

Jan 8/77
Mr M. M. - for file

Mr Heppell

From: M A Harris HSI

Date: 15 June 1988

cc. Mr Cashman o/r
Mr Hale CMP
Mr Lillywhite FB
Dr Walford Med IMCD
Mr Barton (AIDS Unit)
Dr Moore

COMPENSATION FOR THOSE INFECTED WITH HIV

1. Your minute of 10 June to John Cashman asked us to explore whether recipients of HIV infected blood and organs could be given financial help through the Macfarlane Trust. I think there are some problems with extension of the haemophiliac scheme which you may wish to discuss with us before we go outside DHSS.
2. The Macfarlane Trust deed is specific that their funds must be used solely for haemophiliacs and their dependents. It is not legally possible to use any part of their funds (our £10m) for any other purpose. Solicitors advise that, subject to Counsel's opinion, if additional money was made available for other groups of HIV infected people and the Trustees and the Charity Commissioners agreed, then it might be possible to extend the present Macfarlane Trust deed to include other groups.
3. We suspect the Trustees would be amenable to taking this task on if only to keep Ministers' goodwill. However they would need to be strengthened. This new task would be much less straightforward.
4. The medical history of blood (or organ) recipients is much less clear cut than haemophiliacs. The Trustees would have considerable difficulty and would need expert opinion in medical and transplant medicine to assess claims. There is the likelihood of many grey areas.
5. Unlike haemophiliacs, they are not a well defined group in contact with a few specialist centres. There is no ready way to contact blood recipients. Deliberate advertising or even modest publicity could undermine public confidence in the safety of the present blood supply, and might encourage some of the estimated 7 million people who have had transfusions in the last 10 years to seek tests quite unnecessarily.
6. We have been careful to refer to the haemophilia scheme as financial help for special needs not compensation for some NHS failing. On that basis it would be difficult to argue that it should be restricted to those UK citizens given blood in the UK. Given the infection level of blood supplies in other countries (eg in Africa) it is likely UK citizens will continue to get infected whilst abroad.
7. Similarly, it would be hard to distinguish those incapacitated or killed by HIV from other diseases acquired from blood transfusions eg hepatitis. The financial needs of patients/dependents could be the same.

8. This could be the top of a slippery slope to a general demand to help those injured by their medical treatment (eg Opren victims). The "uniqueness" of haemophiliacs might be artificial but it is important. Following the meeting of H(A) which discussed the haemophilia case in November, we gave thought to their view that non-haemophiliacs should be included provided that the ring fencing arrangements, which they regarded as "clearly vital" were not weakened. It was our view at that time that the haemophilia ring-fence was not particularly robust and thus advised that it should not be weakened further by the inclusion of other groups. I think this remains valid.

9. The cost of any extension is hard to predict. At present we know of 42 cases of HIV infection from UK transfusions. This could well increase following publicity (say to 100). If they were awarded the same pro-rata as haemophiliacs then about £800,000 would be required. The Macfarlane Trustees could incur considerably greater costs in distributing this money so perhaps £50,000 p.a. would be required for their services. However the class is not closed, as explained above, and further cases could arise. I suspect we will have to meet any costs ourselves. We only squeezed the £10m out of Treasury because of the political pressure brought to bear by the Haemophilia Society's campaign. There is no parallel pressure for blood transfusion recipients we could pray in aid. We do not anticipate any major pressure since these victims are isolated and unorganised.

10. I am sorry to be so negative but there are pitfalls in going down this road. Obviously if we do want to help blood recipients then the Macfarlane Trust is the best route since a) it exists; b) it distances DHSS from the problem; and c) regulations are already in place disregarding payments from the Trust for social security purposes.

11. Assuming S of S is fully aware of the issues set out above, then I suggest the next step might be to ask SOL to obtain Counsel's opinion on the legal feasibility of extending the Trust's objectives to embrace the new groups. I think this is preferable to approaching the Trust at this stage, but I will speak with the Rev Tanner if you still prefer this.

GRO-C

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