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Following the recent ruling that Pre-exposure prophylaxis (PrEP) can be prescribed for the prevention of HIV within the National Health Service, discuss the potential impact this may have for individuals, health care and society

Introduction

Human immunodeficiency virus (HIV) still constitutes a major worldwide public health concern with approximately 36.7 million people living with HIV in 2015, which included 1.8 million children (UNAIDS, 2016a). In 2015 approximately 1.1 million people died from illnesses that were related to acquired immunodeficiency syndrome (AIDS), which occurs over time due to HIV (UNAIDS, 2016). Many individuals with HIV/AIDS populate low and middle income countries, (such as sub-Saharan Africa), often due to living in poverty that promotes risky behaviours such as working as sex workers and limits access to poor access to health care and contraception to reduce the risk of AIDS (). AIDS and HIV is also prevalent - although at a lower prevalence - in Western, high income countries such as Europe, United States, Canada and the United Kingdom UNIAIDS, (2016b). In Western Europe and West and Northern America, recent data reveals that 2.4 million people are living with HIV (UNAIDS, 2016b). A key problem however, for public health is to prevent the 40% of people that are living with HIV fail that fail to recognise they have the virus from further spreading the virus (UNAIDS, 2016b). UNAIDS (2016b) reveal that globally there are huge discrepancies in addressing the spread of HIV/AIDS, with a decline of 57% in new HIV infections in eastern Europe and central Asia, in contrast to just 1% in Western Europe and Western and Northern America over the last ten years. To address this low reduction in the transmission of HIV in the United Kingdom and the United States (US), Pre-exposure prophylaxis (PrEP) has been developed as a preventative pharmacological treatment to protect those at a greater risk of gaining HIV (Karim & Karim, 2011). However, there are concerns of the implications that this may have on UK healthcare in funding the prescription of PrEP. This essay aims to examine the recent UK ruling in prescribing by NHS England PrEP and to examine the impact that this ruling will exert upon the individual, society and UK health care.

PrEP

PrEP has been hailed as the holy grail of preventative tools in the battle against HIV, its use can also be combined with other preventative methods – such as condoms - to offer even more effective protection in high risk groups, such as men who have sex with multiple male partners and drug users (Karim & Karim, 2011). However, maintaining patient adherence is necessary to ensure that PrEP is effective, although as studies highlight patient adherence to medication is a highly problematic area (Ware et al. 2012). Therefore, individual must commit to taking the drug daily and maintaining 3-monthly follow-up appointments with health care professionals.

PrEP is a pill that is derived from two medicines (emtricitabine and tenofovir) and reacts to HIV, by preventing the virus from becoming a permanent infection, where

an individual has been exposed to HIV (Van Damme et al. 2012). Research data reveals that PrEP can reduce the risk of being infected with HIV in high risk people by approximately 92%, highlighting its importance in promoting public health and preventing the spread and transmission of HIV in the general population (Smith et al. 2012). A recent ruling on 13 July 2016 in the United Kingdom High Court has ruled that PrEP must be made available in National Health Service Care to actively address and manage the effects and spread of HIV (NHS England, 2016). However, this initial decision was challenged and appealed by NHS England, due to NHS England suggesting that legally they lacked the power to determine NHS service provison as this was now under the Personalisation agenda (Care Act (2014) legislation administered and put in place at a local authority level. At the initial court hearing NHS England argued that that it lacked the power to commission the universal prescription of PrEP within NHS services, as decentralisation of the government from allocation of services (Care Act, 2014) meant only local authorities could implement PrEP in service provisions.

However, a later High court ruling in November blocked NHS England's appeal (Osborne, 2016) stating that the power to prescribe PrEP lay at the door of both the NHS and local authorities. Despite NHS insistence that the appeal was based on legal responsibilities of the NHS, much media speculation for the cause of the appeal placed emphasis on the actual costs of funding PrEP, estimated at around £10m-£20m per year on the NHS decision (Osborne, 2016; The Guardian, 2016). The demands of funding PrEP on already overstretched NHS budget costs in the period whilst the appeal was reviewed, led to nine planned new treatments in NHS services, being suggested to have been placed on hold, raising concerns around cutting provisions of hearing implants, prosthetics, and a drug for treating genetic mutations in young children with cystic fibrosis (Osborne, 2016). Despite these potential cuts, the high court ruled NHS England must fund and ensure PrEP is made available in all localities, with approximately 14000 people being currently eligible for the drug (Osborne, 2016). The High Court ruled that the NHS held the power to act under the NHS Act (2006) rulings that were amended in 2012 And 2013. The positive impacts of this ruling is argued to contribute to public health in reducing risk of HIV http://www.independent.co.uk/life-style/health-and-families/health-news/prep-medicine-could-prevent-around-7400-extra-hiv-cases-by-2020-a6810471.html, although it is difficult to estimate the effects that this may elicit on service users whose access to much needed treatment may be denied.

Impact on society

The implications of the high court decision poses key ethical dilemmas for the NHS and local authorities in planning and delivering health care, in that funding PrEP to prevent the spread of HIV will have a 'knock on' effect in the availability of vital treatments for other patient groups (Beauchamp & Childress, 2001; Osborne, 2016). In relation to the Equality Act (2010) this ruling could also be regarded to favour one group over another group, for example, favouring individuals who engage in evidenced high risk behaviours, such as injecting drugs and numerous sexual relationships over providing new drugs for young children with cystic fibrosis. As Grove and Zwi (2006) othering theory highlights, this elicits value-based judgements as services categorising one groups' needs as being more important than another groups. This ruling could therefore be viewed as discriminatory and contribute to the suffering of individuals with conditions that 'actually' exist in contrast to treating a disease that has yet to be contracted. Indeed, studies have evidenced differences across groups, such as ethnicity and age to contribute to health care inequalities (Smedley et al. 2012) Adopting a utilitarian ethical perspective however, can justify the introduction of PrEP in reducing the risk of HIV in the UK population as the decision can be seen to benefit the whole population, in reducing the spread of HIV/AIDS (Mill, 1901). As Mill (1901) utilitarianism theory suggests, when faced with an ethical dilemma, it is important to weigh up the effects of contrasting decisions, to determine which decision would promote the greatest good for the many, as oppose to the just the few. Thus, the ruling to make PrEP available in the NHS as a preventative intervention can be justified on the basis that it has potential to elicit the greatest good in placing the UK population at a decreased risk of contracting HIV (Mill, 1901).

Impact on individuals

In current UK health care policy, there has been a devolution of government responsibility to local authorities in planning, determining and implementing health care services (Care Act, 2012). However, policy and practice has also shifted to encouraging self-management and personal responsibility in the provision of health care; placing emphasis on individuals managing their own health care needs, by making better lifestyle choices (DoH, 2011). This approach can be evidenced in prior approaches to reducing the spread of HIV, which focused on health promotion strategies, to encourage people to engage in behavioural change, through promoting condom use and supporting drug users through needle exchange services (Laga et al. 1994). However, if PrEP is implemented in health care as a 'miracle drug', which is suggested in scientific and media rhetoric (Knight et al. 2016; Osborne, 2016), there is a danger that Prep can become socially constructed as misconstrued as the 'cure' for preventing HIV (Burr, 2016). This could lead individuals at a higher risk of HIV, to become dependent and reliant on the drug, rather than on one's own actions and choices in preventing the risk of HIV (Knight et al. 2016). Such health beliefs and social discourse could encourage service users to be more likely to engage in risky behaviours, such as not using condoms and using dirty needles, as taking the drug may foster a belief that they are cured from being any longer vulnerable to HIV (Knight et al. 2016). Prescription of PrEP could therefore be detrimental to service users and the population, if it perpetuates a dominant health belief that taking the drug makes users no longer vulnerable to HIV.

Indeed, a mathematical modelling study generated predictive findings based on epidemiological international HIV demographic data that predicted risky behaviours amongst high risk groups - such as sex workers - could be increased when taking PrEP as condom use became lower, which doubled the risk of HIV infection (Maartens, 2008). As Maartens (2008) suggested as a result, PrEP should not be used as a sole preventative measure in eradicating the threat of HIV, but should be implemented alongside health promotion campaigns that still ensure risky behaviours, such as low condom use is addressed. The study's methods and findings however are limited due to using epidemiological data to predict behaviour and as such requires further study to determine the actuality of such predictions in real-life contexts (Parahoo, 2012).

US studies in contrast, evaluating the use of PrEP amongst homosexual men have failed to demonstrate a rise in risky sexual behaviour in this group (Martin et al. 2004; Schechter et al. 2004; Crepaz et al. 2004). A meta-analysis undertaken in industrialized countries also did not reveal any increases in risky behaviour when compared to individuals who did not take PrEP (Crepaz et al. 2004) However, the study did reveal that those individuals who believed that the PrEP prevented transmission of HIV, were found to engage in risker behaviours (Crepaz, Hart & Marks, 2004). Knight et al. (2016) has also identified in participant's self-report data that homosexual young men fear that taking PrEP could lead to engaging in more risky behaviour. The use of counselling however, has been found to help to reduce such sexual risk behaviour, which stresses the importance of talking about such behaviours and integrating PrEP within wider health promotion interventions, to ensure that service users understand how PrEP should be used (Bunnell et al. 2006).

In conclusion, whilst the integration of PrEP within all NHS services is still under development, there is a lack of actual evidence as to what the short-term and long-term effects upon the individual and society will be. Evidence is mostly hypothetical and contained within many UK media reports (Osborne, 2016). However, examining the wider international literature does indicate that PrEP can offer key benefits to both the individual and society in minimising the risks of contracting HIV.

However, it must be implemented alongside health promotion strategies designed to inform individuals of the need to also remain proactive in decreasing such, to fully gain the benefits that PrEP can offer. The consequences however upon the NHS, in terms of funding demands are substantial, and given already overstretched NHS budgets, prescription of PrEP will foster key health inequalities within NHS healthcare. Such inequalities could lead to much suffering amongst other groups of service users who may find services, interventions and treatments withdrawn or cut. This ultimately poses an ethical dilemma for NHS England, as in promoting the health of people at risk of HIV, the needs and lives of other service users may be placed at risk. Decisions to favour one group above another can be seen to breach the NHS (DoH, 2013) and government's commitment to ensuring equality of care and fails to ensure services that do not promote discriminative practices. Consequenlty, only in time will the full impact of prescribing PrEP under NHS care, be evidenced, upon the individual, society and on health care service provisions and care quality.

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