GEB 1
HTS3

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Date: 3 December 1990

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ANTI-HCV TESTING

1. In my judgment the case is weak and the draft's confident and assertive tone is not justified by the evidence it presents. The draft does not give enough information to allow the reader to make up his or her own mind. It should present what evidence there is that blood transfusion has caused hepatitis C in the UK. It should also provide an estimate of the scale of the problem. It does not seem convincing to rest the case on the authority of ACSVB without also giving some indication of how they arrived at their conclusions. As far as I can see, an important element of the case is merely that other countries have decided to screen (but presumably not all - what about Germany, Switzerland, Canada, New Zealand?). In some of these countries, notably the US, there does appear to be evidence of a substantial burden of transfusion-related hep-C. But surely that does not justify a presumption of a similar effect in this country.

2. Alternative, less costly testing options do not get a fair crack of the whip (para 13). The second sentence of the para is preaching at the Minister. It would be better to discuss the issue in the following terms. Note that annual donor screening would halve the cost, at the expense of some increase in risk: since the average donor gives blood twice a year, there is the slight risk that a donor who screens negative at the first donation of the year could acquire infection during the year and this would not be picked up until the next year. Then make the recommendation.

3. The risk of a policy of annual donor screening vis-a-vis screening all donations could be quantified by a modest trial. Indeed if screening of blood donations is introduced it would be useful to monitor the incidence of new infections in donors when they give blood on a second or subsequent occasion within a year. This information would then provide a basis for assessing the option of moving to an annual donor screening programme.

4. If no extra money is to be made available, perhaps the draft should advise HAs what they should give up to release resources for this programme.

5. One or two general comments:

(a) The tone of the draft may need attention. It gives the impression of talking down to the reader. Sketchily described options are presented only to receive brusque dismissal. Para 14 provides an example.

(b) The arguments are qualitative when what matters are the numbers. Para 14 also exemplifies.

(c) There is little point in attaching the economic appraisal if virtually no use is made of it. For example, para 10 refers to the estimate of the cost of three tests but fails to note that the least-cost option, taking account of all the circumstances is a two-test option, ELISA plus RIBA. Adding PCR increases the net cost. More generally, although the statement in para 11 is correct, the annex does not specifically support the actual proposal recommended against alternative options.

(d) There is running through the draft an underlying assumption that risk must be eliminated whatever the cost.

6. A minor point - in para 9 change "deferred" to "debarred"?

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