Drug Distribution and Usage Control in Health Care

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Within the enormous complex activities that characterise the marketing institution is an elemental structure, the so-called marketing channel which is commonly called distribution. In its broadest sence not only trading concerns– Pharmaceutical or not–engaged primarily in selling and buying–producers, wholesalers, retailers, selling agents, commission houses, but non-trading concerns like commercial banks, advertising agents are found in marketing channel situation. Marketing channel decisions are among the most critical decisions faced by management and the channels chosen for a company's products intimately affect every other marketing decision. These include pricing and discounting decisions, sales force decision and in fact, involve companies in relatively long term commitments to other forms.

In this discourse, we will limit ourselves to drug distribution and its effect on the usage and control of drug within the health care delivery system. But I feel sure that it will be necessary to lay a little background on distribution per se. We will in the process discuss the nature of marketing channels or distribution and what trends are taking place and secondly the role of physical distribution decisions and their effect on drug usage, control and customer satisfaction.

Distribution is generally regarded as the ability to move goods in our case and services, in the right quantity, to the right place at the right time and price. This could vary from a simple case of a farmer by the roadside selling to a consumer to a complicated system involving long chains of distribution channels i.e. through middlemen. The essential function of the channel is to transfer title and the parties concerned include the producer or manufacturer the consumer and the middleman–either wholesaler/distributor or retailer. Channels of distribution therefore bring about matching of goods and the desires to potential buyers (users).

The distribution channel tends to bridge the gap between the producer and the user. This gap is not only geographical in nature, which is bridged by physical movement of goods but there are four other examples:–

1. **Time Gap**–months may elapse between production and the final purchase of the product. This may in our case result in deterioration with loss of potency for short life products or development of degradation products that might be dangerous. Also, time gap may have serious consequence for the user (patient) who cannot wait like the diabetic, hypertensive or cardiac patient. It also has an implication for the producer who may not only loose a sale but also a customer to competition by a simple act of substitution.
2. **Knowledge Gap**–the producer may not know his potential buyer and will therefore bring market research into play to identify his potential market or target. Also, the buyer may have no knowledge of where to obtain the products or even that the products are available. Here again, the producer or the pharmaceuitcal enterprenuer will employ the services of medical representatives, salesmen or advertisement using the appropriate media to educate his target audience. In our case Doctors and Pharmacists. Unlike other products, in the case of drugs the target audience is not necessarily the user but influences usage. In fact, if the law is applied to the latter, usage can only be affected at his instance for scheduled drugs.
3. **Technological Gap**–the producer must be able to acquire the necessary technology to produce enough of the products to meet the necessary demand.
4. **Possession Gap**–i.e. title must be transferred in one or several stages from producer to user. It is during this process that control could be effected by the necessary authority. Since drug could only be misused when in possession by those who should not be in possession, be it a channel or end user.

The several functions outlined above must be performed in order for goods (drugs) to be transferred from manufacturer to the consumer. The actual performance of these function is split among parties in such a way as to maximise the overall efficiency of the system. Efficiency in the usual satisfaction/cost sense, it may be assumed that, in a free enterprise system, each channel in use provides the greatest total satisfaction for all parties at an acceptable cost This is the concept of optimum channel. The mix of activities could be changed by each member to satisfy his own cost/satisfaction relationship e.g. carrying of inventory by wholesaler for manufacturer. In order to obtain this cost-satisfaction relationship channel innovations could develop e.g. retail chemists can pull together and buy direct from a manufacturer to obtain better price. This results in retail operated wholesale enterprises or retail co-operatives. On the other hand the manufacturer may decide to have his own salesmen and thereby operate two channels. In a competitive society it is necessary to review the performance of distribution channels in order to maximise channel efficiency.

It is now ripe to briefly look at the major distribution channels for drugs in this country and their effect on drug usage and control.

1. **Government**—The governments in Nigeria, because they own the majority of the hosptials in the country, form the one single largest distribution channel for pharmaceutical products. Also, they are able to hold large inventories because of the size of their medical stores which is also a reflection of the size of the number of users they have. In other words, for any manufacturer to be able to have an extensive distribution of his products he must have the governments as his major distributors or channel. Depending on what are the objective of the manufacturer the emphasis on this channel will vary. For one, due to the low cost at which goods are purchased by this outlet, it may not be cost efficient in the usual satisfaction/cost sense. The manufacturer will have to weigh volume usage and large inventory carriage against unit profitability viz-a-viz his total company profit objective. Since government institutions andparastatals form the largest distribution centre, they also form the largest usage centre and therefore most difficult point of control. Followed ethically and according to law this sector should offer no problems and drugs and medicines should be used properly and drug movements properly controlled. Unfortunately, this is not the case. Ideally, all drugs will be dispensed essentially on prescription—be it in the wards or in the pharmacy. In such a case the medicines and drugs are used properly and controlled. But it is regrettably true that because this channel is large it also constitutes one of the largest outlets of drugs and medicines that are distributed through the unauthorised channels. Unpalatable as it might sound it is true that drugs meant for this channel do find their way into the open markets of Onitsha, Aba, Lagos, Jos, Kano and Kaduna etc. Once drugs get into this channel it becomes available, without control, to all and sundry leading to drug abuse and misuse.

2. **Direct Distribution**—This involves a direct manufactuer/user relationship. This will be a viable proposition in a small scale but in a large scale will present many problems. For instance, the producer must be able to solve both production and marketing problems. He will need to be an expert in retail store operations and field sales force management. This distribution know-how may be costly to acquire and in fact will not make commercial sense Also, under such a situation the manufacturer will operate a very large number of customer accounts which will be difficult to service and control.

3. **Manufactuer Retailer Channel**—This provides a shorter channel and is being used by small outfits It could at times be worthwhile even for a big outfit as one aggressive retailer interested in his business could outsell several who are content simply to carry the line and sell to those who ask for it. However, unless the company is prepared to work closely with the retailers and unless the volume generated by each retailer is sufficient to offset the higher marketing costs involved, the shorter channel will not be profitable.

4. **Wholesales/Distributor**—This is the channel used by most manufactuers to get to their users through the retailers of their wholesalers/distributors. These take full title and may offer full service or limited service and may carry full lines or limited or special lines. The sales function is however not always performed to the satisfaction of the manufacturer. He therefore offer services as the most efficient outlet for the distribution of relatively undifferentiated products which have been "pre-sold" to the users/retailers through the manufacturer's advertising and promotional activities. At times the manufacturer is forced to use channels 2 and 3 above because he has been let down by his wholesaler who are unable—

(a) to buy and carry reasonable inventory because they are owing and are unwilling or unable to pay.

(b) they are interested only in stocking some fast moving old established products.

5. **Franchise System**—This system is used by some wholesale chemists involved in direct importation. This involves a monopolistic and exclusive distribution rights. In this case the middleman operates under his own name using his own methods or operation. The franchisee, in effect, buys an operating package which has been tested and proved successful through experience. Unfortunately, some of our colleagues are unwary of this. He furnishes capital and some degree of business know-how and he quite fairly assumes that he will be coached and aided by the franchisor in the conduct of the business. This hope invariably fails as the franchisor is only interested in selling his drugs and establishing a quick outlet with a quick return i.e. a financial myopic view.

Channel 2 to 5 help in many ways to service the unauthorised channels in the open market mentioned above. In the dire need for quick turnover and profit drugs are supplied and sold to these outlets with complete disregard to the laws and ethics governing the distribution, use and control of the drug and medicines market. Ideally, all prescription drugs should be sold through the retail outlets on prescription. One wonders how many ethical medicines are sold in this way. It is a known fact that one could buy anything in a drug store or open market without prescription and without being asked what one intends to use the drug/medicine to treat. Self-medication is the order of the day. This of course lead to drug misuse and abuse. The machinery for control is virtually non-existent and Pharmacists are unwilling to apply self-discipline. The authorities are also regretably unwilling to discipline colleagues.

I will quickly say at this point that the basic problem, the resultant effect of which is this uncontrolled use and distribution of drugs, is the inability of the authorities to streamline the dichotomy in the practice of medicine and pharmacy. The Doctor in Nigeria practises both pharmacy and his profession and at times more pharmacy and the Pharmacist tries to do the

direct opposite. In this mad confusion those who are unable to cope with the struggle take the easy wayout –sell to the market "Doctor/Pharmacist" who of course dispose of his wares without any regard for the danger to human life. But who will blame him? He is in 'business.' Next in the group of those who aid the misuse and abuse of drugs are those members of our profession who hawk their licences to laymen to practise and worse still those who sign blank order sheets for market traders for peanuts. These are but some of the ways through which the unauthorised channel of drug distribution is supplied. I will add for completeness pilferage from all five channels and through the ports as also a regular source of supply to this unethical channel.

I have deliberately left to the last the Patent Medicine Dealer (PMD). These are authorised channels for the distribution of non-prescription products. Unfortunately, they do not restrict themselves to the over-the-counter lines. They distribute everything. Their source of ethical drugs is as for the unauthorised channel. As far as Iam concerned their existence is temporary. They are there to fill a gap with less than 500 wholesale/retail pharmacists. It is little wonder that the authorities still register new patent medicinesdealers. They could be wiped out quite quickly with an increased number of pharmacies, improvement of mass literacy and strictly disciplined drug distribution channels.

It is now pertinent to make bold and state possible solutions to the improper drug and medicine distribution and usage–

(i) There must be a deliberate government policy to train more Doctors and Pharmacists. At the moment the generality of the populace have not the slightest chance of consulting a doctor neither can they easily see Pharmacist to dispense their prescription if they ever get one. This is of course provides a fertile operating ground for the "quacks" more pleasantly called the unauthorised channel.

(ii) The authorities must acquire adequate manpower with commensurate authority necessary to carry out effective inspection of the practice of pharmacy.
(iii) The practice of medicine/pharmacy should be streamlined. If this is done the Doctor will have enough work not to bother about dispensing and the same will go for the Chemist. At the moment most Pharmacists will starve if they wait for a prescription before they sell.
(iv) There must be a deliberate attempt by the disciplinary committee of the Pharmacists Board to discipline erring Pharmacists. It does not matter how highly placed the Pharmacist. Start with one or two people and some sanity will be infused into the system.

Finally, since the Pharmacy is the last port of call of any health care delivery system it is vital that the products of pharmacy i.e. drugs and medicine are properly distributed and controlled. This is the only way we can prevent these potentially dangerous products from falling into wrong hands and misuse.