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**PAYMENTS FOR THOSE INFECTED WITH HEPATITIS C THROUGH BLOOD  
TRANSFUSION/BLOOD PRODUCTS**

1. Thank you for your letter of 9 May about the proposals to institute a payments scheme for those infected with the Hepatitis C virus through blood and blood products. I wrote on 25 May to advise you that I would be seeking the views of Ministers on this matter. I have now done this and my Minister of State, Lord James Douglas-Hamilton, has agreed the terms of this response.

2. While there is considerable public and political pressure for the Government to establish some form of no-fault compensation scheme for those infected with HCV this is not in itself sufficient justification for such a scheme. Experience prior to the HIV settlement does however suggest that this is an issue which will not simply fade away and one which in the longer term may cause damage to public confidence in the safety of the blood supply. Clearly this must be taken into account in considering our policy objectives and I think the situation must be kept under close review particularly once the views of the Courts are known.

3. It remains the case that the treatment given conformed to the best medical and scientific knowledge at the time and this defence will be tested in a number of legal actions, arising out of various cases, which are currently pending in both England and Scotland. It is not yet clear, however, if the argument will be sufficiently robust for the Courts, particularly in view of the payments already made in respect of HIV infection and the settlement which we understand Baxter has recently offered to patients infected with HCV by "Gammaguard". I will ensure that you are informed of the outcome of any legal actions in Scotland and I would be grateful to be kept in touch with developments in England.

4. My Minister is of the view that it is not realistic to imagine that a scheme could be contained to those infected by blood and blood products. Patients exposed to HCV through organ and tissue transplants would have an equally strong case in legal terms and any attempt to exclude these would be likely to fail. Similarly, the parallels with CJD are strong and the arguments employed against compensation are the same. The inclusion of those who received potentially infected pituitary derived Human Growth Hormone would therefore need to be considered at the outset.

5. We have considered the proposals contained in Annex B to your letter and I would have to say that we have serious reservations about the feasibility of linking payments to social need or clinical condition. Our main reservations can be summarised as follows:

(a) linking payments to the degree of illness or hardship suffered would involve complex legal and medical judgements, particularly in view of the lengthy period during which the disease may (or may not) develop and the uncertainty as to its eventual effect.

(b) A sliding scale of compensation would make such a scheme both difficult and costly to administer and would be unlikely to be acceptable to potential claimants, especially haemophiliacs who might prefer to pursue the matter through the Courts in the hope of a higher settlement.

(c) No fault compensation infers compensation or damages for loss sustained and for future loss and does not proceed on a means tested basis. The proposals amount to the introduction of a means-tested benefit for a certain group of individuals only.

(d) Despite the arguments set out in the proposals, the initial discretionary scheme to make payments to those infected with HIV on the basis of financial and social need did not prove entirely successful, this is why a flat rate compensation scheme was subsequently established. There is no reason to suppose that HCV would be different.

(e) The assumption that those who only suffer stress and anxiety as a result of the infection are entitled to little or no compensation does not reflect recent settlements paid for such damages.

(f) If CJD were included in the scheme, then it would certainly be necessary to offer compensation on the basis of risk alone. It is not possible to test for CJD and it would not be acceptable to offer compensation only once the disease had developed.

6. I am aware that Peter Davenport at the Welsh Office has voiced similar concerns. I endorse these and in particular acknowledge the argument that the HIV settlement does constitute a significant precedent in this case. However while it may be difficult to maintain the distinction between the way in which the Government has responded to 2 different, but both potentially fatal viruses it may be necessary to do so, at least for the moment.

7. The question of funding is already a major cause for concern. Whilst it would be possible to establish relatively quickly the number of haemophiliacs infected with HCV, the current look-back exercise is still some way from establishing with any certainty the potential numbers infected through fresh blood components. So far as I am aware there has so far been no assessment of the number likely to have been infected through organ or tissue transplants. Treasury is not expected to support the idea of compensation in the first instance and an inability to quantify the potential cost is unlikely to make the case more convincing. The best estimate of the numbers and costs we have in Scotland is 300 haemophiliacs and 350 non-haemophiliacs and even if settlement could be limited to these groups, the costs of compensation (at £60,000 each as per



the HIV settlement) amounts to £39 million. There is no provision for this in PES and if it could not be met from the Reserve would have a serious impact on other health spending.

8. My Minister of State therefore takes the view that if a compensation scheme were to be established there would be no option but to make payments on comparable terms to all those who have acquired HCV through blood transfusion or other components. However, in view of the unpredictable nature of HCV and the fact that it may not invariably be fatal, it might be possible to arrive at a smaller settlement figure than that offered for the HIV settlement. For those individuals, mainly haemophiliacs, co-infected with the HIV and HCV who have a worse prognosis, compensation might need to be at the upper end of any sliding scale.

9. Because of its far reaching implications we believe that the policy and general principles of such a scheme will need to be considered collectively by UK Health Ministers and possibly Cabinet. The scope and costs of the scheme would first need to be agreed with Treasury before the mechanics of the scheme were discussed in detail.

10. However, there is still uncertainty about the number of individuals infected with HCV through blood and blood products but the costs of compensation are likely to be considerable and would impact heavily on other health spending. There is also a risk that any settlement would weaken the general arguments put forward against no-fault compensation and lead to future claims from other groups of patients claiming damages for the unforeseen consequences of NHS treatment. In the circumstances, therefore, my Minister of State is of the view that claims for compensation should continue to be resisted, at least until the outcome of the Court cases is known and a more precise estimate can be made of the likely numbers and costs involved.

11. I hope this is helpful.

12. I am copying this letter for information to John Breen, Northern Ireland and Peter Davenport, Welsh Office.

I A SNEDDEN