F

Mr Cobb

cc Mr Dewey
Mrs Baxter
Mrs Bullock
Mr Dobson
Mr Canavan
Dr Rejman

1. Mr Canavan
Well done – no sign of wavering from S of S!

2. PA [illegible]
GRO-C
22.3

GEB 16
ACQ 9

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 01 210 3000
From the Secretary of State for Health

09 MAR 1990

The Rt Hon Cranley Onslow MP
House of Commons

Dear Cranley.

Thank you for your letter of 9 March about people who have contracted the AIDS virus (HIV) as a result of receiving blood transfusions.

The position at the end of January 1990 is that there have been 101 reported cases in England and Wales and Northern Ireland of an individual becoming infected by HIV as a result of a blood transfusion. However of those, only 17 were transfused in the UK, 35 were transfused abroad and the place of transfusion for the remaining 49 is not known. There have been 18 reports from England and Wales and Northern Ireland of people developing AIDS following transfusion in the UK. Of course 15 are known to have died.

I have the greatest sympathy for those who have become HIV positive through blood transfusions. However, the ex-gratia payments given to provide help for haemophiliacs with HIV and their families, recognised their wholly exceptional circumstances. Haemophiliacs were already suffering from a serious disorder which affected their employment prospects and insurance status. They had little opportunity to insure their lives or their mortgages or to build up savings in order to provide for their dependents. These difficulties have been compounded by the onset of HIV. Also the hereditary nature of haemophilia can, and in some cases does, mean that more than one member of the family may be affected. This combination of circumstances does not generally apply to those who have unfortunately become infected with HIV through blood transfusions.

Moreover any special provision for those transfused could itself create inequity and attract criticism. Difficult questions would arise whether to distinguish between those transfused in the UK and those transfused abroad; between those abroad for a UK company and those on holiday. The validation of claims would also not be as straightforward as for haemophiliacs whose medical history is well known. Some of those transfused might not be able to establish their entitlement and this would make them feel aggrieved.

More widely, it would be difficult to maintain a distinction between blood transfusion cases and the recipients of skin grafts or organ transplants who have been infected with HIV, people with other transfusion transmitted diseases or people who have suffered catastrophic side effects of other medical treatment.

We have never had a general system of no fault compensation for medical accidents in this country. The Pearson Commission carefully considered the matter in 1978 but came down against changing our system for seeking compensation through litigation in the Courts. There have been no substantial changes in the basic arguments since then. No fault schemes can be costly and while they remove the perceived unfairness between those who can prove negligence and those who cannot, they create unfairness between those disabled as the result of a medical accident and those who are equally disabled through natural causes. No fault compensation also removes an incentive for doctors to maintain standards of practice.

The ex-gratia payments for haemophiliacs with HIV recognise the special combination of circumstances facing them but the same justification cannot be made for those infected through transfusions. I think we cannot allow our sympathy for that group to lead us towards a policy of no fault compensation for medical accidents which we believe to be wrong.

This may be a disappointing reply but I hope it explains why we have no plans to extend the special financial help for haemophiliacs to those infected through blood transfusions.

GRO-C

KENNETH CLARKE