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Date: 19 July 2001

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HAEMOPHILIACS WITH HEPATITIS C (HCV)

You asked for a response to three questions:

What would have happened if the no fault compensation scheme had been in place at the time of the Judgement? Would it have made a difference and, if so, what?

1. Were one to be introduced, a no fault compensation scheme would remove the need for claimants to prove negligence. The Consumer Protection Act 1987 does this already where the damage is caused by a defective product such as HCV infected blood. Had a no fault compensation scheme been in place at the time of the Judgement, it would have:

- avoided the need for the claimants to seek legal action;
- awarded payments to *all* those infected with HCV through blood, not just those who were prepared to run the risk of going to court or who qualified for legal aid. This would have increased the payments made from the £3m damages awarded by the courts to at least 4 or 5 times that amount (although the individual payments under a no fault scheme might well be smaller);
- saved the NHS some £7m in legal costs;

By giving haemophiliacs money, what other groups would them want compensation? Would the floodgates open to several more groups of people? And if so, who?

2. If you give money to haemophiliacs with HCV, the immediate group wanting compensation would be non-haemophiliacs infected with HCV by blood transfusion. 669 patients in this group have been identified from a look back exercise conducted by the National Blood Service. Of these, 113 received damages through the High Court leaving 556 unrecompensed.

3. These numbers may be manageable within any scheme. More worryingly, it is estimated that there are between 4,000 and 5,000 other patients still living who were infected with HCV through blood transfusion who cannot be traced. These people may or may not know that they are infected and a proportion of them could well come forward if a compensation scheme is announced. It is likely that the existence of a scheme would encourage people who have had a blood transfusion to seek a HCV test. For the vast majority there will be no documentary evidence to prove that blood transfusion was the cause of their infection. However we would probably be obliged, if we had a scheme, to award damages on the basis of probable cause.

4. It would be difficult to compensate the haemophiliacs without making payments to this group also. An identical situation arose in the late 80s when the payments made to haemophiliacs infected with HIV through blood were extended to non-haemophiliacs. However, in the event, a relatively small number of non-haemophiliacs came forward.

5. Other groups currently seeking compensation are:

- RAGE (Radiotherapy Action Group) – patients who have suffered permanent damage as a result of breast cancer but failed to win damages in the courts. Ministers have maintained the line that no scheme will be introduced for this group but that Trusts must pay compensation where harm has been caused by clinical treatment and negligence can be established;

- Bristol Royal Infirmary Inquiry Cases – No compensation has been offered by the Department. Parents will be taking action through the courts;

- Retained Organs – Parents are taking action through the courts.

- Myodil Action Group – seeking compensation for alleged injury following use of Myodil, a diagnostic agent. It has been established that there is no basis for a negligence claim against the Department or MCA and, on that basis, compensation has been refused by the Department.

- MMR Vaccine – there is no evidence to date that children have been injured through use of MMR but, if this were proven, claimants could be eligible to claim through the vaccine damage payments scheme

6. Despite the existence of these groups, it would be possible to justify payments to haemophiliacs as exceptional given that Hepatitis C related illness, which can lead to cirrhosis and liver cancer, is a devastating, debilitating disease. Around 200 haemophiliacs have died as a result of this infection and at least as many again are likely to die in future.

If we were to make some sort of symbolic gesture, what could that be? What would a money package look like? What kind of sums are we talking?

7. We have looked at options using the following criteria:

- *affordability* – any scheme will be fairly expensive given the numbers involved but we have tried to strike a reasonable balance between affordability and:

- *acceptability* to the Haemophilia Society – we need a scheme that will persuade the Haemophilia Society to drop their campaign

We know that the Haemophilia Society are preparing a proposal for a compensation scheme which they intend to present to Ministers in the next couple of months. We also know that they recognise privately that they not in a strong bargaining position. They would therefore look favourably on any proposal made by Ministers.

8. A package which we can be fairly confident the Haemophilia Society would find acceptable is at Annex A. This gives a range of cash payment to all infected haemophiliacs based on the extent of their illness. It is very similar in structure to a scheme put in place by the Canadian Government. We have calculated the total cost at £37m with the bulk of this falling in year 1. This could be reduced to £20m by restricting payments to those with cirrhosis and end stage liver disease and those who have already died. This group would equate with the haemophilia/HIV group who, at the time the awards were made. were all expected to die. However, such a scheme would be harder for the Haemophilia Society to sell to their members because not everyone will benefit.

9. A cheaper alternative still – in the short term – would be to make no cash payments but to set up a hardship fund run by the Macfarlane Trust (who administer the HIV scheme). This could take the form of monthly payments to haemophiliacs with HCV who are at an advanced stage of illness to meet additional needs such as heating. This could be done by announcing a grant of say £10m to the Trust to run the scheme. However, such a scheme is likely to have a prolonged life – the HIV scheme has now been running for over 12 years – and is likely to require additional funding in the future. The HIV scheme currently costs the Department £2.5m a year.

10. If, additionally, payments were made to non-haemophiliacs this would push the cost up considerably. At the very least, the scheme would have to be extended to the 550 or so infected transfusion recipients identified by the NBS. Very roughly, this would add a further 25% to the cost of the scheme.

11. It should be added that no money has been identified that would allow us to make payments to haemophiliacs. If a scheme were to be introduced immediately or within the next 18 months, money would have been found from within existing Directorate/Divisional SR funding envelopes. A longer term solution would be to be include a bid in SR2002 but this would tie our hands until 2003/04.

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