

Equity and solidarity in healthcare

a patient-centred pharmaceutical model

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The perceived application of the principles of Equity and Solidarity in healthcare has been amply debated over the years, nationally and internationally, particularly in the context of the allocation of resources. It is a consideration of grave concern to various stakeholders. It is significant, that at this moment in time, a time of change, opportunities and challenges, both nationally and globally, are addressed from a bioethical dimension, with a pharmaceutical perspective and a patient - centered focus. In this ambit the pharmaceutical model to counter inequality of access to pharmaceutical services is presented.

Introduction

In one of his renowned drawings, Homo Vitruviano (Fig. 1), Leonardo Da Vinci may be said to have placed Man at the centre of the Universe. The Creator Himself placed Adam (and Eve) above all other creations. One might be also tempted to add, therefore, that healthcare should be patient-centred and that this should be a moot point.

Malta's healthcare

Malta's healthcare is delivered by two completely separate systems, public and private. The public or national health system is traditionally based on a paternalistic welfare state model, based on the principles of Equity, Justice and Solidarity (Table 1).

The terms 'free healthcare', 'free medicines', 'free medical treatment' are

an integral part of our vernacular! But, over recent years, an intensifying debate has developed at various levels, locally and globally, on

- the sustainability of such a model,
- the extent of solidarity,
- the equity of access to care,
- equity in accessed care.

In this ambit, one cannot overlook the importance of the ethical consideration of the Allocation of Resources in healthcare at various levels. In the bioethical domain, management of resources must be based on equity. The entire population should have access to the necessary health services with particular regard being given to those who have specific needs - the disabled, the elderly, indeed, all the weaker members of the community. Health Professionals themselves have a(n) (bio)ethical obligation to exercise the principle of Human Solidarity in extending their help to the weaker members of society.

Moreover, contributing to the needs of people should not be provider-centered but should, in turn, be based on the Principle of Subsidiarity, whereby decisions are taken as close to patients as possible, so that with suitable support, taking into consideration their values, conscience and beliefs, they can make decisions about their health, in a spirit of concentration with their healthcare provider.

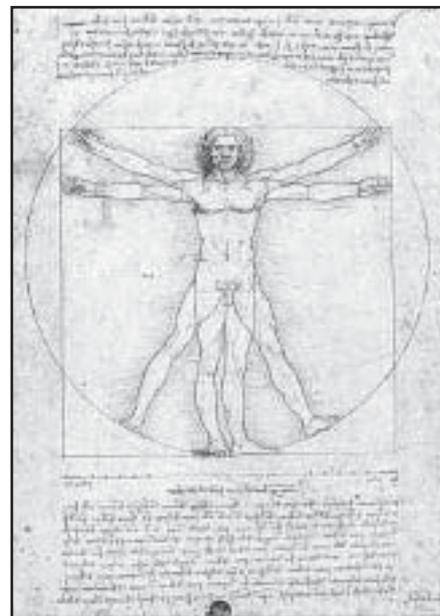


Figure 1: Leonardo da Vinci, Homo Vitruviano

The challenges brought about by new knowledge - the explosion of information following the decoding of the human genome is a case in point - innovative expensive medicines and interventions, new technologies, an aging population (demographic changes) emerging unhealthy lifestyles (e.g., explosion of teenage female smokers) environmental factors, increasing patient awareness, and patient expectations call for developments in the healthcare sector. These necessitate the adaptation of new strategies so that society will have access to health services that are comprehensive, efficient, effective and affordable. Inherent to the provision of quality healthcare that is sustainable are the principles of equity and justice and partnerships with all stakeholders.

A pharmaceutical patient-centered model of equity and solidarity in primary healthcare

The dimension of the issue of the allocation of resources includes the macro-level decisions taken by governments, insurance companies and other major healthcare funders.

In Malta, the bulk falls on Government, together with the private sector, which is separate and distinct but which may be considered to be complementary to the public system with hospitals and doctors' clinics and a network of 204 pharmacies, many of which are pharmacy-clinics providing to a certain extent still untapped synergies in the interest of patient-centered clinical pharmaceutical services.

Pharmacists' private practice in the community has always focused on the establishment of a good patient-pharmacist relationship, which is fundamental to the provision of patient focused pharmaceutical services. However, those patients who receive their pharmaceutical services through the public health system are being deprived of such a service because the public system is a barrier to the development of personalised services in an area where direct pharmacist-patient contact is essential. This is ethically and morally wrong, since it is

tantamount to inequity in access to services, which are necessary to attain positive outcomes of medicines usage and a better quality of life.

Thus people should have the equitable right to access to the services of a pharmacist, basing on the principle of social justice.

This is the main objective of the Malta Chamber of Pharmacists in insisting with successive Administrations to implement a "Pharmacist of Your Choice" scheme by decentralising the distribution of national health service medicines to the pharmacy/pharmacist of the patients' choice so that patients choose their private community pharmacy and pharmacist, not only on the basis of convenience in the location but significantly on the basis of the nature and quality of professional services that are delivered by the pharmacist.

This premise is based on the principle that "Freedom is essential to make choices" which can be considered to be derived from Kant's introduction of the concept of personal autonomy: that people, being free human beings are free to think, and free to act (in matters of morality).¹ Moreover, an individual's autonomy is a value that can be considered as basic - an individual's right to freedom to exist, to act, to think and to communicate.²

Our Society is organised as a state, and democracy can be organised as a system of parliamentary democracy. Thus, through the common interests of all individuals, democracy will result in a form of solidarity. Values that are considered as "essential" in today's western society are the individual's autonomy, democracy and solidarity, and justice. Indeed, healthcare as a common good is strongly connected to democracy. On the other hand, disease is one of the conditions that threatens autonomy. Thus, a compromise between autonomy and general interest is a

reasonable objective to avoid a climate of anarchy. An interesting premise is Rorty's,³ who explained that a certain level of solidarity guarantees a society that is stable enough to secure individual safety and prosperity. In fact, the public agreement about this is translated in a democratic political system, which forces by a majority vote every citizen to comply with this system. The result is a constant and dynamic tension between what Rorty calls the private and public domain.

In this bioethical scenario, the Pharmaceutical Profession has proposed the establishment of a public-private partnership between private community pharmacists and Government, whereby the distribution of National Health Service medicines (under the Social Security Act) from the government 'bereg' (postal system) and the health centre pharmacies is decentralized to be dispensed from the network of private community pharmacies of the patient's choice. This should entail the phasing out of the 'bereg'/postal system where patient and carers are deprived of any contact with their pharmacist.

It is also an excellent opportunity for the optimal use of healthcare resources through better involvement of private community pharmacists, whose expertise and services are at present underutilized. Thus, the implementation of such a system would "free" such highly trained human resources in the public health sector to use in the development of clinical pharmacy services in the hospital setting, thus improving patient care and outcomes. Moreover, the scheme is envisaged to require the re-evaluation of the entitlement criteria, with the exclusion of certain items under the "pink card" classification, in favour of a better service in other areas, such as extension to cover other chronic diseases under the 'Schedule V' criteria.

Table 1: Glossary

EQUITY	fairness, justice, and fairness in the adjustment of conflicting interests
SOLIDARITY	unity of fellowship arising from common responsibilities and interests and characterized by, or involving community of responsibilities and interests

One must distinguish between 'patients' wishes' and 'patients' needs'.

Árnason⁴ addressed the Rawlsian/Daniels arguments on justice in healthcare. With regard to the "principle of individual responsibility", it was argued that it is not a social obligation to provide health services which arise out of individual preferences and are not necessary to restore a person's functioning; while, in the context of the present paper, it would be more relevant to support the "principle of medical need", whereby, the Rawlsian/Daniels arguments revolve around the premise that it is more important to prevent, cure, or compensate for those disease conditions which involve curtailment of an individual's share of the normal opportunity range than to treat those conditions that affect it less.

Indeed, the present system does not satisfy patients' needs and requires revisiting insofar as it limits access to innovative, expensive medicines, in line with international trends for the treatment of diseases and conditions, based on proven efficacy (evidence-based), safety, cost effectiveness and improvement of the quality of life. More consideration should be shown to the prevalence of disease and conditions in Malta, and the consequences of non-treatment. In this regard, the support that government gives to those with ill-health should not be "rationed" to control expenditure on:

- innovative, expensive medicines for the treatment of those few patients with terminal or debilitating disease; and,
- treatments which can prevent serious health repercussions that can translate into expensive, invasive hospital-based treatments later on in life and a negative impact on patients' quality of life.

Rather, government should express a firmer commitment to solidarity and enable patients in their state of vulnerability to have access to medicines that not only add months or years to their life but also improve their well being.⁵

In this context, one cannot but re-emphasize the important and decisive roles that are played by continuously updated formularies, national and local,

and prescribing protocols. These are important tools to secure 'quality of outcome' intended as an optimised predictable, and uniform outcome of a specified intervention. In pharmacotherapy, it implies that a specific disease indication or problem is treated according to principles of 'evidence-based medicine'.⁶ Pharmacists and Doctors as healthcare professionals cooperate to compile, and update regularly, protocols, and groups of protocols to set-up formularies. These contribute to the practice of rational drug use, which must not be allowed to become restrictive but educational, being continuously monitored and evaluated with attention not only to e.g., consumption and expenditure, but also to e.g., efficacy and safety.⁷ Indeed, they should respect patients as individuals. The protocols should be communicated to the professional domain in a clear and unambiguous way and to society, where the decision takers have the responsibility to oversee the total field of request for public interference into the individual's life and to communicate their view to the people. The individual must recognise his ambiguous role in society, his different qualities and responsibilities, as this is fundamental to the acceptance of the daily consequences of any decisions concerning healthcare at the personal level.⁶

One such forum could be a national drugs and therapeutics committee which should include representatives of stakeholders, including, patients and professional associations, at the decision-taking level, introducing incentives for rational prescribing and dispensing and accountability; and to be able to evaluate requests for the introduction of new medicines and inclusion of new indications taking into consideration scientific evidence obtained from the maximum possible number of sources and not to restrict oneself to one sole institution.⁷

The pharmacy/pharmacist of the patient's choice

The primary objectives⁸ for the implementation of a system whereby the 'national health service' medicines are dispensed together with associated care services by the pharmacist of the patients' choice are summarized in Table 2.

Studies have consistently shown that there is strong support by the public for the decentralization of these services to the private community pharmacies in the towns and villages in Malta. Significantly, a body of knowledge is also building up, nationally¹⁰ and internationally, whereby research revealed evidence that pharmaceutical services in community settings make a positive

Table 2: The pharmacy/pharmacist of the patient's choice – objectives

- to ensure equitable access by the public to the expertise of pharmacists in medicines management and care services;
- to promote concordance to patients' treatment ensuring, not only compliance to medication but also empowering patients' responsibility of their own health⁹ and the rational use of medicines and other health resources;
- to contribute to the improvement of medicines management and to discourage the indiscriminate use of medicines, decreasing misadventures due to abuse;
- to eventually decrease hospitalization of patients as a result of drug misadventure and inadequate control of their condition;
- to develop the professional service of pharmacists in the community, upgrading the professional standards in the service of society;
- to develop seamless and continuous care between primary and secondary healthcare structures at the interface between public and private pharmaceutical care services.

impact on patient outcomes (e.g., clinical, humanistic, economic).¹¹

Patients, pharmacists and society: partners in healthcare

Patients are key partners in healthcare. Their needs are the leading principle in care-ethics.¹² Community pharmacists can empower them to take a more active role in their own healthcare, to take on responsibilities

to pursue healthy lifestyles, become more knowledgeable about their condition and their treatment, and to participate in decisions, and cooperate in accepted therapeutic regimes which should have the objective of restoring the maximum achievable autonomy.

The proposed "Pharmacist of your Choice" model is a public-private partnership initiative between the community pharmacists and 'society' intended as people, i.e., patients and other healthcare professionals, and

government. It would consolidate the role of the pharmacist as the gatekeeper to avoid negative outcomes of pharmacotherapy and the promotion of health. In the present circumstances, this is expected to receive an increasing public endorsement. Such a focus on patients together with the social imperative to provide medicines and care are deeply held convictions of our society, which are, in turn, ingrained in the principles of solidarity and equity in healthcare.

References

1. Kant I in Dessing RP. Ethics Applied To Pharmacy Practice. Pharm World Sci 2000; 22(1):10.
2. Universal Declaration of Human Rights. 1948.
3. Rorty R. Contingency, Irony and Solidarity, Cambridge University Press, in Dessing, RP Ethics Applied To Pharmacy Practice, Pharm World Sci 2000; 22(1):11-2.
4. Árnason V. Justice and Solidarity in the Nordic Health Care Systems. Abstract, European Conference on Philosophy of Medicine and Health Care, Qawra, Malta (August), European Society on Philosophy of Medicine and Health Care and National Bioethics Consultative Committee (Malta). 2002.
5. Malta Chamber of Pharmacists. Priority Areas Related to the Coming Budget. Report to the Malta Federation of Professional Associations. 2003.
6. Dessing RP. Ethics Applied To Pharmacy Practice, Pharm World Sci 2000; 22(1):10-6.
7. Shaw C, Sant Fournier MA, Saliba JR, Vella PA Team Approach to the Management of Patients and Medicines in Psychiatric Care. 3rd International Symposium on the Role of the Pharmacist in Health Promotion and Disease Prevention, abstract, EuroPharm Forum WHO/Euro, Ordem Dos Farmaceuticos and Associação Nacional das Farmácias, 10-12 November 1999, Lisbon.
8. Ministry of Health, Malta Chamber of Pharmacists and General Retailers and Traders Union (GRTU)-Pharmacy Section. Pharmacy of Your Choice Scheme. Report of the Joint Committee between Ministry of Health, Malta Chamber of Pharmacists and the GRTU to the Hon. Minister of Health. 1999. 13-26.
9. Noyce P. Pharmacy and Pharmaceuticals: A Partnership In Healthcare Management, abstract, A National Agenda For Sustainable Healthcare - A Consensus Conference on the Future of Health Care in Malta (February 2000). Foundation for Medical Services and the Forum of the Health Care Professions. Available at http://www.fms.com.mt/a_peter_noyce.htm.
10. Cordina M, McElnay JC, Hughes C. An Assessment of a Community Pharmacy Based Programme for Patients with Asthma. Pharmacotherapy. 2001; 21(10):1196-203.
11. Singhal PK, Raisch DW, Guchip GV. The Impact of Pharmaceutical Services in Community and Ambulatory Care Settings: Evidence and Recommendations for Future Research: The Annals of Pharmacotherapy. 1999; (33):1336-1355.
12. Tronto JC. Moral Boundaries: A political Argument for an ethic of care. Routledge, New York/London, in Dessing RP, Ethics Applied To Pharmacy Practice, Pharm World Sci 2000; 22(1):14.