



**SPANISH BIOETHICS
COMMITTEE**

**REPORT OF THE SPANISH BIOETHICS COMMITTEE ON THE PUBLIC
FUNDING OF THE MEDICINE PRE-EXPOSURE PROPHYLAXIS (PrEP) ON
HIV PREVENTION**

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Through the Directorate General for Public Health, Quality and Innovation of the General Secretary for Health and Consumer Affairs of the Ministry of Health, Social Services and Equality it is requested to the Spanish Bioethics Committee, under article 78.1 a) of Law 14/2007, of 3th of July, on Biomedical Research, and under article 2.1 a) of its Organization and Internal Functioning Regulations, a report on the ethical dilemmas deriving from public funding of a medicine, pre-exposure prophylaxis (PrEP), for the prevention of transmission of HIV in HIV-negative people at high risk of developing the infection.

In the aforementioned request, three questions were made to the Committee, in particular:

1. Is it ethical to publicly finance PrEP in Spain? (especially when there are other priorities in terms of Health which are not covered).
2. Is it ethical to finance PrEP if patients do not comply with the preventive measures that should accompany it, such as condom use?
3. Would it be ethical not to provide PrEP in Spain to people at high risk of infection, knowing that they will not use other preventive measures?

Based on the previous questions it can be concluded that we are specifically asked about two ethical dilemmas that, although interrelated, should be evaluated and answered separately and successively:

Firstly, we are asked whether, from an ethical perspective, pre-exposure prophylaxis (PrEP) should be financed publicly and, therefore, freely provided within the public healthcare system. The dilemma is substantially motivated, according to the enquiry, on two issues: firstly, the existence of other health priorities that would be excluded from public coverage since resources are limited (including new treatments usually means excluding or not including others); and, secondly, the fact that the prevention to be retrieved through the

new drug could also be achieved through other non-strictly pharmacological measures with a clear lower impact on public expenditure, such as, we would say, abstention in the field of risky sexual behaviours or the adoption of traditional prophylaxis measures that also reduce the chances of transmission of the disease (see condom and lubricant use).

As we can appreciate, the first dilemma is especially complex due to the fact that it refers to the financing of a medicine to prevent a disease that in some cases, as can also be deduced from the enquiry, can simply be contracted by the individual's own behaviour in the field of sexuality. It is a disease that sets out different options to avoid it, although not as effective or even possible as would be to suspend risky behaviour or to adopt other prophylactic measures which are less costly for the public system, and which do not have the adverse effects that the taking of all medication usually entails to the patient itself (although these, in this particular case, do not seem to be especially relevant, as is clear from the enquiry).

Secondly, we are also faced with a second ethical dilemma which is not less complex than the first one, and we are thus asked whether it is ethical to prescribe it to people who may not commit to completing its taking by adopting other prophylactic measures that several studies have proven to be useful for the preventive effects of the drug to be fully guaranteed; or who may be committed to taking it regularly, what seems to significantly affect the prophylactic success of the treatment.

The question is, in this particular respect, whether it is ethical for a person to receive the medicine, with the public expense involved, which means limiting, excluding or not covering other health services, when not previously committed or does not subsequently fulfil its commitment to adopt other prophylactic measures which are essential for the medication to meet its preventive objective (see the example of *barebacking*) or to take it regularly.

We shall proceed to set out in the first place, prior to an introduction to the debate, the first of the dilemmas that we are faced with, given that the second one should only be addressed if we consider it appropriate from an

ethical perspective to publicly finance the said medicine. If this were not the case, the second dilemma would necessarily fall, since it would not make sense to raise any limit or exclusion to the publicly-funded prescription when we have not accepted that it is ethical to publicly fund the medicine.

Prior thereto, we would like to point out that this pioneering initiative carried out by the Ministry, involving the Spanish Bioethics Committee on the difficult debate about the distribution of health resources, we believe promotes transparency and good governance and represents a relevant commitment to the bioethical perspective in public decision making, which is especially relevant in areas as complex and sensitive as the one at hand.

1. On the right to health protection

The World Health Organization defines Health as *“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,”* which translates into a very wide and different range of rights for individuals and, therefore, of duties for the State in order to protect health. In this way, it can be affirmed that the right to health is a broad concept that may refer to different areas of protection. It is a complex right that involves different contents and obligations for the State as guarantor of it.

Health protection usually has three meanings: the right to individual and collective health protection in a strict sense, the right to health care and the right to decide in the field of medical treatments. In these three meanings the role of the State as guarantor of health would be quite different, and thus, although in the first case it would have a fundamental duty to do (such as promoting public policies that foster individual and collective health and prevent diseases), in the second case its duty would be to give (provide health care), and in the third, a duty to not do, and therefore, to allow (respect the decisions of the individual in the field of health).

These three meanings are clearly described in one of the most relevant international standards in this area, to which we shall refer later: the General

Comment No. 14 of The International Covenant on Economic, Social and Cultural Rights: *“The right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.”* (Section 8).

The right to health protection is proclaimed in the Treaties and International Agreements of the highest level. Thus, Article 25.1 of the Universal Declaration of Human Rights states that *“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”* This statement is further specified in art. 12 of the International Covenant on Economic, Social and Cultural Rights of 1966 which proclaims *“the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”*

The aforementioned General Comment No. 14 to the cited International Covenant is indeed important. Such Comment begins by pointing out that: *“1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable.”* The same General comment adds that: *“3. The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association,*

assembly and movement. These and other rights and freedoms address integral components of the right to health.”

For the Comment, the right to health is: *“an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.”* (Section 11).

The UNESCO Declaration on Bioethics and Human Rights of 2005 provides in article 14 that *“1. The promotion of health and social development for their people is a central purpose of governments that all sectors of society share,”* adding that *“2. Taking into account that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, progress in science and technology should advance: (a) access to quality health care and essential medicines, especially for the health of women and children, because health is essential to life itself and must be considered to be a social and human good.”* Letter (d) of the same article promotes: *“the elimination of the marginalization and the exclusion of persons on the basis of any grounds.”*

At European level, we can highlight, on the one hand, the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Convention on Human Rights and Biomedicine), done at Oviedo on 4 April 1997, ratified by Spain by means of an instrument dated 23 July 1999, which declares in its article 3 equitable access to health care: *“Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality.”*

In addition, the Charter of Fundamental Rights of the European Union, provides in its article 35 that: *“Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in*

the definition and implementation of all the Union's policies and activities." This provision is completed with the proclamation of health protection in its dimension of freedom, establishing in Article 3 that: *"1. Everyone has the right to respect for his or her physical and mental integrity,"* adding that *"2. In the fields of medicine and biology, the following must be respected in particular: the free and informed consent of the person concerned, according to the procedures laid down by law; the prohibition of eugenic practices, in particular those aiming at the selection of persons; the prohibition on making the human body and its parts as such a source of financial gain; the prohibition of the reproductive cloning of human beings."*

In our constitutional system, the proclamation of the right to health is enshrined in Article 43 of our Constitution which responds to a tradition that begins, mainly, in the second half of the twentieth century and which coincides with the juridical-constitutional expansion of the principle of social state, being a precedent of this the Italian Constitution of 1947; its article 32.1 provides that *"The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent."* Article 43 of the Spanish Constitution presents in its three sections a plural view of health, as it covers both the public health perspective and the benefit perspective; its organization is given to public authorities. In addition, it is observed that, on the one hand, the rights and duties of all persons are guaranteed by law and, on the other hand, health and physical education, sport and leisure are promoted from a healthy point of view.

With regard to the present report, the meaning of the right to health about which we are consulted is twofold. It refers both to the right to health as the right to the protection of individual and collective health in the strict sense and as the right to health care. The drug to which it refers is framed within the field of HIV disease prevention and community protection through the prevention of the spread of the disease, although its effective delivery is carried out within the framework of the healthcare system, as is the case of most medications linked to disease prevention (e.g., vaccines).

Such right generates an alleged duty for public authorities to do and to give, which places the debate within the scope of the financing of medicines

and health products from public budgets. It is important to remember the very legal nature of the right to health protection enshrined in Article 43 of the Constitution which, in short, has to substantiate such public decision. As the Constitutional Court has recently reminded us in its Judgment 139/2016, of 21 July, the legislator has an outstanding freedom of configuration of the right, given the systematic location of this provision in accordance with the provisions of Article 53.3 of the Spanish Constitution. The right to health, according to the High Court, *"is shaped and specified in accordance with the provisions of the law, which must regulate the different conditions and terms in which health services are accessed...The extent and graduation of this gratuity will be at all time determined by legislation, as well as the economic bonuses in the health services according to the exigencies derived from the changing circumstances, respecting the constitutional limits", since, "the sustainability of the public health system imposes on the public authorities the need to adopt measures to rationalize health expenditure, necessary in a situation characterized by a demanding reduction of public expenditure, so that the competent public administrations are obliged to distribute equitably the public resources available and favor a rational use of this System,"* that is, what some author has described as *economic reserve to the possible extent* (see, Carmona Cuenca).

Therefore, any control, whatever its nature, of public decision must be developed within the maximum respect to the configuration power that is given to the public authorities by the Constitution itself. However, the Constitution, as has been proclaimed by its most important interpreter, guarantees an essential minimum or core of the right to be preserved, that is, a few features that characterize and differentiate the law, making it recognizable. Although measures to rationalize health spending are always necessary and resources, especially public ones, will always be limited to attend the needs of all, it is also necessary to establish a balance between the expenditure control and the guarantee that each one receives the assistance it needs and that the decision to incorporate a treatment into the public financing system is done in accordance with the principles of proportionality and formal rationality and with full respect for the constitutional principles and values that are enshrined in our constitutional system, which usually have a clear profile and

effectiveness in the field of health and bioethics, including human dignity, equality, equity, autonomy, beneficence, non-maleficence and justice. Consequently, in decision-making as the one concerning us now, it is necessary to address not just purely economic reasons but also the human context to which the decision affects, above all when it comes to especially vulnerable social groups.

Such dimension has also been recognized by our Constitutional Court, when it states that the resolution of these conflicts requires a judgment to be weighed between the right to life and to the physical and moral integrity that also integrates the individual subjective right to personal health and management of the economic support that makes its daily achievement possible, without prejudice to the duty of all public authorities to guarantee the right to health protection to all citizens. Such weighting requires placing on one side the general interest shaped by the economic benefit associated with savings and, on the other side, the general interest of preserving the right to health, notwithstanding that this opposition also has individual projections (Order 239/2012, of 12 December). This tension between one term and another, the individual and the social *“is already in the Constitution, since its article 43 begins with the recognition of the right to health protection, which opens indefinitely the expectation to all adequate and conducive means to the conservation and recovery of health, to conclude the paragraph of the second number, with the mandate of “The law shall establish the rights and duties of all concerned in this respect,” thereby extending to “all” the right, is necessarily excluding those means that are outside the special scope of sovereignty of the law or that, by its own emergent or limited nature, such as the services of an exceptional physician, are only accessible to some, not all”* (STS (Fourth Chamber) of 31-X-1988).

In short, the constitutional location of the right to health implies investing the public powers with a wide configuration power that is not, in any case, exempt from a minimum control from the perspective, essentially, of proportionality and formal rationality and in which the values and principles enshrined in our constitutional order play a substantial role, as well as the rights and freedoms it proclaims.

2. On the distribution of health resources

The debate on the incorporation of a treatment to public funding in the field of health is always a particularly complex one since resources are limited. Consequently, its inclusion usually means not giving public funding or limiting or excluding that of other treatments. The interests at stake are difficult to deal with, understanding the problem of sanitary rationing means accepting that the conflict is part of it from the beginning. It has been pointed out (Puyol González, among others) that the ideal would be to have equal access, that is to say, that whoever needed health care would obtain it, independently of other considerations. However, the problem is that is exactly what is not possible. Not all of us can have equal access to the resources we need due to their scarcity.

Bioethics shows therefore numerous types of tragic elections where any decision on the distribution of resources substantially affect the lives of people because the choice is not between evil and good but between two evils (Puyol González). In addition, we can distinguish between tragic choices in which the good to be distributed is inevitably scarce, as in the case of organ transplants; and tragic choices in which the good to be distributed is insufficient because it is too expensive; in words of Jon Elster, in indivisible and divisible goods (Elster, 2000). In the latter case, what appeared to be a problem of tragic choice can be transformed into a matter of political choice where social responsibility is not easy to evade, since the suffering caused by the shortage is no longer imposed but elected (Zúñiga Fajuri). It is not a problematic choice derived from the good being scarce, but from the economic resources being scarce to publicly finance the treatment.

Likewise, within the distribution of health resources we can distinguish between vertical and horizontal prioritization. The vertical prioritization refers to the establishment of a classification or preference of interventions and treatments against diseases or to prevent them. In the case of horizontal prioritization, a general classification is made through a series of different

groups of conditions and patients and / or care objectives. In the case under consideration, both types of prioritization are concurrent, since it is intended to prevail HIV prevention above other health needs and, in addition, it is promoted to do so, targeting certain groups at greater risk.

In any case, the increase in the prices of medicine that imposes limits on health care in a fair and socially acceptable way is the price that must be paid for the success of medicine, not its failure (Daniels and Sabin, 2002). The debate we are now discussing is an almost paradigmatic example of such success, the advance of medicine in the attainment of a medication that prevents the transmission of HIV, which has been, for decades, the great goal to be achieved by medicine itself.

Furthermore, the problem becomes even more complex in the absence of formulas that allow reach a universally valid solution. The evaluation of the medical benefits and costs of a treatment is an extremely complex task, as demonstrated by the heterogeneity of the methods used. This diversity in the methodology can also be seen in epistemological terms as uncertainty and it is reflected in the voluminous literature on various analytical methods. In addition, the perspectives from which the conflict can be faced are different: economic, political, normative or ethical. Evaluations based on economic considerations have neither neutral politically nor ethically calculations and models. Its application raises powerful justice questions that require careful reflection. But even from the strict ethical perspective and from the moral values that are enshrined in a legal system through fundamental rights, the debate remains open.

There are authors who advocate an eminently utilitarian approach, so that if the objective of health institutions is to offer health to citizens, the more health they are able to provide, the better. It can even be argued that the utility principle is one of the most used ones in health policy: choosing the option that has the most beneficial consequences and is the least harmful for society as a whole. The distribution, from this position, does not depend on the severity of the patient but on the expected benefit of the treatment. Thus, the years of life gained and the quality of life that accompanies those years are usually

combined (see, the well-known model QUALY, which measures the health status of a person or group in which the benefits, in terms of lifespan, are adjusted to reflect the quality of life and are used in the United Kingdom). However, this approach presents different problems:

First, it requires specifying as a preliminary step what consequences should be counted: minimize costs, prevent new infections, or ensure fairness in distribution. It is evident that the utilitarian principle can produce different results depending on this.

In addition, the utilitarian approach would fall into the fallacy of the absence of moral detachment of people. It assumes that the moral value of people is interchangeable: the health one earns compensates for the one that others lose whenever the result is a positive sum. Likewise, as Elster recalls, it does not show respect for the Kantian categorical principle which prohibits the use of persons as means for the ends of others and which allows to form a universal and secularized concept of human dignity. The interpersonal compensation of human lives with each other in order to maximize the fictitious collective benefits is incompatible with the primacy of human dignity.

Under the utilitarian approach, the rights of individuals can easily be infringed because their individual benefits are combined to constitute collective benefits. In classic utilitarianism the consequentialist principle of maximizing collective benefits prevails, so that the rights of the individual, including fundamental rights, are assigned solely according to their contribution to profit maximization and do not enjoy any independent theoretical status. This principle contrasts with ethical positions based on the original rights of individuals. Fundamental rights do not only seek to develop in their objective dimension as an expression of the values on which a community is politically based and as such should be protected, but also as expressions of a status of protection of the individual, even in the face of the community (subjective dimension). In a community based on the rule of law, individual rights cannot be merely subordinated to the goal of an aggregation aimed at maximizing collective benefits.

Finally, experience has shown that the proposed policies resulting from this approach do not satisfy neither the decision-makers nor the affected community itself. Communities, even more so in social states such as those developed in Europe after World War II, reject the idea of a distribution of resources in the public health system based on the maximization of medical benefits. It seems, therefore, more a preferred model by certain health economists who follow a liberal approach than by the community itself and its representatives.

In the area of the primary social goods, criteria of efficiency do not work. They are valid in all other goods that are not considered primary. In the field of healthcare there are things that fall within the scope of the primary social goods, and others that do not. The first have to equally reach the entire population, due to its economic cost, but not the second (Diego Gracia).

There are other alternative criteria to prioritize patients that are not negligible from the point of view of ethics. For instance, we could prioritize citizens through a lottery system or mere time priority, so that access to treatment would not be made dependent on other factors. This model, which has a great tradition (remember, the partition of the raiment of Jesus Christ, John 19: 23-24, or the decision about which shipwreck was to be devoured by others, as reflected in novels like *Moby Dick* or *The Narrative of Arthur Gordon Pym of Nantucket*) is also common as a response to the distribution of health resources because it appears to be respectful of equality. Since individuals in the community are not treated differently, making access dependent on mere chance, without including any qualitative or evaluative element, what we have already raised is difficult. However, this formula does not appear to be respectful of the principle of equity and includes the untruthful presumption that the community is divided into subjects in a perfect equality situation, which does not require the implementation of any corrective mechanism.

Another alternative would be to prioritize those individuals who have made a greater social contribution, those who are expected to do so, those who have greater social obligations (e.g., care of dependent family members), those who have been able to perform better health care, or the poorest. Once again, it

is clear that equality and equity (in this case, the medical one) are not univocal concepts, they have different meanings, each with their own weight in an open ethical discussion and committed to the principle of equality. While the principle of equality demands equal treatment to all those in need, the principle of equity allows contextual factors to be considered in an equitable distribution of resources. Thus, in the specific case of pre-exposure prophylaxis, PrEP, the decision is to determine whether all those in need should receive the same treatment or whether preference should be given to certain groups, such as the marginalized, stigmatized or typically neglected. The application of a lottery system to the group of potential users when resources are limited does not, as we have seen, make distinctions as to who could benefit most from an intervention or which option would best serve public health objectives. The principle of equity has a specific meaning in the context of access to health care and, therefore, seems to be the one that best accommodates a case such as the one at hand. Prioritizing the most vulnerable groups or at higher risk of infection is shown *prima facie* as an adequate criterion. It has been concluded in this respect that justice presupposes an equitable distribution of the available resources and that the said distribution will be achieved when the equals are treated equally and the unequal ones are treated unequally (Ramiro Avilés).

In Sweden, a parliamentary commission developed in 1992 a system of three basic principles through which any prioritization process should be measured: the principle of human dignity, the principle of necessity and solidarity and the principle of profitability (cost-effectiveness). In addition, the principles which shall not be used were also established: principle of benefit of greater number, principle of lottery and principle of demand. The committee considered that the first of the latter was in conflict with dignity and solidarity, requiring moral efficiency (Couceiro Vidal).

Subsequently, the same Parliament established a ranking of priorities in five groups: priority group 1 would include patients with life-threatening illnesses, with a clear risk of permanent disability or premature death, patients with severe chronic diseases, palliative and terminal care and, finally, patients with reduced capacity for self-determination. The priority group 2 would refer

to prevention and rehabilitation measures with a relevant level of health benefit. Priority group 3 includes the care of patients with less severe acute and chronic illnesses. Group 4 includes borderline cases of care, and priority group 5 covers the desired treatments for reasons other than illness or injury. As can be seen, such classification would place the medicine at issue, without assessing other issues, at the very high priority level, 2 out of 5.

The principle of equity seems to be one of the criteria that determine the distribution of health resources as a priority if we consider our positive law. Thus, article 20.2 (3) of Law 16/2003 provides that, in the process of elaborating services portfolios, whether the common or specific portfolios of each Autonomous Community, it must be taken into account: efficacy, efficiency, effectiveness, safety and therapeutic usefulness, benefits and care alternatives, and care for less protected or risk groups and social needs, as well as their economic and organizational impact.

Therefore, it can be concluded that our health system incorporates a mixed model that, based on utilitarianism, completes this vision with the principle of equity and protection against vulnerability. Such stance coincides with that of some sectors of bioethics that have always preferred to resort to mixed formulas that integrate several elements (see, Childress and Beauchamp).

As Hankins, Macklin and Warren have pointed out in relation to the specific financing of the PrEP, although the cost-effectiveness analysis seeks to determine how the most effective policy can be implemented at the lowest cost, the result may conflict with the application of ethical principles designed to introduce important values that are not monetary. The principle of justice can identify different priorities for the PrEP allocation, although the principles can conflict, requiring a balance of all of them, since there is no single and best way to achieve it. In addition, there is no consensus as to what weight to give to different principles. It has even been argued that the inability to reach consensus on the principle of choice requires abandoning the pursuit of substantive principles and, instead, introducing a method that implies equity in the procedural aspects of decision-making. However, procedural equity does not guarantee equity of outcome.

In countries where an explicit prioritization model has been put in place, even with a broad social debate on the goodness of the criteria, there has been no way to achieve sufficient consensus. The more detailed the resulting list of criteria, the more disagreements emerge. One of the reasons for this failure may be the general population's refusal to assume that not everything that is scientifically possible is also economically achievable for all, and much less when it comes to medical care. However, the difficulties in facing sanitary rationing also depend, and this might be the main problem, on the tragic choice characteristic of sanitary prioritization. In a tragic election any decision on the distribution of limited resources substantially affects the lives of people.

In any case, all these difficulties (which are not negligible) do not prevent the possibility of the debate of public funding or not of medical treatment to be able to at least explore the different elements of the specific case and, try to assess which interests are at stake, the groups of people they affect, and the effective impact that the decision can have on individual and collective health. In this way, it can be said that the presence of elements such as the preventive and non-curative nature of the measure, the involvement of vulnerable social groups or the absence of other alternative measures allow us to move towards an initially positive response, as we shall see hereafter.

3. On the public financing of pre-exposure prophylaxis (PrEP)

In relation to the first of the ethical dilemmas that are being consulted, we must begin by pointing out that this Committee does not have all the necessary knowledge and data and even less the faculties to resolve this dilemma, being a decision that belongs, as we have seen above, to the public authorities directly responsible for the management of public expenditure and financing, and even more so when, in this field, those powers enjoy, *ope constitutione*, a broad decision-making power. However, this does not prevent the Committee from providing a series of reflections which could help such public authorities to adopt a decision that goes beyond mere purely economic criteria, taking into account the bioethical aspects in the adoption.

From bioethics, it has been pointed out that when we benefit and harm some patients or others we are making moral choices, not just technical ones, and therefore, efficiency is a good reason to justify a prioritization, but does not exempt from moral responsibility to who it uses it, since, strictly speaking, another decision could be made. Therefore, a balance must be sought between efficiency and equity, and between efficiency and the rights of people, as we have described in the previous section.

It is important to reflect that in the consultation we are not offered any term of comparison, except for the one that is established between the pre-exposure prophylaxis against HIV treatment, what makes the debate more complex. The question is formulated in very generic terms, raising the dilemma between publicly financing the pre-exposure prophylaxis PrEP or financing other health priorities that are not covered, although those priorities are not specified. We are offered, as we say, a term of comparison in the body of the consultation in which we are told that the cost of publicly financing the said medicine amounts to an approximate annual sum of 6,125 euros per user (5,500 euros for the medicine and 625 for consultation and control tests). This amount is compared with the cost of antiretroviral (ARV) treatment, which reaches 6,500 euros.

As can be seen, from the perspective of the cost per subject, there are no evident differences, although from the perspective of the total cost, it will be understood that the prophylaxis treatment will be somewhat superior, since it will be facilitated to more people than would effectively contract the HIV virus if not treated, but this is not clear either. Thus, it can be concluded, in purely didactic terms, that from the perspective of savings in public spending, the cost of antiretroviral treatment of a few that will contract the HIV virus is preferable than that of providing pre-exposure prophylaxis to a greater number of users. However, this does not seem the right way or, at least, the main one to solve the dilemma, for two fundamental reasons:

First, if we accept such approach, it would mean accepting that it is preferable for some of the population to contract the HIV virus, even though there is currently a treatment that can avoid it. Since the cost of treating the virus when already contracted is lower than that of the prevention. In the debate we are dealing with, we are not comparing two different treatments for the same disease, but a preventive treatment that seeks to prevent an evil from occurring and which is quite likely to avoid it and, on the other hand, the treatment of such evil (disease) when it is already contracted. Consequently, the purely economic approach is clearly not adequate.

Secondly, such approach is fallacious from an economic perspective because it forgets that along with the strict cost of the treatment, there are other added or indirect costs that derive from the disease, such as the cost of disability, lost income, etc. The cost of compensation that occurs in numerous cases in which the disease develops and there is a loss or decrease in the ability to produce (incapacities) should be added to the direct cost of both treatments. These indirect costs are related to the macroeconomic perspective of the loss of productivity. They assume that, from the macroeconomic point of view, health spending represents an investment, for example, in the ability to work. The indirect costs of a disease result from the loss of productivity in the workplace, the number of workdays lost due to illness, and the possible reduction of the life expectancy of an economically active person who is ill.

Beyond a purely economic perspective, from a bioethical stance it is evident that the effort must be placed in the prevention of disease, in avoiding the evil.

Therefore, discarding a purely economic approach, it is necessary to explore if there are other factors that, together with the strictly economic ones, allow us to offer a solution. We anticipate from our understanding that there are several particularly important elements that could inform, *a priori*, in favour of publicly funding the medicine in the terms of the consultation itself (see the inclusion criteria included in it that limit it to risk groups). In particular, the following:

1. Firstly, its status as a preventive medicine that we have already highlighted. In this regard, it is in favour of public funding, both from an individual and collective perspective. As Daniels reminds us, preventive health institutions are the first step, since they act to minimize the risks of deviation from a normal situation, being preferable from the distribution of resources to prevent than to cure and to cure than having to compensate for the loss of functions, even if all levels of health protection are necessary if equality of opportunity is to be maintained.

The prevention of the disease is an elementary value of medicine for three reasons. First, common sense tells us that it is preferable to avoid illness and injury as much as possible. Second, evidence suggests that there are economic benefits derived from prevention efforts, thanks to a lower rate of morbidity and chronic diseases at more advanced ages, with the reduction of the economic burden that it entails. Also, while still being expensive, these efforts are cost-effective ways of preserving health. Thirdly, it is important to highlight to the medical profession and to the general public that medicine encompasses much more than the salvation and treatment of those already sick, and that health care systems go beyond "patient care." If we give prominence to disease prevention, everyone in and out of medicine would see that a greater emphasis on this area would bring immense social and individual benefits (Hastings Center).

2. Secondly, the area of practice to which the medicine refers, such as unsafe sexual practices, which although may be limited from the perspective of risk of transmission to a not very prominent group of the population, it is, in fact, a very important public health problem if we take into account the risk of expansion of the disease which is intended to be avoided. It should be remembered that HIV has been considered one of the main public health problems of the last decades, as it has even been stood out in several of the Treaties and International Agreements to which we have referred previously. Thus, General Comment No. 14 explicitly states in its paragraph 10 that *"Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and*

has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. Moreover, formerly unknown diseases, such as human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health.” (Emphasis added).

Equally, we must remember that both HIV prevention and universal access to the treatment have been identified as global health priorities in the Millennium Development Goals by the World Health Organization's Political Declaration on AIDS in 2006 and the General Assembly of the United Nations in 2011. These are complementary objectives, since reducing the number of new infections will reduce the need for treatment.

Therefore, the debate that concerns us relates to one of the main public health problems that, although has been quite mitigated in our environment in the last years with the treatments advances and the education and information to the population to prevent it, continues to be of great importance from an epidemiological perspective. The consultation itself states in its body that it is estimated that in 2014 in Spain there were approximately 150,000 people infected with HIV, that is, a prevalence in the general population of 0.4% (95% CI, 0.4% to 0.5%), among which 20-25% do not know their serological status, which implies a prevalence of undiagnosed HIV infection of 0.1%.

A *Lancet* editorial of April 2015 describes access to PrEP as a matter of equity and human rights, calling on global health organizations, national authorities and the pharmaceutical industry to increase access to PrEP in low-, middle- and high-income countries. This large-scale implementation requires a better understanding of the acceptability of PrEP among potential users (Beyrer et al., *Pre-exposure prophylaxis works-it's time to deliver*).

3. Third, the difficulties that currently present other possible strategies for the eradication of the disease, as also pointed out in the consultation itself

when it indicates that the persistence of 20-25% of people with undiagnosed infection has led to the promotion of interventions in order to increase early diagnosis and early initiation of treatment (the Ministry's data indicate that almost half of diagnosed people in the last years have a late diagnosis). Therefore, it is necessary to search for new preventive strategies that contribute to minimize the transmission of HIV in at-risk populations. That is, it seems that pre-exposure prophylaxis is necessary at the present time, and it is not possible to resort to other strategies to avoid the spread of the disease, such as those for diagnosis and early treatment.

From a public health perspective, it is clear that if all people with the disease were diagnosed and treated and therefore had the virus in blood at an undetectable level, the risk of transmission would be practically non-existent. Even when a 100% quota of diagnosis was not reached; a quota of more than 90% would be sufficient. Before the scenario, the debate that we are dealing with would obviously be less necessary, but, as reflected in the consultation itself and as presented in literature, this is not the case. Consequently, new strategies to fight against the expansion of the virus are needed and pre-exposure prophylaxis (PrEP) is particularly noteworthy.

In addition, as noted, although develop HIV can be prevented through the use of condoms and behavioural strategies such as abstinence or mutual monogamy, these strategies have limited use in many circumstances. Abstinence can be socially and / or economically impossible for many people. Mutual monogamy assumes that both partners are HIV negative from the start and that ongoing monogamy can be assured, while a body of evidence demonstrates that this is unrealistic and that many women worldwide have acquired HIV through their single sexual partner. Condom use requires the ability to detect when there is a risk of HIV acquisition and negotiate the use of condoms for such acts or the use of condoms for all penetrative sex acts. Although many authors discuss the notion of "responsible" sexual behaviour as a desirable moral standard, this overlooks the fact that HIV risk is largely determined by structural factors such as the prevalence of HIV in the community in which one has sexual relations, combined with the predominant

sexual mores. Due to the difficulty of negotiating condom use in a variety of sexual settings and to the dampening of sexual pleasure and / or erectile dysfunction that some experience when using condoms, new strategies to reduce HIV acquisition become necessary (Haire and Kaldor).

4. Fourth, we must remember, with regard to the above, that the presence of sexual transmission of HIV at present precisely occurs, although not exclusively, in socially vulnerable groups, including the following; people who engage in prostitution and who are often forced by their clients not to use other preventive measures, such as condoms, and foreigners who are less informed, have less resources and do not take such measures due to lack of information and economic measures. The statistics on HIV transmission currently include both groups as the most prominent. The World Health Organization itself states, literally, that *"People who are particularly vulnerable to HIV infection – including young women, men who have sex with men, and injecting drug users – are often characterized by social and economic disadvantage and discrimination."* (Health and human rights, Fact sheet N°323, December 2015.)

In this way, the socio-economic profile of those who will mainly benefit from the measure informs in favour of its public financing. In this respect, it should be remembered that pre-exposure prophylaxis can already be purchased without major difficulties in the United Kingdom where it has already been approved and is dispensed. There are also websites that indicate how to get the drug beyond our borders so that once it has been approved in the European environment, people with greater purchasing power will be able to easily access it, putting the most vulnerable individuals at clear disadvantage. We do not believe that simply because Spanish citizens with a certain purchasing power can access it by traveling abroad or acquiring it under an amount of money through Internet. This at least reports in favour of a favourable decision to its incorporation into public funding for reasons of strict equity. Thus, it has been pointed out from a strictly ethical perspective that if the health of the population is to be sacrificed for reasons of sustainability, equity demands that the sacrifice is equal for everyone, regardless of the economic power of the citizens. And if we accept unequal access to health services, those who have less

access to health services should be fairly compensated, since all roads of health equity lead to a decrease in unjust inequalities in health, that is to say, to a reduction of the social and economic inequalities of the population. In our case, there is already an unequal situation since the medicine can be purchased without special difficulties by those with greater purchasing power, which determines that the most vulnerable groups, among which should be noted the people who exercise prostitution, would be deprived of this preventive measure to which the more wealthy groups would have access, being this one of the groups at high risk of sexual transmission of HIV, especially when it comes to men who have sex with men (MSM).

In addition, such access to the medication outside the health system itself also generates problems, since it determines that its users have not been properly informed about its use, indications and adverse effects and that a system of early control and diagnosis of the disease cannot be developed. Thus, public funding allows redirecting the users with greater purchasing power to a framework of better protection of their health and of the community itself, without prejudice to the fact that a priority objective is to satisfy equity.

5. Along with these four factors, the context in which the decision is to be taken should also be considered and it reflects, as the consultation itself points out, a social perception about the risk that HIV poses to people's health and about the quite distorted and erroneous perception of the risk of transmission, unlike in the past. The success of the treatments itself is shown, as in other areas of medicine, as the main enemy of the disease, since it implies a decrease in the individual and social perception of risk. This explains, as described in the consultation, that new cases of HIV continue to be reported, reaching, for instance, in 2014 the not insignificant number of 3,366 (3,428 in 2015 as recorded on the website of the Ministry-source AIDSInfo / UNAIDS -), the 80% of new diagnoses had their origin in sexual transmission. Of the 2,814 new diagnoses with known mode of transmission, 54% occurred in MSM, 26% in heterosexuals and 3.4% in people who inject drugs (PID).

In relation to all what we have been considering, the Conclusions of the recent Ministry of Health's Epidemiological Surveillance Report on HIV and

AIDS in Spain of 30 June 2016 highlight the following data of interest for our report: although the rates of new HIV diagnoses are similar to those of other countries in the European Region of the World Health Organization, they are higher than the average of the countries of the European Union and of Western Europe. The sexual pathway is the main mode of transmission in the new HIV diagnoses also the transmission among MSM the most numerous and people of other countries of origin a relevant part of the new diagnoses. It adds that late diagnosis is high and maintains a stable trend and, although slowed down in recent years, the downward trend in new cases of AIDS started after the introduction of the highly active antiretroviral treatments in the mid-1990s.

These data correspond substantially to the one reflected by the World Health Organization for Europe. The report entitled *HIV / AIDS surveillance in Europe 2015*, published jointly at the end of November by the WHO Regional Office for Europe and the European Centre for Disease Prevention and Control on the occasion of the forthcoming celebration of World AIDS Day notes that 27,022 infections were diagnosed in Western European countries (18%), which means that there has been no substantial decrease in the last decade. Meanwhile, 5,297 new cases of HIV were diagnosed in central European countries (3%) and although the intensity of the epidemic remains low in the area, this is a substantial increase compared to 10 years ago. In addition, 121,088 new cases of HIV were diagnosed in the countries of Eastern Europe (79%). New infections have doubled in a decade, and the number of AIDS cases in this area has increased by 80% in 10 years.

According to the same Report, the mode of transmission also varies by geographical area. Thus, HIV infections increased steadily among men who have sex with men in the western and central parts of the region, while in the eastern part, transmission among heterosexuals increased.

In the United States of America, the number of new cases each year reaches 50,000, the said progression has not changed in recent years. Regarding the groups at risk, we can see that the figure is not reduced despite more than three decades of development of different strategies such as the use of condoms. For instance, between 2008 and 2010, the incidence of HIV in MSM

increased by 12 % (*HIV in the United States: At a Glance*, Centers for Disease Control and Prevention). The federal government acknowledges that it has not made any significant progress in reducing sexual risk among certain high-risk populations, particularly MSM (Jason Potter Burda). It has also been pointed out that this is largely due to the fact that the fear of contagion and death, which dominated the end of the eighties and the nineties, has disappeared (Peter Staley).

For this reason, the World Health Organization recommends interventions to be adapted to the local epidemiological context. Therefore, in Western European countries, prevention and control interventions should be targeted at men who have sex with men; this should continue being the cornerstone of the response to HIV. In addition, new strategies, such as pre-exposure prophylaxis for HIV as part of the comprehensive prevention strategy, recognize that it could help curb the growth trend.

In any case, what we do consider essential, and here we connect again with the current context of HIV in Spain, is that the public financing decision has to be accompanied by other measures aimed at combating the risk of sexual transmission of HIV, combining public funding for pre-exposure prophylaxis with other prevention strategies (combination prevention). Education and information should not only be aimed at users but also at the treatment prescribers themselves and at those who do the control and follow up. Giving providers the knowledge and tools (e.g., guidance documents, risk calculations, etc.) to be able to prescribe PrEP could greatly enhance their sustainability as a preventive tool in the fight against HIV (Blumenthal et al).

As Frankis and others point out, it is vital to consider PrEP amidst the increasing complexity of HIV prevention and intersectionality with various risk management strategies (e.g., sero-adaptive behaviours). As such, "high-risk" men could incorporate new strategies such as episodic PrEP, either with positive partners or as backing for specific sexual acts. This highlights the importance of considering multiple PrEP strategies beyond daily and continuous use. The guidance covering the episodic and situation-based use of PrEP and the "effective prevention-adherence", along with the currently

planned model of sustained use of PrEP, will respond more closely to the expectations of behaviour of MSM. In addition, such guidance should be linked to the contexts and temporal aspects of the implementation of PrEP among those who need it most. These complex risk management strategies, such as PrEP, regular HIV testing and condom use, require a high level of information about HIV throughout the population of MSM in order to effectively reduce the incidence of HIV.

Furthermore, the emergence of pre-exposure prophylaxis (PrEP) may, as already described in literature, pose the problem that certain unsafe sexual practices not only *vis-à-vis* contracting HIV but also other infectious diseases may increase due to risk disinhibition (Blow & McLean, 1994; Cassell, Halperin, Shelton and Stanton, 2006, Golub, Kowalczyk, Weinberger & Parsons, 2010), although it is true that previous studies that examined the awareness and intentions of using PrEP with sexual behaviours have provided largely inconsistent findings (Bauermeister et al., 2013, Mustanski et al., 2013).

This informs in favour of jointly developing public campaigns to raise public awareness about the fact that risk exists and the best prevention is the adoption of traditional methods. Success in advancing the fight against the disease cannot make us forget that it has not disappeared.

In this respect, it is an issue that must be addressed with regard to the incorporation of the PrEP into the service specifications and, we can even say, that it would report against its public funding, since it can precisely act against the objectives of public health that are being pursued. If citizens misinterpret such incorporation, which is not difficult, and there is a false sense of security about risk practices and, therefore, the danger that HIV still poses today increases, the public decision objective on which we are now being asked can fail dramatically. Consequently, such inclusion would be contrary to a public policy in favour of eradicating HIV.

On 10 August 2016, the Spanish Agency of Medicines and Medical Devices published some changes of special health interest in already authorized medicines, and among the new instructions with a positive opinion for its

authorization includes for Truvada® as a new instruction the "Prophylaxis pre-exposure", in line with the previous decision of the European Medicines Agency and the one adopted much earlier by the US FDA, with the following text: *"Truvada is indicated in combination with safer sex practices for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 in adults at high risk (see sections 4.4 and 5.1 of the fact sheet)."*

In addition, in the fact sheet of the medicine, among the *"Special warnings and precautions for use"*, it is emphasized that although it has been proven that viral suppression with effective antiretroviral treatment substantially reduces the risk of sexual transmission, a residual risk cannot be excluded and precautions should be taken to prevent transmission, in accordance with the national guidelines. Thus, according to the experts, there are few described cases of failure of PrEP, consequently, the medicine pre-exposure prophylaxis is considered to be a good tool, and, combined with other strategies, dramatically reduces the risk of infection by the HIV. However, the importance of sexual health counselling and routine control of people receiving PrEP in both PrEP studies and programs in those countries where it is available should be underlined. Therefore, Truvada® should only be used for pre-exposure prophylaxis as part of an overall strategy for the prevention of HIV infection that includes the use of other HIV prevention measures such as the correct and consistent use of condoms in sexual intercourse, awareness of HIV status, and regular testing for other sexually transmitted infections. Furthermore, taking into account that the medicine should only be used to reduce the risk of contracting HIV in uninfected individuals, it should be confirmed again that individuals are not infected with HIV frequently, at least every 3 months, with a combination test of antigen / antibody while they take it. Another key issue is that HIV-uninfected individuals should be advised to adhere strictly to the recommended dosage patterns, since the efficacy of PrEP to reduce the risk of contracting HIV is closely related to the adherence to treatment, as the measurable concentrations of the medicine in blood show.

Therefore, if public authorities finally decide to finance it out of public budgets, it is especially important that such decision is accompanied by an

education and information campaign on the current risks of HIV, making citizens aware that the funding should not be interpreted as a call to disinhibition, not in the field of sexual practices, but precisely in the convenience of adopting various means of transmission prevention, beyond the PrEP itself, given that the statistical data precisely show that the incidence of HIV is increasing. The funding must be accompanied by awareness, in order to avoid failure of the said public health measure.

Despite the above concern, and even if this cannot be the main purpose of the decision to publicly finance the PrEP, doing so could also act as an element that would help to resume the public policies of education, information and prevention on the disease. The still existing risk that it involves according to the data that have been facilitated to us in the consultation, this risk may also be higher in the younger social groups, which, having been born long after the social alarm caused by HIV in the 1980s, are not particularly sensitized to the disease, in a context in which recourse to the services of prostitution appears to have increased among the younger population, according to a number of studies and reports. As Grov and others point out, being in treatment with PrEP requires one to see their prescriber every certain regular period of time, this can serve as an important opportunity to engage men in sexual health discussions and in interventions to prevent transmission of HIV.

We are also concerned with three more issues which we believe are important to highlight:

1. The difficulties that may exist, not in defining, which clearly makes the consultation itself, but in applying this public health decision to risk groups. How can the access to PrEP be ensured for individuals that are not included in the two groups of risk defined by the consultation (MSM and sex workers)? In any case, being aware that the fight against HIV already has several decades of experience, we understand that adequate mechanisms and procedures will exist in order to avoid the inability to access the prophylaxis medicine precisely by those who economically have least need of it and who are not within the defined risk groups.

2. The call effect that can be produced towards citizens of other States that have not included the drug in their corresponding public catalogues. It is true that this problem cannot operate as a relevant criterion when it comes to financing PrEP or not, but at least we do believe that it should be taken into account, providing and implementing the appropriate measures to avoid it. In any case, very recent events determine that the call effect is already very diluted, given that the two bordering States, France and Portugal, have incorporated PrEP as a strategy against HIV. Thus, on 28 February, in France, it has been agreed to finance the medicine at 100%, ending the temporary nature of the recommendation of its use, which was in force for a little more than a year, as already considering the indication established and adequate, and being officially approved as a preventive treatment for AIDS. In Portugal, it was announced last 20 February that the PrEP will be introduced soon with indication as a preventive measure in people with high risk of HIV infection.

3. Finally, we are also concerned that the evidence on the benefits and risks of the medicine does not have sufficient time to determine its value or its potential side effects in the medium and long term as a measure for fighting HIV. Certainly, the current scientific literature seems to undoubtedly endorse its benefits, describing a very low percentage of health risks. However, it is clear that if it is decided to publicly fund the medicine, such decision must be accompanied by a process of monitoring the results it has over prevention and health. It is also true that such evidence seems to have already been substantially reinforced when, on 23 February, the Committee for Medicinal Products for Human Use of the European Medicines Agency adopted a positive position recommending an extension of its indication as a treatment not only for adults but also for children from the age of 12. Although does not refer to prevention this can give us an idea from an institution as reliable as this one about consider the use of the medicine.

Concerning the latter, we are also aware that many of the therapeutic advances in the fight against HIV have led to an undeniable success in reducing transmission in many other risk areas. An almost paradigmatic example of this was the treatment for the prevention of vertical or mother HIV transmission to

the foetus. Following its incorporation into public funding, its results are clear and, as stated in the Epidemiological Surveillance Report on HIV and AIDS in Spain. In its update of 30th of June 2016, published by the Directorate General for Public Health, Quality and Innovation of the Ministry of Health, Social Services and Equality, the cases of paediatric AIDS and of mother-to-child transmission declined drastically since 1996 and remain at very low levels in recent years, to the extent that the Report reflects that there are no cases in the year 2015.

It is also interesting to recall that, as part of the debate about such treatment for the risk of vertical transmission, there was also a concern about the risk that the incorporation of the treatment into the public system could produce in the disinhibition of the cautions of HIV-positive women at the time of getting pregnant, which could cause an increase in the pregnancies of HIV-positive women and, therefore, the increase of HIV in newborns. However, reality suggests otherwise. It is true that the case we are dealing with in our report and the one we now bring up as an example have elements that make them different, but this does not detract from the experience to be taken into account.

In concluding this section, we would like to reiterate once again that our purpose is not to appropriate some powers that must correspond solely and exclusively to the public powers, but only to develop a reflection of the problem from a bioethical perspective that can help to adopt an appropriate decision from that perspective or, at least, to take it into account. Thus, our approach can be concluded by stating that, from a bioethical perspective, there seems to be no objection to the public financing of pre-exposure prophylaxis (PrEP). On however, it is necessary to add the recommendation that the PrEP administration should be accompanied by an education and information campaign on the risks to individuals and society, and the commitment that the patients to whom it will be applied will be frequently submitted to HIV testing.

In short, as Haire and Kaldor point out, as a preventive HIV intervention, PrEP reduces the risks of poor health resulting from the actions of others - sexual partners who do not use barrier protection correctly or

consistently and environmental conditions, as well as the prevalence of HIV in the population which is so high that exposure is hardly inevitable. But PrEP also protects the health of vulnerable people, as people at high risk for HIV are vulnerable in this regard and in many other aspects of their lives. It involves an "adequate medical service" given that it is an effective risk-reduction tool and reduces the inequality of some people facing a disproportionate risk of HIV acquisition. In any case, it should not be forgotten that, due to the required adherence, the effectiveness of PrEP is linked to voluntary, motivated and informed use.

Finally, and by way of illustration, it is interesting to recall that the debate about public financing has already been raised in other States around us, even in the judicial sphere. The High Court of Justice issued a judgment on 2 August 2016 (*National Aids Trust v NHS*) precisely on the public funding of pre-exposure prophylaxis. This litigation which faced a non-profit organization, National Aids Trust, against the refusal of the National Health Service to include the pre-exposure prophylaxis (PrEP) in the public financing mainly related to a problem of competence, since the National Health Service considered that, being a preventive medicine in the field of sexually transmitted diseases, the jurisdiction over its funding rested with the local authorities, a position that was not shared by them. As expressly stated by the Chamber in the Judgment, the plaintiff was trapped between the two authorities and the possible victims of this disagreement would be those who will contract HIV but who would not contract it if the preventive policy was implemented.

However, while the case focused substantially on a debate on competences in the area of HIV treatment, and not on the medicine itself, the judgment contains some considerations of interest to the dilemma we are addressing. Thus, the High Court points out that the cost-benefit analysis is clearly in favour of PrEP (understood in relation to other HIV treatments) also being an effective and integrated means of treating HIV. The Court estimates that the claimant had based its claim on both the cost (much lower than the treatment of HIV) and its preventive nature.

4. On the possible limitation in the access to the medication of people who refuse to follow additional prevention guidelines or who do not show a sufficient and regular adherence to treatment

Given that in the answer we gave in the previous section we consider that, in principle and from the bioethical perspective, there are more elements that report in favour of financing the PrEP than against. Although we have also described some issues that cause us to raise some doubts or fears, we shall now proceed to raise the second of the dilemmas on which we are consulted.

We must remember that the right to health, both in its meaning of right to health protection and to health care, like any other right, finds limits and, among them, those behaviours of the right holder who are clearly contrary to their own health are particularly important. This is recognized in the General Comment itself, which provides that *"The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and **the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health.** Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health."*

Obviously, the authority to limit such right based on the conduct of its holder does not necessarily follow from the wording of the General Comment, but it does in some way incorporate the principle of responsibility for decision-making in the field of health resources and the right to health protection itself.

As pointed out by some authors (see, specially, Puyol González), health is a requirement of equal opportunity, not only the result of freely using equal opportunities. It is true that individuals can use their social and vital opportunities to put their health more or less at risk, and they must take

responsibility for it, but it is also true that health is a condition of almost all social opportunities of individuals. Without good health, life is very poor and few vital projects can be carried out. Therefore, health cannot be treated as a reward or a punishment for the free actions of individuals but, above all, as a condition of freedom.

The decision to publicly finance a medicine or not should be based on the economic burdens and difficulties involved in the treatment. But not on a possible social judgment about the person who will receive it and, much less, on a moral judgment about their life behaviours, especially when these are framed in spaces as intimate and private as sexuality. As a consequence of the fundamental importance of health as a good for the individual and society, the healing of illness and the alleviation of suffering are also collective tasks for society, which benefit all in the same way, regardless of whether a person has individual responsibility or not. No one argues that the treatment, rehabilitation, preventive and palliative medicine should be universally accessible.

However, it has also been pointed out that the criteria that are indifferent to personal responsibility when contracting the disease are not shown to be respectful of the required health equity, since it would penalize the patients who have taken care of their health and reward the irresponsible. Therefore, it is considered that, somehow, the value of personal responsibility should be incorporated to the criteria of health equity, that is, to develop a responsible distribution of health resources. A political community should aim to mitigate differences in personal resources among individuals but not to compensate for differences in personality, for that part of our destiny for which we must be responsible because it has been the result of our own choices. Individuals must be responsible for the consequences of their personalities and when a decision that can determine our future is made, we often have to contend with our inclinations, habits and dispositions of mind (Ronald Dworkin). The system of distribution of health expenses should not, therefore, take into account the difference of personalities, of freely realized vital options, but the difference of resources. In this egalitarianism of fortune in which a

distinction between elections and circumstances is made, once the possibility of suffering a contingency is equated (which would happen by financing the PrEP to all individuals at a particular risk situation, see MSM), any damage derived from the voluntary options of the individual must be assumed by the former.

It has also been argued that by making the person responsible for the consequences of his or her behaviour in the distribution of health resources there is a sort of restorative justice. This allows the person who has not developed the risk behaviour to obtain the benefit from the one who has developed it is achieved, assuming, as usual, that resources are limited and cannot be made available to all members of the community (Wilkinson). There is, in this case, no punishment for those who have put their health at risk, but an application of a corrective dimension of justice.

In addition, as the German Ethics Council (Deutscher Ethikrat) pointed out in its 2011 Report, under the title *Medical benefits and costs in healthcare: The normative role of their evaluation*, individual responsibility constitutes an indispensable contribution to solidarity, since, in a solidary society, it is essential that individuals act in such a way as to prevent the imposition of excessive burdens on the community. From this point of view, there would be no contradiction between individual responsibility and solidarity.

In any case, being responsible from a health perspective supposes, firstly, that the subject is causally responsible for the health status itself, as it depends on the decisions we make and on our behaviour. Second, a person is responsible for his / her own health to the point where it accounts for the cost and other consequences derived from the illness. In this way, it is a concept that involves not only a causal relationship with the factors that constitute the origin of the disease, but also with the economic results (Zuñiga Fajari).

It has been pointed out that a decision to deny health care could only be justified when different factors were involved: the possibility of identifying and differentiating the causal factors of the disease and of asserting that the subject's decisions were autonomous (Beauchamp and Childress). Autonomy would require as a prerequisite not only an ability to act, to decide, but also the

possibility of access to the necessary knowledge. Public information, accessible and understandable, as well as a system of assistance and expert advice, is an essential requirement of such autonomy.

Causality and autonomy would thus be the basis for the application of the principle of responsibility in the health field. Being these elements transferred to the debate in question, it can easily be said that in the case of MSM both would attend, which, on the contrary, would not be so easy to affirm, and could even be denied, in the case of persons exercising prostitution. Thus, denying the access to pre-exposure prophylaxis to that group on the basis of causality and autonomy is perfectly feasible from a bioethical perspective. However, we consider that the assessment of the problem is wrong if we only attend to the behaviour of the individual and to the impact it has on it, forgetting the one it has on the health of the community which is precisely one of the main arguments pursued by the decision to publicly finance the drug.

Although the principle of responsibility may operate in many areas related to the right to health as a mechanism to correct the distribution of resources, without contradicting the principles of equity and solidarity. In this case there should be addressed the direct consequences that the risky situation in which the individual can be voluntarily placed and may have on the health of the community.

It is important to assess, from a purely strategic perspective of the fight against HIV, what it would mean to decide to deny treatment to those individuals who refuse to comply with the complementary prophylaxis measures or to adhere to treatment at levels that guarantee protection. In this respect, it is not difficult to conclude that, given the fear to have restricted access to the medicine, individuals would conceal these extremes and, what can be even worse, would not agree to participate in the routine checks that follow the treatment such as the routine HIV test. Thus, from the perspective of collective health, this decision does not precisely benefit it. On the contrary, if the patient agrees to the treatment in that context, at least there is a greater possibility of early diagnosis of HIV and of adopting the corresponding therapeutic measures to keep the virus in the blood at an undetectable level.

On another note, the data on the transmission of HIV in the MSM group do not confirm that the autonomy requirement necessarily exists and that we are not in a context of vulnerability, as is the case with people who exercise prostitution. This can be deduced from the latest statistics on HIV prevalence published by the Ministry of Health, Social Services and Equality. In its Report on the epidemiological surveillance of HIV and AIDS in Spain in its update of 30 June 2016, published by the Directorate General for Public Health, Quality and Innovation, it is highlighted, in the Conclusions section, that unprotected sex between men occupy the first place in terms of the probable mechanism of infection in the global data set. They are also the majority among people born in Spain and among men, whether Spanish or foreign. For this reason, the MSM group is a priority for prevention programs, specially the group between 25 and 34 years old, where rates are higher. It is added that in line with the increase in immigrant population that occurred in Spain, people from other countries account for almost a third of new HIV diagnoses, although it seems that their impact on the total figures, is downward in recent years. Thus, it is not ruled out that a significant percentage of the MSM group in which transmission continues to occur does not respond, at least in the majority, to contexts of vulnerability.

Finally, we do not believe that causality and autonomy can operate so easily in the field of health as the basis for the exclusion of access to the medicine when, many risky behaviours that do not impede access to health care despite attending both criteria have been socially accepted. As we shall explain now, we would be unequally dealing with behaviours which, although not being equal, represent a voluntary increase in the health risk of the subject, and also falling into a certain moral perfectionism.

Indeed, the demand for responsibility to individuals in the field of health care is not an unknown principle by our legal system. Thus, we can use as a paradigmatic example of this in recent years the initially controversial legal reforms aimed at limiting and even banning tobacco use in certain contexts and places. However, the debate is quite different in this case and the one we are addressing in our report. With respect to smoking as a habit that directly affects

the distribution of health expenditures, the main argument for promoting coercive and prohibitive measures was supported not so much by the sustainability of the health system itself (through the rates at which tobacco is taxed, consumers granted significant economic amounts to their future health care), but by the fact that the activity had a direct effect on third parties and not only on the smoker. Limiting and prohibiting tobacco use had as direct beneficiary those who, having opted to take care of their health in this area, became passive smokers, that is to say, subjects that, unintentionally, could be affected by the diseases that it entails. Collective health was directly benefited and, specially, the abstract collective of passive smokers.

Moreover, at no point in the debate on the fight against tobacco was the option of limiting or excluding access to health care considered by those who *irresponsibly* put their health at risk from tobacco consumption. The debate focused on the prohibition of the activity which we do not believe is possible in our case since it would entail as much as the public authorities entering personal spaces as private as are those related to sexual behaviour (reminding us of the debate that H.L.A. Hart and Lord Devlin have already happily kept too many decades ago on the occasion of the *Wolfenden Commission* report).

In any case, limiting, in purely hypothetical terms, the access of the smoker to health care for having followed a clearly unhealthy course of life does not directly affect third parties, what affects them is that the smoker continues with his or her habits. On the contrary, in the present case, it does not seem acceptable (or even practically possible) to prohibit risky sexual behaviours (without prejudice to the criminal or civil liabilities that may be incurred by the transmission to third parties of the disease, with deceit or lack of knowledge by the latter) or to limit or deny access to the medicine to those who do not follow complementary prophylaxis measures or who do not offer an adequate level of adherence to treatment who do not only put their health at risk, but also that of the community. The problem is not so much to demand sanitary responsibility for the own risk behaviour, but to assess what decision is more adequate from the perspective of the collective health and that, we believe, has a simple answer.

In addition, in relation to this issue, it is important to re-emphasize the relevance that jointly developing educational and information measures about the importance of adopting complementary prophylaxis measures and about the appropriate level of adherence to treatment. In order to meet its objective has on this field. It would not be a matter, as we have said, of just publicly financing the drug and making it available to these risk groups, regardless of their conduct and / or responsibility, but to develop an effective health protection public policy that includes other measures (see, in particular, counselling programs).

Furthermore, in the case at hand we should avoid incurring a devaluation of the behaviours that give rise to the situation of risk by the fact that they may not be shared by the general community. Indeed, rights are consecrated as mechanisms for the protection of minorities, so that their position of presumed political weakness does not allow the majority to deny their virtuality because they do not share the needs to which they respond. And this is especially relevant in the field of health protection because, socially, a large number of risk behaviours are admitted without their practice being accepted and this does not imply any limitation of the right to health. Denying pre-exposure prophylaxis to who, because of their sexual behaviours and habits, have not adopted certain measures may imply a vision of society that formulates human diversity in hierarchical and moralistic terms, dividing subjects between those responsible for following the most accepted morals, and irresponsible; between superiors and inferiors. Thus, it will be necessary to distinguish between those goods that must be equally guaranteed to all regardless of their behaviour and those that do not and which are subject to the rules of individual responsibility. As an example, the smoker should receive the corresponding medical treatment to cure his / her cancer, but not a compensation for the loss of well-being for being hospitalized and for his / her reduced lung capacity (Elisabeth Anderson).

Therefore, we must avoid falling into positions that express an exclusionary moral, which is obviously more complex when we do not talk

about small disagreements, but about activities and attitudes that can affect the deepest of our convictions or our heart.

In this respect, it has been stated that in the field of pre-exposure prophylaxis (PrEP) there is no specific ethical dilemma from the perspective of the activity that gives rise to the financing of this medicine, since there are many other risk activities which, although accepted by the majority of citizens, are not allowed to serve to justify a limitation of access to preventive or care services. Venter, Allais and Richter illustrate their position with two hypothetical cases that we think are interesting to reproduce here:

Case 1: A professional is going on a holiday for a month. He intends to have sex with several men and, although he usually uses condoms, in some circumstances, he does not. He would like to take pre-exposure prophylaxis to prevent HIV during that month.

Case 2: A sex worker asks to take pre-exposure prophylaxis to avoid contracting HIV. She has clients who often refuse to use condoms, sometimes violently. She complains of constant anxiety at the prospect of getting HIV, and would like to take medication to prevent it. She says she is on the pill to prevent pregnancy, and she would like to reduce the risk of getting HIV.

In both cases, the authors present what the alleged ethical dilemma would be in the light of both: since PrEP does not provide complete protection against HIV, there may be a concern that pre-exposure prophylaxis stimulates and allows a risk behaviour that may outweigh the protective effects of PrEP. Moreover, giving these patients the prophylaxis, instead of advising them about safe sex, might be thought to be giving the wrong message or a short-term health promotion strategy. And so, they suppose, in hypothetical terms, that giving PrEP leads to a certain disinhibition of risk. However, they do not think that providing PrEP to patients in both cases is ethically problematic. To this end, they come to a quite common and socially accepted example of a prophylactic medicine which they compare to the two cases: the prophylaxis of malaria. People who are preparing for a holiday in a malaria area are encouraged to take prophylaxis and receive prescriptions. This prophylaxis

stimulates and allows the visit to malaria areas, where the population is exposed to malaria against which prophylaxis offers incomplete protection, and prophylaxis may even have encouraged resistance (when prophylactic and treatment medicines were the same). In this case, doctors prescribe for uninfected healthy people an expensive drug, which can cause a number of side effects, which must be taken consistently over a period of time, and which allows them to engage in risk behaviours, exposing themselves to an infection that prophylaxis cannot always prevent. It is not thought, however, that malaria prophylaxis raises ethical dilemmas.

They believe the same lack of ethical dilemma takes place with respect to PrEP and they consider that the reasons why PrEP is viewed differently from malaria prophylaxis will likely include the fact that sex is involved. Thus, they suspect that the reason why case 1 can be viewed differently from malaria prophylaxis is that one might think that if sex is voluntary and performed simply for pleasure, it is not a sufficiently grave reason to administer the prescribed medication. Such argument, for them, is an example of inadequate moralization about sex. The holiday trip to a malaria area is a voluntary activity undertaken for mere pleasure in many cases. Sex for pleasure, like travel and tourism, is an important part of many people's lives. A concern in case 2 is that it could be assumed that providing PrEP would be encouraging and allowing a controversial behaviour: sex work. However, the obligations of the health system and its professionals are for the health of the patient, not in relation to their sexual morality.

The same authors also cite, in connection with this last issue, needle exchange programs to prevent the transmission of viruses such as HIV and hepatitis. It may also be thought that such programs facilitate the taking of illegal drugs, but the main concern of the health system must be the well-being of its patients.

In short, our society tolerates many risky activities and sometimes even medicine facilitates participation in them. The desires to enjoy the holidays in an exotic destination rather than in a nearby or safer place would justify not publicly financing the corresponding vaccine or, further, refuse to treat

someone on his / her return under public expenses? Improved access to effective and safe contraception has plausibly led to increased sexual activity. The possibility of increasing risk behaviour in relation to sexually transmitted infections is not considered a reason to prohibit access to contraceptives. Similarly, it may be thought of in the case of pre-exposure prophylaxis PrEP. This does not mean that the autonomy of the patient is the only value that must be met. However, the health system has no ethical reasons for denying PrEP in the two previous cases if patients volunteer for HIV testing, accept further risk advice and acknowledge that protection against HIV is not complete using PrEP. In this case, the PrEP offers a clear medical benefit. In addition, since PrEP prescription will imply that patients will be frequently tested for HIV, HIV is also likely to be diagnosed more quickly, benefiting them and reducing the possibility of transmission of HIV to others. Both cases do not involve typical members of the population, but they highlight important aspects of the ethical debate about pre-exposure prophylaxis.

In any case, our whole argument should not be interpreted in any way as a renunciation or rejection of the operability of the principle of responsibility in the field of the decisions on the distribution of health resources and the sustainability guarantee of the public health system. The response we suggest is based on the specific circumstances that in this case affect the principle of responsibility and, above all, in the community health protection. The incorporation of the MSM group, regardless of the individuals that are included in it, who are vulnerable, is considered plausible from the perspective of collective health protection. Denying them the access to prophylaxis because they meet the double criterion of causality and autonomy, obviously outside the cases of vulnerability as we say, can cause greater harm to the health of other citizens, without prejudice that a reflection as the one we have developed on the social tolerance of certain risk behaviours is also, we believe, opportune.

Therefore, its inclusion as a risk group and, hence, with access to the medicine also requires developing, we reiterate, a system of education and information that allows us to convey that the best weapon against the spread of HIV depends, inevitably, on prudence and prevention, which does not mean

giving up the behaviours that form your own life path, no matter if it or them are not shared by the majority. The required self-responsibility does not mean a rejection of the behaviour that is not shared by the majority, but a mere awareness that health is a collective good, both in its public health dimension and in the economic sustainability of the public health system that has been so difficult to develop and is still difficult to maintain as expression of the principle of justice and equality.

And thus, the importance of counselling, referred to above, becomes relevant again. The medical consultation is managed, as an immediate mechanism of protection of the collective health and mediate of HIV education, which shall transmit to the individual the necessary self-responsibility in the conducts without it being accompanied by sanction or refusal of the benefit. It is, therefore, an oriented but respectful advice of the dignity and freedom of the individual. Dialogue also becomes an effective means of combating HIV.

To conclude, and in relation to what we have just discussed, it is important to remember once again that the implementation of the pre-exposure prophylaxis PrEP requires a monitoring, reevaluation and improvement work, since the risk profiles change (for example, drug resistance and toxicity), as well as the evidence base for interventions. Ethical issues are not static either they change according to the evolution of the study and surveillance. For example, if PrEP accelerates drug resistance or if individuals increase risk behaviour, political leaders would have to modify their recommendations and strategies (Lawrence O. Gostin and Susan C. Kim). This would inform in favour of a system of monitored and supervised access that allow to verify the effects of the prophylaxis measure in the fight against HIV in the medium and long term.

Conclusions

In conclusion, following the discussion of the arguments raised, we proceed to answer the three questions we are asked in the consultation by the Ministry of Health, Social Services and Equality through the Directorate General for Public Health, Quality and Innovation of the General Secretariat of Health and Consumption:

1. *Is it ethical to publicly finance PrEP in Spain? (especially when there are other priorities in terms of Health which are not covered)*

The decision to incorporate new medicines into public funding is often a complex decision since resources are limited, a question which must be considered not only by the public authorities but also by all actors involved, especially, the pharmaceutical industry and the biotechnology companies. The increase in the cost of medicine which obliges to limit health care is the price that must be paid for the success of medicine, not its failure, such as having a medicine that prevents the transmission of HIV that a few decades ago constituted the great goal to achieve.

The weighing judgment between the right to health protection and the management of economic support requires placing on one side the general interest shaped by the least economic damage associated with savings and on the other side, the general interest of preserving the right to health, without forgetting its individual projections. The decision must be adopted in accordance with the principles of proportionality and formal rationality, and with full respect for the constitutional principles, values and rights, not only paying attention to purely economic reasons but also to the human context to which the decision affects, above all, when it comes to especially vulnerable social groups.

The decision is even more complex as there are no formulas that allow to achieve an universally valid solution. The perspectives from which the conflict can be faced are different, economic, political, normative or ethical, posing far-reaching justice problems that require careful reflection. The purely utilitarian approach is not acceptable, falling into the fallacy of the moral separation of people and using people as means and not ends. The interpersonal compensation of human lives with each other in order to maximize the fictitious collective benefits is incompatible with the primacy of human dignity. The option for a mixed decision model that, based on utilitarianism, completes this vision with the principle of equity and protection against vulnerability is the most precise.

There are no obvious differences in the economic cost between preventive and antiretroviral treatment. However, the mere comparison of costs cannot serve as the main element of resolution of the conflict, as it is not comparing two different treatments for the same disease, but a preventive treatment that seeks to avoid a disease against the treatment of the already produced disease. The mere comparison of costs is also a fallacious approach because it forgets to add other indirect or added costs that derive from the disease which prevention would avoid, such as the cost of the disability, loss of profit, etc.

The arguments that support public funding for pre-exposure prophylaxis (PrEP) are relevant, highlighting the specific field of health at which the drug is targeted, the failure of strategies to eradicate HIV, the absence of alternative measures that achieve the same prevention outcomes as PrEP, the special impact of the disease on particularly vulnerable groups, and changes in social perception of HIV risk.

It is also essential that such public funding is accompanied by a detailed ex-post evaluation of the effects of the decision and of the future evidence on the medium- and long-term preventive value of PrEP, as well as possible new evidence of risks or side effects

2. *Is it ethical to finance PrEP if patients do not comply with the preventive measures that should accompany it, such as condom use?*

Individual responsibility constitutes an indispensable contribution to solidarity and health equity, especially in circumstances such as the one we are dealing with, however, the decision to publicly finance a medicine or not should not be based on an eventual social judgment about the person and, even less, in a moral judgment about their life behaviours. The public funding decision should be accompanied by the promotion of other measures aimed at combating the risk of sexual transmission of HIV, combining such funding with other prevention strategies such as education and information for users, prescribers and those who carry out the control and follow-up, along with the development of public campaigns that make the population aware of the existing risk and of the advantages of traditional methods of prevention.

Some doubts can be raised, including the possible increase in risky sexual practices because of the false sense of security, if the drug was administered as an isolated action from the rest of issues that form the contagion prevention strategy of HIV. Therefore, in the medicine's fact sheet, the "Special warnings and precautions for use" state that although it has been proven that viral suppression treated with effective antiretroviral therapy has shown to substantially reduce the risk of sexual transmission, a residual risk cannot be ruled out, and precautions should be taken, in accordance with national guidelines, to prevent transmission. The medicine, as a pre-exposure prophylaxis, is considered to be a good tool due to the small amount of reported cases of PrEP failure and, combined with other strategies, reduces the risk of HIV infection dramatically. However, emphasis should be given to the importance of both counselling in sexual health and routine control of people receiving PrEP in both published studies and PrEP programs in those countries where it is available.

Therefore, it must be concluded that the drug should only be used for pre-exposure prophylaxis as part of an overall strategy for the prevention of HIV infection which includes the use of other HIV prevention measures, such as the correct and consistent use of condoms in sexual relationships, awareness of HIV

status, and regular testing for other sexually transmitted infections. In addition, taking into account that the medicine should only be used to reduce the risk of contracting HIV in uninfected individuals, it should be reconfirmed with a frequent test that individuals are not infected with HIV. Another key issue is that HIV-uninfected individuals should be advised to adhere strictly to the recommended regimen, since the efficacy of PrEP to reduce the risk of contracting HIV is closely related to adherence to treatment, as the relation between its efficacy and the measurable concentrations of the drug in blood shows.

3. *Would it be ethical not to provide PrEP in Spain to people at high risk of infection, knowing that they will not use other preventive measures?*

Individual responsibility constitutes an indispensable contribution to solidarity. From a health perspective, this responsibility would mean, on the one hand, that the subject is causally responsible for his / her health, excluding the cases that are determined by external factors, and on the other hand, that he / she is autonomous in his / her decisions, that is, that he / she has the capacity to act and access the necessary knowledge. Causality and autonomy are the foundation of the application of the principle of responsibility in the health field, but causality and autonomy cannot operate so easily in the health field as the basis for the exclusion of access to the drug when many risk behaviours that do not impede access to health care are being socially admitted, without forgetting the impact that such exclusion would have on the health of the community.

In any case, suggesting not to provide a medication to a person at high risk of infection, as in other clinical situations different from those analysed in this report is an issue to be solved individually by the responsible care team which should be based on both their and other clinical circumstances, with a comprehensive vision. To this end, the collaboration of the corresponding Ethics Committee for Health Care may be of great interest, which will help to

consider the specific circumstances that arise in the individual case, as well as the foreseeable consequences of the different courses of action that may arise, in light of the ethical principles to consider.

Denying treatment to subjects who do not comply with complementary prophylaxis measures or who do not maintain adherence to treatment at levels that guarantee protection can be detrimental to the health of all. The principle of responsibility must operate in the sphere of decisions on the distribution of health resources, so that the decision to fund would be largely based on the protection of the health of the community.

Madrid, 7th of March 2017

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ANNEX: CONSULTATION OF THE DIRECTORATE GENERAL FOR PUBLIC HEALTH, QUALITY AND INNOVATION OF THE GENERAL SECRETARIAT OF HEALTH AND CONSUMPTION OF THE MINISTRY OF HEALTH, SOCIAL SERVICES AND EQUALITY OF 24 NOVEMBER 2016