

Ethics and Solidarity in Malta's Health Care

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Introduction

Leonardo Da Vinci in one of his famous (and might I add, ubiquitous) drawings, 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 also be tempted to add, therefore, that Health Care should be patient-centred and that this should be a moot point. These are some of the reflections that came to my mind in preparation for the discussion of the theme, "Equity and Solidarity in Malta's Health Care".

The perceived application of the principles of Equity and Solidarity has been amply debated over the years, nationally and internationally, particularly in the context of allocation of resources. It is a consideration of grave concern to various stakeholders. It is of course, significant, that at this moment in time, a time of challenges and changes, nationally and globally, it is addressed from a bioethical dimension. The variation on the theme here is that, given the fact that I am a Pharmacist by vocation, I shall address the bioethical consideration of "Equity and Solidarity in Malta's Health Care" with a pharmaceutical perspective and a patient - centred focus.

MALTA'S HEALTH CARE

It can be stated that Malta's health care 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. Solidarity. The terms "free medicines", "free medical treatment" and "free health care" are an integral part of our vernacular! But, over the last years, there has developed an intensifying debate at various levels, locally and globally, on:

- the sustainability of such a model,
- the extent of solidarity that is manifest,
- the equity of access to care,
- the 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.

To begin with, let me define below, the limited glossary that I shall be resorting to:

EQUITY, may be defined as - “fairness, justice, and fairness in the adjustment of conflicting interests; and **SOLIDARITY** as, “unity of fellowship arising from common responsibilities and interests”; and characterised by, or involving community of responsibilities and interests”.

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.

Solidarity in the bioethical domain can be understood as responding by contributing to the needs of the people, standing together as a multidisciplinary healthcare team to deal with “life’s misfortunes”. It involves a network of interactions, and intertwines models of communication in *trust*, and *co-operation* in trust, whereby each member of the team contributes in accordance to his competence and skills whilst being mindful and respectful of the functions of others (WHO, 1988). Moreover, solidarity necessitates that members of a community, i.e., the health care team, understand the meaning of illness and suffering, and gain an insight into the patients’ experience. Such

understanding would ensure the most effective therapeutic interventions, but, and perhaps even more significantly, they would ensure that the patient is treated *as a person*.

Indeed, contributing to the needs of people should not be provider-centred 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 friendly fellowship with their health care provider.

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 ageing 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 health care that is sustainable, are the principles of equity and justice and *partnerships with all stakeholders*.

The World Medical Association (WMA, 1996) had issued a statement on allocation of health care resources and one of its working groups issued a guidance paper for the National Medical Associations. This paper addresses the diversity of views regarding the ethics of allocation of health care resources which, “can be due to the diverse national health systems or understanding of the key terms”. In this regard, the term ‘**ALLOCATION**’ was defined as “*an act of distribution of resources, tasks, etc., which does not necessarily imply any shortage among things to be distributed*”; whilst ‘**PRIORITIZATION**’ as “*the establishment of a rank order among things (values, tasks, outcomes etc.) usually when not all goods can be attained at once.*”

I share the hesitation expressed by the WMA Working Group to include the term '**RATIONING**' to which the paper attributes the following two distinct meanings:

- (1) distribution of limited resources according to specific criteria where needs of recipients are fairly uniform and predictable e.g. foodstuffs; it implies a just and equitable distribution apart from the ability to pay and
- (2) deliberately restricting access to needed and potentially beneficial resources on the grounds of cost alone. This is considered to be bad especially if health professionals are involved.

Thus this term was considered ambiguous and omitted.

The dimension of the issue includes:

1. **the macro-level** decisions taken by governments, insurance companies and other major healthcare funding bodies. 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-centred clinical pharmaceutical services.

2. **the meso-level** allocations of categories of patients to treat, which medicines, equipment, etc. to procure and allocate. The principal decision makers are physicians, administrators, members of elected or appointed boards. Pharmacists play an important role at this level through their practice in the areas of drug selection, procurement, the spearheading, establishment and implementation of national drug policies, *the setting up of protocols and formularies*, their proactive participation in pharmacy and therapeutics committees and other decision-taking fora.

3. **the micro level** - individually, where, more often than not the decisions are taken between physician (e.g. which therapeutic intervention to use, for how long, etc.), and patient, depending on the authority and culture. In Malta, the pharmacist plays an important role as the *patient's advocate* insofar as he consolidates the physician's prescription and instructions; and in recommending non-prescription medicinal products (pharmacist-recommended medicines) and care. These services depend directly on the professional knowledge, expertise and responsibility of pharmacists. These may take the form of direct advice on medicines, disease and/or attaining and maintaining a healthy lifestyle; screening of the prescribed medication regimen for accuracy of dosage within safety limits, drug interactions, etc. Moreover, the pharmacist guides the patient to choose suitable medicines, when necessary for the treatment of minor ailments, through the dispensing of pharmacist-recommended medication; and refers the patient to the doctor when this is deemed necessary, often without dispensing any medicines.

Malta's Health Care And Resources

It would be in context to ask here, is it immoral to discuss the cost of health care?

In Malta, the Government plays a decisive role in the allocation of health care funds. The current model of Malta's public health care system approaches closely that of the National Health Service (NHS) of the United Kingdom post World War 2 experience, which is based on fixed funding from the general taxation. Its founding principle is that of providing access to care to all on the basis of need, not the ability to pay (HMSO, 2000). The latter model has been significantly below OECD norms and lacks flexibility, having failed to fully satisfy patient expectations as measured against countries in continental Europe. Moreover, the central control system is no longer satisfactory and there is reluctance to embrace the "free for all" of the completely market-led American model, considered by all Europeans to lack the essential solidarity and equity values. (Bannister and Jonsson, 2000). In July 2000, the UK Secretary of State presented to Parliament "The NHS Plan - a plan for investment, a plan for reform" making a

commitment to increase funding for the NHS over four years; the challenge being to use the resources available to achieve maximum benefit for the patient and ensure that the NHS is modernised to meet public expectations. (HMSO, 2000).

In Malta, the sustainability of the present system, together with the need to integrate the delivery of health care by the private sector was intensively discussed locally at the consensus conference entitled *A National Agenda For Sustainable Healthcare*, organised by the Foundation for Medical Services (FMS) and the Forum of the Health Care Professions (FHCP) (February 2000)

The Health Care Professions' Forum

The Forum consisting of the national medical, nursing and pharmaceutical associations, was established in 1999, to address the urgent exigencies felt by the health care professions, *independently*, with regard to the status of Health Care in Malta, the need to establish a *forum* creating an environment that promotes inter-professional communication, co-operation and collaboration; the individual professional issues to be addressed; and the matters on health of national interest, so that we could have one voice for the good of the patient, the service provision, the professions and the nation, where health is concerned. A *forum* where “we could understand each other better, understand our expertise which is different but complementary; and our concerns, and existent barriers in our health system, all of which, in most instances, are common factors to all”. (FHCP, 1999) The Forum of the Health Care Professions had also brought together the expertise of different health care professionals with their international affiliations, who have common goals and objectives (FMS- FHCP, 2000).

Consensus Conference: Aim and Objectives

The aim of holding the conference was to achieve consensus on the way forward in healthcare to attain a sustainable healthcare system based on:

- solidarity in the care of medically and financially weaker members of society,
- autonomy and patient empowerment,
- flexibility,
- to present a document outlining a strategy;

Important topics were discussed. These included: The New Hospital And Associated Changes, Health Care In The Community, Financing And Quality Of Health Care, Improving Performance And Outcomes, Tomorrow's Healthcare Providers, And The Elderly - In Sickness And In Health. Significantly, there was also extensive discussion on Equity And Empowerment In Health Care, and intensive discussion between pharmacists, doctors, representatives of the pharmaceutical industry, policy makers, and patients and ethicists on Quality, Equity And Financing Of Medicines.

In the light of all the above considerations, not least those of equity and solidarity, the outcome of discussions centred amongst other on:

- finding an equitable and sustainable way of funding the health care needs of all Maltese citizens
- motivation of all health care professionals;
- the need for a reform of primary health care and the entire community health system with fruitful co-operation between the public and private systems, promoting seamless care.

In particular the working group on *Quality, Equity And Financing of Medicines* recommended that there should be “stringent criteria for entitlement and co-payment”.

In general, the conference found it necessary to consider other alternatives in addressing the problems faced with the sustainability of the present system, whilst re-evaluating such ingrained concepts as: should everything be completely free of charge? In such a scenario, the patient has no degree of responsibility and is not reminded that nothing is truly free; “waste today”, translates into having less

availability or higher payment rates later; and, should costs be moved in a controlled manner from the State towards the individual and companies who have the interest to have healthy employees? (Bannister and Jonsson: 2000).

Overall, the most significant recommendation was that of the establishment of a Health Authority with representation of all stakeholders not least of patients and professional associations and non-governmental organisations to spearhead the much needed reforms (Bannister and Jonsson, 2001).

Equity And Solidarity In Primary Health Care - A Patient-Centred Pharmaceutical Model

Pharmacists' private practice in the community has always focused on the establishment of 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 of access to the services of a pharmacist, based on the principle of social justice.

Indeed, 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) (Dessing, 2000). 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 (Universal Declaration of Human Rights, 1948).

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, health care 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 that of Rorty (1989), who explained that a certain level of solidarity guaranteed 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* (local health clinic) and the health centre pharmacies is decentralised to be dispensed from the network of private community pharmacies of the patient’s choice. This should entail the phasing out of the *bereg* system where patient and carers are deprived of any contact with their pharmacist.

It is also an excellent opportunity for the optimal use of health care resources through better involvement of private community pharmacists, whose expertise and services are at present under-utilised. 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”, in favour of a better service in other areas, such as extension to cover other chronic diseases under the Schedule V criteria.

One must distinguish between ‘patients’ wishes’ and ‘patients’ needs’. Árnason (2002) addressed the Rawlsian/Daniels arguments on justice in health care. 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 made 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 (Malta Chamber of Pharmacists, 2002).

In this context, one cannot but re-emphasise the important and decisive roles that are played by continuously updated formularies, both 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 pharmaco-therapy, it implies that a specific disease indication or problem is treated according to principles of 'evidence-based medicine'. (Dessing, 2000). Pharmacists and Doctors as health care professionals co-operate 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 factors like efficacy and safety (Shaw et al, 1998). 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 health care at the personal level. (Dessing, 2000).

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 sources and not to restrict oneself to one sole institution (Malta Chamber of Pharmacists, 2002).

The Pharmacist of Your Choice Scheme: Objectives

The primary objective 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 may thus be summarised as follows:

- 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 health (Noyce, 2000) 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 hospitalisation of patients as a result of drug misadventure and inadequate control of their condition;
- 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 health care structures at the interface between public and private pharmaceutical care services; (Ministry of Health, *et al* 1999).

Studies have consistently shown that there is strong support by the public for the decentralisation of these services to the private community pharmacies in the towns and villages in Malta. Significantly, a body of knowledge is also building up, nationally (Cordina et al, 2001) and internationally whereby research revealed evidence that pharmaceutical

services in community settings make a positive impact on patient outcomes (e.g., clinical, humanistic, economic) (Singhal et al, 1999).

Patients, Pharmacists and Society: Partners in Health Care

Patients are key partners in health care. Their needs are the leading principle in care-ethics (Tronto, 1993). Community pharmacists can empower them to take a more active role in their own health care, to take on responsibilities to pursue healthy lifestyles, become more knowledgeable about their condition and their treatment. And to participate in decisions, and co-operate 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 health care professionals, and government. It would consolidate the role of the pharmacist as the gatekeeper to avoid negative outcomes of pharmaco-therapy 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.

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