

Date: 1 June 1998

EX-GRATIA PAYMENTS TO HAEMOPHILIACS INFECTED WITH HEPATITIS C

1. As you know, I had a meeting last week with officials to discuss the question of screening for the rare HTLV1 virus and ex-gratia payments to haemophiliacs infected with hepatitis C. We now have a further meeting in the diary for 25 June to discuss the HTLV1 issue with you, and I do not therefore wish to dwell on that issue here. However, I think it is useful to let you have my views on the hepatitis C issue.

2. You are already fully aware of the background to the request from the Haemophilia Society for a special payments scheme for those infected with hepatitis C through NHS treatment. I understand that, as a result of the many representations made on this subject, you were contemplating a scheme similar to the hardship fund offered to those infected with HIV, but limited to haemophiliacs only. I have considered this carefully, and discussed with the officials and really don't think that it would be feasible for a number of reasons.


3. First, there would be immediate pressure to extend the scheme to non-haemophiliacs, as there was with HIV and, similarly, it would be very hard on equity grounds to resist. This would more than double the numbers eligible to apply. Secondly, the HIV scheme is based on clearly defined medical criteria, linked to the progression of the illness. There are no such established markers for hepatitis C. Qualification for the scheme would therefore have to be based on infection alone, irrespective of the effect on the claimant's well-being (and many of those infected will remain well). Again, this would dramatically increase the number of payments involved. Thirdly, there would be continuing pressure - once the principle of ex-gratia payments had been accepted - for any such scheme to be extended to mirror the HIV scheme. Given the above, whatever type of scheme were set up, we would be looking at considerable costs which could be difficult to control. (A scheme comparable with the HIV scheme would cost approximately £400m for all those infected and £220m for haemophiliacs alone. We can imagine the likely response from Treasury!)

4. Most significant, however, are the wider implications. There are as you know, similar claims from other patient groups relating to harm arising from NHS treatment, where negligence has not been proven in the courts. These include 2,500 patients claiming compensation for severe side effects following radiotherapy treatment for cancer and 22,000 people seeking a scheme for those suffering side effects following cortico-steroid treatment. I think it would be very difficult to distinguish the hepatitis C claim from the others. Further, as new blood screening tests become available (and as you know we hope that there will be one for nvCJD in the next few years) having accepted the principle for both HIV and hepatitis C, we would face demands for ex-gratia payments for those infected with nvCJD. There are also, as you know, requests for compensation affecting other Government Departments.

5. As I see it, we cannot add to the precedent already set by the HIV scheme without leaving ourselves exposed to such wider claims. We would then face the prospect of the introduction of compensation for non-negligent harm for the NHS (and possibly wider Government) piecemeal and by degrees. I do think that the logic of the position dictates that we adopt one of two diametrically opposed approaches. Either we accept the fundamental case for no-fault compensation for non-negligent harm through NHS treatment, and acknowledge that those infected with hepatitis C will receive payments under such a scheme, or we refuse the claim on the grounds that the HIV/AIDS case was exceptional and a one-off.

6. Having fully considered all the arguments around this issue I believe that we must hold the line and resist the pressure for such payments. As you know, our public stance on this issue so far has been that compensation should only be paid where legal liability has been established, and that the Department's key objective must be to spend as much of its resources as possible on direct patient care. I also think it is very important, if patients are to have realistic expectations of the NHS, that they are encouraged to accept that virtually any treatment involves risk, and that while known risks will be drawn to their attention, and the NHS will always do its best for them, success cannot always be guaranteed. There may be an adverse outcome of any treatment, either in the short or longer term. The inescapable fact in this case is that, while it is undoubtedly very unfortunate that these patients contracted hepatitis C through their NHS treatment, without that treatment many -if not most - of them would not be alive today.

7. Clearly, a decision not to offer some form of payments scheme to haemophiliacs infected with hepatitis C will be deeply disappointing to the Haemophilia community and would need to be carefully handled. One possible way to soften the blow, and make the best use of available resources, might be to support projects providing practical support for those infected with hepatitis C. The Haemophilia Society are currently working up a funding bid for a project to identify how the Society can best help young haemophiliacs with hepatitis C to cope positively with the impact of the infection on their lives. One option might be for us to give the Society an undertaking that they will have first call on any further Section 64 money which might become available this year (through programme slippage). This could be backed up with an assurance that funding for the project for next year will be given priority.



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