To: PS/PS(PH)
PS/SoS

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INFECTED BLOOD PAYMENT SCHEMES: OPTIONS

Purpose

1. This note sets out some of the key issues with the current schemes and considers three specific options for changes to the ex-gratia payment schemes for those affected by HIV and/or hepatitis C (HCV) through historic treatment with NHS supplied blood or blood products.

Options for reform

2. You asked us to explore three options, in the context of two steers: to make as few changes as possible, and for no losers compared to the current scheme. The options are:

Option 1. Reform the current schemes into one non-charitable scheme, with no additional spend

Pros

- This could resolve the issue of the complexity of five different payment organisations, and dissatisfaction with the charitable nature of payments.

Cons

- [redacted]
- The reputational risk of failing to make substantive changes to the scheme is high. Successive Governments have promised to address the concerns of beneficiaries for a number of years.

Option 2. Reform the current schemes into one with £5m additional funding a year for the next 5 years (i.e. the £25m spread over 5 years)

Pros

- This could also resolve the issue on the complexity of five different payment organisations, and dissatisfaction with the charitable nature of payments.
- With "no losers", an additional £5m pa for the life of the schemes could fund annual payments at the current rate for approx. 330 of 2,200 HCV stage 1 individuals who do not currently receive them.

Cons

- Adjusted eligibility criteria would need to be established that might create demand for additional annual payments to only 330 of those with Stage 1 HCV. Identifying these from the bigger cohort and ensuring the budget is not exceeded due to the demand led nature of the payment schemes will be difficult without individual assessments.
- If additional funding is limited for only the life of this Parliament there is little that could be done meaningfully as part of the payment schemes if there are no losers and few changes to the payment criteria as payments would continue.

Option 3. Reform the current schemes into one with £25m additional funding a year for the next 5 years

Pros

- This could resolve the first issue on the complexity of five different payment organisations, and dissatisfaction with the charitable nature of payments.
- With "no losers", an additional £25m pa for the life of the schemes could fund annual payments at the current rate for approx. 1650 of 2200 HCV Stage 1 individuals who do not currently receive them.

Cons

- Whilst £25m pa for the lifetime of the schemes would not extend annual payments to all, it might be sufficient to extend annual payments to all those disabled with stage 1 HCV. However providing the same level of annual payment to all disabled beneficiaries would not reflect individual circumstances.
- As with Option 2, adjusted eligibility criteria would need to be established that might create demand for additional annual payments to only 1650 of those with stage 1 HCV.
- If the additional funding is limited for only the life of this Parliament there could be some scope to use the funding for lump sum or transitional payments as part of the scheme refresh.

Discussion

[redacted]

4. If potential annual funding for the lifetime of the schemes was to increase, the likelihood that annual payments at their current level could be extended to all beneficiaries disabled from their HIV and/or HCV wouls increase. However, as the budget increases, spending may be seen as increasingly disproportionate and poor value for money.

5. Further, changing the criteria with a result that nearly all beneficiaries receive the same level of payments would then result in the payments not reflecting the variation in individual circumstances [redacted]

Rationality

6. If the schemes are reformed and operated from a single new organisation, any payment policies would need to be consistent within each group of beneficiaries. However, given the current variation between the policies of the three charities, it would not be possible to apply such consistent policies within existing budgets, nor with an additional £5m pa, with no losers compared to the current schemes. This might be possible with an additional £25m pa for the lifetime of the schemes.

Financial sustainability

7. Under the current scheme rules, once beneficiaries meet a qualifying criteria, an individual receives annual payments for life. However, the reality of upcoming treatment prospects could mean that we will be making generous annual payments to people whose HIV is well managed, and/or have been cured of their HCV with few side effects. This could be considered disproportionate in those cases, in particular where health improvement enables people to return to work.

8. As you know, DH central budgets are already facing significant pressure in the Spending Review in order to help deliver the savings required to meet pressures in the NHS and deliver on key manifesto commitments such as seven day services. Increasing spend on the scheme will reduce the funding available for the NHS. [By way of illustration, £25m per year equates to around 600 nurses or around 200-300 GPs.]

Summary

9. [redacted] With all options, there potentially remains a reputational risk in failing to satisfy campaigner expectations.

Conclusion

10. You are asked to note the above considerations for the three options requested. In particular, you are asked to note that for all the above options, [redacted].

Happy to discuss.