RCEE/CALP-BOOT MODEL/NCB-SSA-I/2010-11 of RAJASTHAN COUNCIL OF ELEMENTARY EDUCATION dated Date: 25/04/2012

- i. Rajasthan Council for Elementary Education invited Sealed Technical and Financial bids vide above Bid reference on 09/07/2010 for implementation of Computer Aided Learning Programme (CLAP) in 2500 upper primary Schools in the State of Rajasthan including supply of hardware, Software and maintenance of the System on a BOOT (Build, Own, Operate and Transfer) basis over a period of 5 years (2010-11 to 2014-15).
- ii. Pre-bid meeting was scheduled for 23/07/2010 at 14 hrs In 4th Floor Committee hall of RCEE.

- iii. Eligible Bidders were required to submit technical and financial bids in two separate sealed envelopes accompanied by earnest Money as specified in the Bid documents to the office of Commissioner RCEE on or before 10.08.2010 by 14 hrs.
- iv. Date of Opening the first envelope containing financial bid was fixed as 14.30 hrs on 10.08.2010.
- v. The bid documents included ;Instructions to bidders laying down eligibility criteria, Description and Scope of Contract, Technical specifications for Electrified Schools, General Conditions of Contract and Special Conditions of Contract laying down schedule for Installation, Testing and Commissioning of Computer Systems.
- vi. 43 bidders participated in the Pre-bid meeting held on appointed date, time and venue.
- vii. Changes suggested during Pre-bid Meeting as considered necessary were incorporated in the bid documents.
- viii. Technical bids of eight bidders were opened on 10.08.2010 at 14.30 hrs as per schedule. Six bids were found technically suitable. It was recommended by the Bid Evaluation Committee to open price bids in case of all six bidders whose technical bids were found suitable.
- ix. Six bidders were informed through fax/letter communication to be present in the chamber of 'Controller of Finance' at 11 hrs on 03.09.2010. All six attended price bid opening at the appointed time.
- x. Following Bidders offered lowest Price Bids for schedule 1,2&3 as mentioned against each:

SN	Nome of The Bidder	Schedules	Lowest Price Bid
1	M/S Manipal K-12 Education Pvt.Ltd.Bangalore	Schedule1&3 covering 836 Schools each.	Rs.1,15,900/- per school for Schedule-1. Rs.1,21,000/-for Schedule-3
2.	M/S Compucom Software Ltd. Jaipur.	Schedule-2 covering 836 schools.	Rs.1,25,100/-per school for Schedule-2.

- xi. After considering above, Price Evaluation Committee decided to call firms who offered lowest bid for Schedules 2&3 for negotiation keeping in view the lowest bid received for schedule 1.
- xii. Accordingly, Negotiation with two bidders was fixed on 13/09/2010 and following negotiated price Bids were received:

SN	Nome of The Bidder	Schedules	Negotiated Price Bid
1	M/S Manipal K-12 Education Pvt.Ltd.Bangalore	Schedule 3 for 836 Schools	Rs.1,20,900/-per school for Schedule-3
2.	M/S Compucom Software Ltd. Jaipur.	Schedule-2 for 836 Schools	Rs.1,24,500/-per School for schedule 2.

- xiii. Based on the Negotiated bid proposals, Work orders for Schedules 1,2 & 3 were issued to M/S Manipal K-12 Education Pvt.Ltd.Bangalore for schedules 1&3 and to M/S Compucom Software Ltd. Jaipur for schedule-2 as per scope of the work after the bidders submitted Performance Security and signed the agreements with RCEE.
- xiv. **Post review by Government of India** - EE Bureau shall cause a post review of the contracts awarded on procurement of goods, works and services by the programme implementing agencies in the States on a random basis. For this purpose, all documents relating to the award of contract should be retained by the project implementing agencies and made available to the review team of GOI.
- xv. **Mis-procurement** - The goods, works and services that have not been procured in accordance with the prescribed procedures outlined in this manual or other State Government procurement procedures, as the case may be, shall be treated as mis-procurement. The expenditure incurred on such procurement shall not be eligible for financing from SSA funds.

Chapter 5

Conclusion and Recommendations

- i. Analysis of governance structures and regulatory frameworks highlighted lack of communication, coordination, cohesion and coherence amongst various institutions/ministries that have an effect on access to medicines in the country. Key informants also voiced their concern regarding lack of policy environment to offer a road map to ensure commodity security in the country.
- ii. The public procurements in many departments and ministries suffer from serious delays, indecisiveness, and frequent change of specifications, lack of accountability, inadequate competition, and acceptance of goods of inferior quality. Public procurement is the government activity most vulnerable to waste, fraud and corruption due to its complexity, the size of the financial flows it generates and the close interaction between the public and the private sectors. Public procurement in India has been characterised by the malpractice of cartel formation accompanied by collusive bidding and bid rigging. Suppliers/bidders can eliminate competition in public procurement in many simple ways, for example:
 - a competitor agrees to submit a non-competitive bid that is too high to be accepted or contains terms that are unacceptable to the buyer;
 - a competitor agrees not to bid or to withdraw a bid from consideration; and,
 - a competitor agrees to submit bids only in certain geographic areas or only to certain public organisations.
- iii. Also, lack of a scientific mechanism and system to generate evidence on the type of drugs produced, quantity produced, prices of production, drugs consumption and other related indicators limits governments capacity for evidence based policy making. Another recent trend is that of collusion between medicine manufacturers, super-speciality hospitals, pharma-retail chains and health insurance agencies. This may have negative impact on availability of affordable medicines in the country in near future.
- iv. Lack of robust procurement and supply chain systems hampers the availability of medicines to frontline facilities as well as leads to leakages and inefficient procurement practices incurring financial losses.
- v. Health spending in India at around 4.8% of GDP is not considered at par with spending in Organisation for Economic Co-operation and Development member countries. Therefore, while there has been considerable success in developing physical infrastructure and coverage of primary health provision, significant challenges remain across the

country in health care provision, especially in terms of accessibility, coverage, rural areas, ineffective management, and inadequate quality and availability of health care professionals. The problem can be addressed by strengthening accountability framework in government. Accountability is at once a key deterrent to corruption and collusion and a pre-requisite to procurement credibility.

- vi. Education spending in India is estimated at about 4.1% of GDP. While there has been considerable progress in enhancing access and building the school network over the recent past, significant gaps continue to hinder quality education across the country. Gaps between boys and girls, rich and poor, and rural and urban areas remain.
- vii. It would not be out of place to mention about launch of a pan India scheme/intervention of the Central Government in the context of drugs procurement, which, as per news reports, may be announce by the Government, whereby there will be free supply of essential medicines to all those who seek healthcare in public health establishments anywhere in India. It would be wholly funded by GOI. Procurement for this scheme would be (a) only of generic-generic and unbranded generic medicines, (b) only from national essential list and state list of essential medicines, where applicable, and (c) procurement would be in bulk and directly from manufacturer.
- viii. The Tamil Nadu model of drug procurement is proposed to be replicated by the Central Government. In order to implement the proposed scheme, money would be given by Central Government to State Governments to procure drugs through a MOU requiring the latter to have certain necessary systems in place, as pre-condition. This is being done to avoid misuse. For instance, it would be mandatory for state governments to form a corporation for the purpose of procuring drugs and having proper staff to do inventory etc. Main concern for GOI is leakage due to corruption, particularly at the PHC level. At present the GOI is thinking towards having a community oversight/social audit mechanism to check such leakage.
- ix. It is pertinent to note that like TN and Delhi models, GOI for this scheme also proposes certain technical criteria with respect to minimum turnover (e.g. Rs.25 crore) and operational timeframe (e.g. 3 years) on part of the suppliers. This is being done in order to obtain quality generic drugs with certainty in their supply.
- x. It is true that in India we have a plethora of domestic manufacturers of medicine hence we may not be required to incentivise the new comers. But would we like to maintain this concept of turnover and minimum operation as

criteria for high-end medical devices? Would we not like to incentivise new comers, viewing the scanty presence of high-end medical devices manufacturers in India? Therefore we need to review the concept of putting turnover and operation time as criteria for firms to qualify for bidding to supply goods and services to government, without compromising on quality and sustainability of such supplies.

- xi. A major deficiency in the public procurement system in India is the confusion created by the existence of multiple procurement guidelines and procedures issued by multiple agencies. There is neither a single comprehensive public procurement standard nor a single nodal agency to deal with public procurement policy. There is an urgent need to put in place a comprehensive public procurement standard in India with a single authority to handle public procurement issues. The Government has already presented the Public Procurement Bill in the Parliament. One enacted, the proposed Act is expected to sort out many issues raised by the Study.
- xii. **Impact of corruption and other mal-practices:** Bribery and corruption are frequently associated²¹ with other crimes, such as money laundering, accounting fraud, tax evasion and extortion. The public procurement process can also be abused through collusion and corruption. From the interactions with various government officials and private companies it emerged that presence of corruption and other mal-practices results in lack of participation by brand name conscious companies or the companies which do not wish to engage in corrupt practices. In terms of competition it means that presence of corruption and other mal-practices exerts a market distorting impact by way of reducing the number of potential suppliers. This intern means that companies which participated a tender greater opportunity to: a) collude and raise the prices, and (b) supply lower quality goods but at a higher price. Therefore, it is reasonable to say that corrupt practices distorts markets and undermines trust in government and institutions.
- xiii. **Impact of procedural delays** - Interactions with various experts reveal that tenders are concluded either at a short notice or after excessive delays. In the case of excessive delays, it adversely impacts the price quote and the shelf life of the drugs. After the commencement of tender proceedings the interested suppliers taken in to their production account and accordingly choose to produce the demanded good. However, at the time of actual supply considerable time may have laps. This means that the drug, which comes with a

²¹ OECD (2007), Bribery in Public Procurement - METHODS, ACTORS AND COUNTER-MEASURES, ISBN 978-92-64-01394-0

predetermined expiry date, has to be consumed in a short span of time. In addition to the temporal issue, the time lag also has the potential to adversely affect the cost of supplying drugs. When a potential drug supplier takes this in to account and raises the price quote, it fails to meet the L1 criteria stipulated by the GFRs. **Such a scenario may significantly reduce the number of suppliers in effect.**

- xiv. Information technology (IT) has the potential to contribute to reducing risks associated with corrupt practices in public procurement. IT can limit face-to-face contacts between suppliers and procurement sides, allow the efficient exchange of information to a large number of potential suppliers at low cost, increase transparency of forthcoming and current tender opportunities. In India, the use IT in public procurement is rising but needs to further leveraged.
- xv. An issue regarding timely availability of procured goods (text books and medical supplies for the purpose of this report) was also raised during consultation with experts. However, this was outside the scope of the research, which sought to focus only on impact of competition on the procurement process and not the logistics of distributing the procured goods.
- xvi. Besides a good framework of policies and procedures, the quality of manpower which operates the procurement system is equally crucial. In India, public procurement has never been treated as a specialized activity requiring specialized knowledge and skills. Even the most critical and complex procurements are handled in a non-professional manner. Except for the Railways and the DGS&D, no organization has created a specialized cadre for this purpose; even in these organizations inefficiencies are galore. There is a need either to have qualified staff handling procurement or to provide adequate professional training to convert procurement officials into procurement managers.

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List of People interviewed

1. Mr. B.B. Sharma
Deputy Secretary, Bureau of Elementary Education,
Ministry of Human Resource Development,
Government of India.
2. Mr. A.K. Panda
Joint Secretary (Procurement),
Ministry of Health and Family Welfare,
Government of India.
3. Mr. Vikram Sahay
Director, Bureau of Elementary Education,
Ministry of Human Resource Development,
Government of India.
4. Dr. B.R. Meena
Director, Public Health,
Government of Rajasthan,
Jaipur.
5. Mr. Neeraj Sharma
Executive Director (Procurement), Drugs,
Government of Rajasthan,
Jaipur.
6. Ms. Gayatri Rathore
Mission Director, National Rural Health Mission,
Rajasthan.
7. Mr. S.C. Sharma
Executive Director (Procurement), Surgicals,
Government of Rajasthan,
Jaipur.
8. Mr. Vimal Kumar Jain
Additional Commissioner,
Rajasthan Primary Education Council,
Jaipur.
9. Ms. Anjali Anand Srivastava
Joint Secretary & Financial Advisor, Ministry of Coal.
Government of India.

10. Dr. Samit Sharma
Managing Director, Rajasthan Medical Services Corporation,
Jaipur.

11. Sh. Harsahay Meena
Director, Directorate of Elementary education,
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