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Towards a theoretical model on medicines as a health need

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A B S T R A C T

Medicines are considered one of the main tools of western medicine to resolve health problems. Currently, medicines represent an important share of the countries' healthcare budget. In the Latin America region, access to essential medicines is still a challenge, although countries have established some measures in the last years in order to guarantee equitable access to medicines. A theoretical model is proposed for analysing the social, political, and economic factors that modulate the role of medicines as a health need and their influence on the accessibility and access to medicines. The model was built based on a narrative review about health needs, and followed the conceptual modelling methodology for theory-building. The theoretical model considers elements (stakeholders, policies) that modulate the perception towards medicines as a health need from two perspectives – health and market – at three levels: international, national and local levels. The perception towards medicines as a health need is described according to Bradshaw's categories: felt need, normative need, comparative need and expressed need. When those different categories applied to medicines coincide, the patients get access to the medicines they perceive as a need, but when the categories do not coincide, barriers to access to medicines are created. Our theoretical model, which holds a broader view about the access to medicines, emphasises how power structures, interests, interdependencies, values and principles of the stakeholders could influence the perception towards medicines as a health need and the access to medicines in Latin American countries.

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1. Introduction

Medicines are considered one of the main tools of western medicine to resolve health problems. Currently, medicines represent an important share of the countries' healthcare budgets and it is expected that the prices of new technologies, increasingly regarded as essential medicines, become higher and the expenditures on medicines will therefore increase (Wagner et al., 2014). Although South American countries have established some

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measures in the last decade in order to guarantee equitable access to medicines, access to essential medicines is still a challenge (Giedion et al., 2014). Furthermore, although pharmaceutical spending has considerably increased in recent years, it has not been translated into better health outcomes for the population (Sanchez-Serrano, 2014). Hence, innovative approaches are needed to find solutions to the barriers set up to access to medicines and to improve medicines use.

According to Soares (2013), it is necessary to differentiate access from accessibility in order to improve the analysis of the barriers to access to medicines. For this author, access is an individual behaviour in health that consists of using goods and services aiming to achieve a goal defined by the need of a person or a community. The services comprise the healthcare services provided by qualified professionals, while the goods comprise the products used as inputs in the clinical practice, such as medicines. On the other hand, accessibility is a feature of the health system related to its capacity to supply needed goods and services (Soares, 2013).

Medicines are considered a health need and their valuation can vary depending on the actors involved (users, prescribers, managers, etc.) and differences materialize in the incorporation of certain technologies over others. However, this approach is poorly discussed in the literature, and its relationship with accessibility and access to medicines is little explored in theoretical or empirical research. In view of this scenario, this paper proposes a theoretical model for analysing the social, political and economic factors that modulate the role of medicines as a health need and their influence upon accessibility and access to medicines.

2. Methodology

The model was built as a part of the research project “Public policies and access to high-cost medicines: the situation of Brazil in relation to other Latin American countries” formed by researchers from Argentina, Brazil, Chile and Colombia. The theoretical model was built in three steps. First, a narrative review was carried out to select the theoretical framework on health needs. The databases Scopus, Pubmed and Google Scholar were searched using as keywords “human need” and “health need”.

Secondly, based on the theory-building general procedure proposed by Wacker (1998), the following steps were taken: the variables (what and who are to be included in the model) were defined, the domain (when and where the model is to be applied) was limited, and the relationships among the variables were built according to the conceptual modelling methodology (Wacker, 1998). The theory-building process was supported by the information obtained from three literature reviews: Bigdeli et al. (2013), Emmerick et al. (2013), and Vargas-Peláez et al. (2014); and from the health system analysis framework proposed by Paina and Peters (2012). This information was supplemented with other bibliographic sources.

Paina and Peters (2012) proposed analyzing health systems as Complex Adaptive Systems (CAS), considering 5 aspects: (1) path dependence, (2) emergent behaviour, (3) scale-free networks, (4) feedback loops and (5) phase transitions. Those aspects allow taking into account the influence that external factors have on the health system performance, for instance, the historical background and the relationship established among the stakeholders of the system in answering to or making changes in the operation thereof.

Finally, the model was discussed and validated during two seminars. The seminars brought together researchers to discuss and validate the influence of the factors proposed, taking into account the local realities of the health systems. The debate was audio-recorded and transcribed verbatim. The transcribed data were summarized and used for refining the model.

3. Results

3.1. Medicines as health needs

Different approaches are found in the literature towards a definition for health needs, and many theoretical essays and empirical studies have sought to characterize this construct. However, given its complexity, the results are highly variable and even today there is not a uniformity in the conceptualization of need, either in ontological or epistemological terms, neither in the most appropriate indicators for the measurement of health needs (Acheson, 1978; Butter, 1967; Donabedian, 1974; Jeffers et al., 1971). For the present theoretical model, the definitions of ‘needs’ considered were those proposed by Bradshaw (1972), Willard (1982) and Max-Neef et al. (1998).

Max-Neef et al. (1998) argued that it is necessary to differentiate actual needs from satisfiers of these needs. Fundamental human needs are finite, few and classifiable; they are the same in all cultures and in all historical periods; what changes, both over time and through cultures, is the way or the means by which these needs are satisfied. Then, each economic, social and political system adopts different ways for satisfying the same fundamental human needs.

Satisfiers are not the available economic goods. “While a satisfier is in an ultimate sense the way in which a need is expressed, goods are in a strict sense the means by which individuals will empower the satisfiers to meet their needs”. So, in other words, health systems are satisfiers of the need for protection (Max-Neef et al., 1998), and medicines are goods that allow increasing or decreasing the health systems’ efficiency.

In the same sense, Willard (1982) argued that human needs are not facts (properties, states, processes, relations) about people, but values. This author also defined needs as means to achieve valuable ends; and considered that “needs are goal-oriented and goals are things people value” (Willard, 1982). For this reason, disagreements about what people need are disagreements in attitude toward, and emotional attachment to, things variously considered to be valuable.

Bradshaw, (1972) “Taxonomy of social need” is useful for understanding the different value assessments about medicines. Bradshaw classified social needs, also including health needs, as *normative* (corresponding to a professional standard definition of need), *felt* (corresponding to the individual desire), *expressed* (also called demand, corresponding to the felt need turned into action) and *comparative* (corresponding to a deficit of a population when compared to other similar characteristics).

In terms of access to medicines, the *normative need* corresponds to the *experts'* decision-making on the definition of the medicines to be covered by the health system. The *felt need* is the need perceived by the user after getting a medical prescription or by the effect of pharmaceutical marketing. The *expressed* need is when the patient goes to the pharmacy to get the product; and the *comparative need* corresponds, in practice, to the health system's capacity of responding equitably to the people's needs (Soares, 2013).

Each category of need is influenced by social, political and economic elements, and the different perceptions created about medicines as a health need (according to Bradshaw's categories) do not always coincide, and as a result of this “conflict” the patients sometimes do not get access to the medicines they perceive as a need. Bradshaw's taxonomy is useful to explain why a person gets or does not get access to medicines, using the definition of health needs. Three possible combinations are displayed in Fig. 1.

Situation 1 represents the ideal scenario: the medicine is prescribed, is covered by the health system, and is supplied when demanded by the patient. *Situation 2* represents two possible scenarios: (a) The patient does not receive a covered medicine because

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