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Dr Sheila Adam
Public Health Director
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Dear Sheila,

ANTI-HCV SCREENING OF BLOOD DONATIONS

Thank you for your letter of 4 February inviting me to send you a note to emphasise the key points on anti-HCV screening for Alan Langlands, our Regional General Manager.

As you can see from the attached copy of Harold Gunson's letter of 5 February, the Department of Health proposes that the costs for anti-HCV testing should be charged onto products issued from RTCs and be borne by users. At NLBTC, we think that this is simply appalling. We cannot understand where users will find the money to pay for more costly products without compromising other aspects of health care. A fixed amount of money is being devolved to districts (purchasers), based on last year's NLBTC budget and according to the usage of blood and blood components in each DHA or SHA. The additional £600,000 or more needed for anti-HCV screening are just not there. If purchasers are asked to keep a "steady state" next year, this can only mean that they will be able to order considerably less blood and blood components. Another point that has not been considered by the Department of Health relates to the plasma supplied to BPL. Will BPL pay more for the anti-HCV tested plasma? Will BPL pay for the repercussions if Transfusion Centres are asked to check via a sort of "look-back" on anti-HCV positive donors whose plasma would have been included in previous batches? We feel strongly that if BPL are not prepared to pay for this additional screening, then we should not test plasma collected by apheresis for fractionation. Testing apheresis plasma will leave us with no option but to increase further the charges for cellular components (red cells and platelets) and FFP passed on to Districts.

We are very concerned that our hospitals will be forced to subsidise BPL. I understand that it is one of the principles of cost allocation for NHS contracts that there should be no cross-subsidisation, yet we are forced to do this because of the monopoly position of BPL.

We feel that the Department does not understand the <u>full</u> implications of screening for anti-HCV. It is not only that the blood derivatives

will be more expensive but donors who are found to be positive will have to be counselled and, if necessary, referred to liver specialists who will treat them with expensive drugs such as Interferon. Who will pay for this?

In addition to the above costs, the enhanced Q.C. requirements currently being added to our routine testing burden will apply in full to anti-HCV screening, at considerable expense.

Without central funding, our only alternative is to test for anti-HCV by the cheapest available test and simply to discard the blood without confirmation or without contacting the donors found to be seropositive. If HCV infection is so significant for the blood transfusion recipient population, it should be even more significant for the donor population who, as a whole have more years in which to become ill. To screen and not to confirm or inform is therefore totally unethical, especially where some form of treatment is available. The option of screening without confirmation, follow-up and counselling is itself not without cost implications in collection costs, flagging of "unsuitable" donors and in the additional donor recruitment necessary to replace seropositive donors.

We feel that the decision to implement anti-HCV screening in the UK is a political one and that central funding should be made available. Such central funding should include screening, confirmatory assays, counselling and treatment of seropositive subjects who have liver disease. At a cost of over £2 per test (i.e. nearly 4 times more than anti-HIV tests) it will cost this Centre at least £600,000 to implement screening (exclusive of confirmatory assays by Reference Centres which are reported to be extremely expensive). I do not feel that it is justifiable to implement screening at the expense of waiting lists and bed closures. Moreover, non-A, non-B post-transfusion hepatitis does not seem to be a significant problem in this country. We have recently finished our prospective study of post-transfusion hepatitis, unique in the UK, and we have found that the incidence of post-transfusion hepatitis due to HCV is 0.26%, i.e. 1 in 387 patients. If we consider that half of the blood transfusion recipients are dead one year post-transfusion, then the cost-effectiveness of anti-HCV screening of blood donations should be critically reviewed.

Even when we look at patients with chronic liver disease in this country, there is no significant association with blood transfusion (reported by Dr Sheila Polakoff). Furthermore, there is no association in these patients between a history of blood transfusion and anti-HCV as measured by the latest serological techniques (NLBTC, unpublished data).

I enclose a copy of our manuscript on non-A, non-B post-transfusion hepatitis which has been accepted by The Lancet.

With kind regards.

Yours sincerely

Marcela Contreras
Director
Encs