DEPARTMENT OF HEALTH

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From the Parliamentary Under Secretary of State
Lord Hunt of Kings Heath

Your Ref: GLR/KW/22.4

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24 DEC 19

Dear Mr Ross,

Thank you for your letter of 4 November to Alan Milburn about people with haemophilia infected with hepatitis C.

The recent history of haemophilia shows that while treatment developed very dramatically blood borne infections became a major problem. Initially this was hepatitis B until screening tests in the early 1970s virtually eliminated it from the blood supply. Non A non B hepatitis, mostly hepatitis C, remained a problem until successful viral inactivation of blood products in the mid 1980s and screening of the blood supply in 1991. HIV infection through blood products in the early 1980s was an unexpected blow to haemophiliacs who confidently believed they could at last be free from crippling and often life threatening bleeding problems.

There is therefore huge sympathy for haemophiliacs infected with hepatitis C through the treatments specifically designed to stop their inherited bleeding problems. Government has listened soberly to the arguments for compensation put forward by people with haemophilia and their supporters and Ministers considered, with great care and at length the rationale for a scheme similar to that for HIV. In doing this we recognised that a significant proportion of people with haemophilia had been infected with hepatitis C through the treatment they received before 1985.

At present compensation or other financial help is only given when the NHS or individuals working in it have been at fault. This policy is founded on the strongest ethical and moral principles on which our responsibilities to improve the public health and provide healthcare for all NHS patients are based. We recognise that few treatments are without risk to patients, and that the NHS like all other health economies must take action to minimise damage to patients from the treatments designed to help them. We are determined to do this by supporting evidence based clinical practice and promoting good regulation through the recently set up National Institute for Clinical Excellence and Commission for Health Improvement.

However while our regulatory efforts will help reduce both avoidable and unavoidable harm to the millions of NHS patients we treat every year, a very small number will continue to suffer harm through the treatments they need and which we have a duty to provide. The primary aim is to improve care, reduce treatment-related illness, and make efficient use of resources to treat more patients better. A further aim is to reduce the volume and cost of compensation in the NHS and we are actively considering the issue as set out in *Reducing Litigation in the NHS*. Several options are currently being explored.

The facts are that the technology for virally inactivating plasma using heat, without losing inordinate amounts of factor VIII or XI activity, was not developed for large scale use until the mid 1980s. The driver for developing heat-treated blood products was the advent of HIV, not hepatitis C, which was fortuitously inactivated by the same process. A German pharmaceutical company did in fact develop a heat-treated factor VIII product called Haemate P in 1979 and licensed it for use in the UK in the early 1980s. However general supply of the product was not sustainable, even in Germany, as huge volumes of plasma were required to make it. Even with this, Germany's record on hepatitis C is no better than that of other European states.

With regard to the position in Scotland, officials within the Scottish Executive Health Department have been asked to examine the circumstances surrounding the introduction of heat treatment of Factor VIII in Scotland in the mid-1980s, with specific reference to the alleged discrepancy between England and Scotland. Officials are liaising with the interested parties, including the Scottish National Blood Transfusion Service (SNBTS), the Haemophilia Centre Directors, the Haemophilia Society and the Health Department in England in pursuing these enquiries.

Once these enquiries have been concluded the findings will be placed in the public domain and will be passed to the Haemophilia Society and the Health Committee of the Scottish Parliament. Scottish Ministers will be better placed to consider whether any further action on the part of the Scottish Executive is indicated when these enquiries are completed.

This Government has always been up front about policy on compensating only those patients who have suffered negligent harm from NHS treatment. Nonetheless the decision not to compensate haemophiliacs with hepatitis C was very difficult. We are acutely aware of the needs of people with haemophilia and determined to support them in a number of other constructive ways.

GRO-C

PHILIP HUNT