From:
Health Planning & Quality Division
14 January 2003

Minister for Health and Community Care

Copy to:

Deputy Minister for Health and Community Care (Frank McAveety)
Deputy Minister for Health and Community Care (Mary Mulligan)
PS/HD
Ian W Gordon, Director of Service Policy and Planning
HP&Q
Dr Aileen Keel, DCMO
Press Health
First Minister
Deputy First Minister
Minister for Finance and Public Services
Minister for Parliamentary Business
Deputy Minister for Parliamentary Business
PS/Perm Sec
PS/FCSD
Colin Imrie - Head of Press Office
Press First Minister
Mike Donnelly - Principal Special Adviser
Sam Ghibaldan - Deputy Principal Special Adviser
Jeane Freeman - Head of Policy Unit
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Policy Unit

EX GRATIA PAYMENTS TO 'HEPATITIS C FROM BLOOD' PATIENTS
DRAFT CABINET PAPER FOR 22 JANUARY MEETING

Purpose and Recommendation

1.

Priority

2. Immediate – for submission to cabinet secretariat on 16 January.

Discussion

3. The draft Cabinet paper attached at Annex A discusses the approach that might be adopted on your appearance before the Health and Community Care Committee on 29 January – taking account of the fact that we now understand that DWP officials are now firmly of the view that a scheme to make ex gratia payments would be reserved.

Health Planning & Quality,

ANNEX A

**EX GRATIA PAYMENTS TO 'HEPATITIS C FROM BLOOD' PATIENTS
DRAFT CABINET PAPER FOR 22 JANUARY MEETING**

FOR DECISION **Paper number:** SC (03) 10.

SCOTTISH CABINET

FINANCIAL AND OTHER SUPPORT FOR PATIENTS WHO HAVE CONTRACTED HCV FROM BLOOD TRANSFUSIONS ETC; SCHEME OPTIONS

MEMORANDUM BY THE MINISTER FOR HEALTH AND COMMUNITY CARE

Purpose

1. To agree the presentational approach for my further appearance before the Health and Community Care Committee (HCCC) on 29 January. To decide on the type of ex gratia payment scheme the Executive would wish to establish if associated legal and social security issues can be resolved.

Background

2. I have been asked to appear before HCCC again on 29 January. UK Ministers, however, have yet to reach a conclusion on the issue of devolved powers.

Devolved competence

3. We understand the view of DWP officials is that a scheme to make ex gratia payments is reserved on the grounds that it would provide assistance for social security purposes to individuals who "qualify by reason of old age, survivorship, disability, sickness, incapacity, injury, unemployment, maternity or the care of children or others needing care" (within the meaning of Section F1 of Part II of Schedule 5 to the Scotland Act). The next step may be for the issue to be considered by the UK Law Officers – before the Secretary of State for Work and Pensions is in a position to reply to my letter of 5 November.

Scheme design

4. We are also being pressed in Parliament to be more specific on how a scheme would be designed. A difficulty in this is the variability of the health outcome resulting from HCV infection. Some individuals may never develop liver damage or symptoms, others will clear the virus and the remainder will develop some level of long-term symptoms or liver damage. We expect about 16% of those infected to develop serious long-term harm within 20 years (in the form of cirrhosis, liver cancer etc) – but cannot exclude the possibility that over a longer period this might rise to 60%.

5. The Expert Group's scheme would provide payments to all these groups. It would also make payments to the dependants or estates of infected individuals who are now deceased, which substantially increases the potential cost of the scheme.

6. Our alternative options only make payments to survivors only and are based on lump sum payments because it might be easier for these to be disregarded for social security

purposes. In some cases payments would be relatively front-end loaded. In others they could be spread over a very long period of years. The options are as follows:

Option 1: payments to survivors at the levels recommended by the Expert Group, depending on the severity of symptoms (£10k to all; plus further £40k to all with long-term symptoms or damage; plus further £50k to those with cirrhosis, liver cancer or other similar serious conditions). The estimated cost of this option is between £28 and £52m. It would go a long way towards meeting what the Committee are looking for, but involves substantial expenditure. It would include payments to those who had cleared the virus and had suffered mainly psychological symptoms.

Option 2: payments only to those who contract cirrhosis, liver cancer or other similar serious conditions. If payments of £100k were made to those with cirrhosis, liver cancer or other similar serious conditions, the estimated cost would be between £9m and £19m. This could, however, rise to between £34m and £70m if the proportion contracting these serious conditions exceeded the current estimate of 16%. This option is both less costly than Option 1 and has the merit of focussing help on those who have been worst affected.

Option 3: payments to all those with long-term symptoms or damage (£50k to all with long-term symptoms or damage; plus further £50k to those with cirrhosis, liver cancer or other similar serious conditions). The estimated cost of this option would be between £22m and £44m. As in the previous option, this could rise to rise to between £34m and £70m if more people than expected progressed to the most serious phases of the disease. This would go further towards recognising the real needs of Hepatitis C sufferers, while falling short of payments to those who have suffered mainly psychological harm.

7. The Health Department does not have explicit provision for these costs at present, and its Reserve for next year currently stands at only £25million to meet all unexpected pressures. The PFO has already reported that the central Reserve is also severely constrained. Furthermore, because of the measures we have been taking to reduce the underspend this year, resources available from end year flexibility next financial year (which might normally be used for a one off cost like this) are likely to be less than in recent years. So, if any of the options are pursued, difficult decisions will be required about stopping other activities or developments, with a potential impact on Executive priorities and targets.

8. Our public statements so far have indicated that we would follow an approach along the lines of option 3. I believe this is the most defensible option in terms of meeting the needs of Hepatitis C suffers, while avoiding payments to individuals who have suffered limited effects and setting any new precedents. I invite the Cabinet to confirm that this should be our approach.

Issues for the HCCC meeting

9. It is likely that we will be in the position on 29 January of still waiting for a view from the UK Government on the devolved powers issue. We are likely to be criticised for the length of time it is taking to resolve this. We will have to indicate that the issues are in front of the UK Government, that there are difficult constitutional and legal considerations, and that it is the responsibility of the UK Government to reach a view on these.

10. It would be helpful if I could say a little more to the Committee about the type of scheme and criteria we have in mind. I have in effect already broadly outlined to the Committee our preferred approach, and we should not at this stage be completely specific about what we propose and the costs, in case this further raises expectations of what we will

be able to do. But I could sketch out in broad terms what we propose along the lines of Option 3.

11. Given the state of progress, it is likely that the Committee will wish to take a report to the Parliament, probably recommending implementation of the Expert Group proposals. We will need to consider in due course our response to and handling of such a debate

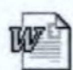
Conclusion

I invite colleagues to agree that we base our design of a scheme of payments to those who have contracted Hepatitis C from blood on Option 3, as set out in para 6 above, and to endorse the handling line for HCCC set out in paras 9 to 11.

MALCOLM CHISHOLM
22 January 2003

From:	
Sent:	14 January 2003 17:33
To:	Minister for Health and Community Care
Cc:	Deputy Minister (McAveety) for Health and Community Care; Deputy Minister (Mulligan) for Health and Community Care; PS/HD Health; Gordon IW (Ian); Keel A (Aileen); First Minister; Deputy First Minister (Minister for Justice); Minister for Finance and Public Services; Minister for Parliamentary Business; Deputy Minister for Parliamentary Business; PS/Perm Sec; PS/FCSD; Imrie C (Colin); Press First Minister; Donnelly M (Mike); Ghibaldan S (Sam); Freeman J (Jeane); Campbell D (Douglas) (Special Adviser); McArthur L (Liam); Policy Unit Mailbox;
Subject:	Draft Cabinet paper for 22/1 meeting: Ex gratia Payments to 'HCV from blood' patients
Importance:	High

4 page submission attached



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Health Planning & Quality

From:
Sent: 14 January 2003 17:39
To: Minister for Health and Community Care
Subject: PREVIOUS CABINET PAPER: FINANCIAL AND OTHER SUPPORT FOR PATIENTS WHO HAVE CONTRACTED HCV FROM BLOOD TRANSFUSIONS ETC;

Sensitivity: Confidential

I attach a copy of the previous Cabinet paper on HCV compensation - in case Mr Chisholm wishes to refer to it.

From: [redacted]
Health Planning & Quality Division
8 January 2003

Minister for Health and Community Care

Copy to:
Deputy Minister for Health and Community Care (Frank McAveety)
Deputy Minister for Health and Community Care (Mary Mulligan)
PS/HD
Ian W Gordon, Director of Service Policy and Planning
[redacted] HP&Q
Dr Aileen Keel, DCMO
[redacted] Press Health
Policy Unit

ESTIMATED COST OF EX GRATIA PAYMENT SCHEMES (HEPATITIS C FROM BLOOD)

Purpose

1. To provide Ministers with estimated costs of variations on the ex gratia payment scheme recommended by the Expert Group on Financial and Other Support.

Priority

2. Immediate – for consideration at 10 January briefing meeting.

Discussion

3. Estimated costs are presented in the Annex to this minute. As requested the estimates are restricted to scenarios involving payments to surviving patients – with no payments being made to dependants or estates of deceased patients. The estimates explore options for two different groups of surviving patients, a] the 568 patients currently reported to SCIEH as having HCV linked to either *blood or tissue* or *blood factor*, b] the 1165 patients estimated to be still alive today (including the 568).

4. Take-up from the schemes is assumed to be in excess of 90% (and 100% in most cases) which is in contrast with the 31% used in estimating the costs of the Expert Group's scheme. This is because the 31% was applied to the total group of patients and it was assumed that in many cases there would be no claims from dependants or estates of deceased patients. In the 1165 group, the scenarios involving payments to those not seriously ill might involve some individuals who have not discovered (and may never discover) that they are infected with HCV – but this is not likely to reduce take-up significantly.

5. The scenarios cover situations where payments are made either to all those infected or only to those with cirrhosis or worse. This is because there are huge difficulties in rigorously identifying any other subsets of debility that could be linked to payment triggers.

6. The most costly scenario (£70m) involves applying the Expert Group payment regime to the 1165 group assuming that 60% eventually progress to cirrhosis. This is definitely a worst case scenario.

Conclusion

7. The estimates demonstrate that there is a very wide range of potential cost (£7m - £70m) depending on the payment scheme selected and the assumptions made about the disease progression. Given this variability, it would be prudent not to make any public commitment to the amount of funding that might be made available for an ex gratia scheme until the way forward becomes clearer.

[redacted]
Health Planning & Quality Division
GER, SAH
Phone: [redacted]

8 January 2003

ESTIMATED COST OF EX GRATIA PAYMENT SCHEMES (HEPATITIS C FROM BLOOD) **ANNEX A**

Target Group: 568 people recorded by SCIEH in latest published figures (31 December 2001)as HCV antibody-positive cases associated with receipt of *"blood or tissue"* or *"blood factor"*. [New figures due from SCIEH mid February – will not get an indication of what they will be until end January]

Debility Profile	**Awards**	**Take-up**	**Cost (£)**	**Take up profile**	**Notes**
[1]	As per Expert Group	100%	28.3m	Very heavily front loaded	All will be aware they are infected. The 343 haemophiliacs will certainly claim immediately.
[1]	As per Expert Group – but pay only cirrhosis or worse [best case]	100%	9m	Virtually immediate	Assumes only 16% (91) ever progress to cirrhosis and will receive £100k awards.
[1] (See notes column)	As per Expert Group – but pay only cirrhosis or worse [worst case]	100%	34m	£9m virtually immediate – rest could spread over 10 yrs +	Assumes that 16% (91) have progressed to cirrhosis (or will do very soon) – 44% (250) have lesser debility now but will eventually progress to cirrhosis or worse.
[1]	As per Expert Group – but pay only those with symptoms or signs of liver damage	100%?	21.6m	Very heavily front loaded	Assumes that 16% (91) have progressed to cirrhosis (or will do very soon) and will receive £100k awards; 44% (250) have symptoms or signs of liver damage and will receive £50k awards. **Corresponding worst case is as above.**
	Lump sums to all – no distinction for debility status	100%	5.7m per £10k awarded	Virtually immediate	
[1] See notes column)	Lump sums to all with symptoms	100%	3.4m per £10k awarded	Virtually immediate	Assumes 60% have symptoms. Could rise to 80% if the 20% who *may never develop symptoms* invented some – increasing cost to £4.5m per £10k awarded.

[1] As given in Scottish Executive leaflet *Hepatitis C: Essential Information for Professionals* i.e. 40% experience stress, anxiety or social disadvantage only (clear the virus or are without liver damage or physical symptoms); 60% develop long term symptoms or signs of liver inflammation – of which 16% (of the total) will develop cirrhosis within 20 yrs and all of the 60% may possibly develop it over a longer period.

ESTIMATED COST OF EX GRATIA PAYMENT SCHEMES (HEPATITIS C FROM BLOOD) **ANNEX A**

Target Group: 1165 people statistically predicted to be still alive (including the 568 people recorded by SCIEH as HCV antibody-positive cases associated with receipt of "*blood or tissue*" or "*blood factor*).

Debility Profile	**Awards**	**Take-up**	**Cost (£)**	**Take up profile**	**Notes**
↑	As per Expert Group	90%[2]	52.4m	Take up by the 568 will be very heavily front loaded.	
↑	As per Expert Group – but pay only cirrhosis or worse [best case]	100%	18.6m	Take up from the 568 virtually immediate – rest might be spread over several years	Assumes only 16% (186) ever progress to cirrhosis and will receive £100k awards.
↑ (See notes column)	As per Expert Group – but pay only cirrhosis or worse [worst case]	100%	70m	Take up from the 568 virtually immediate – rest could spread over 10 yrs +	Assumes that 16% (186) have progressed to cirrhosis (or will do very soon) – 44% (512) have lesser debility now but will eventually progress to cirrhosis or worse.
↑	As per Expert Group – but pay only those with symptoms or signs of liver damage	100%?	44.2m	Fairly heavily front loaded	Assumes that 16% (186) have progressed to cirrhosis (or will do very soon) and will receive £100k awards; 44% (512) have symptoms or signs of liver damage and will receive £50k awards. **Corresponding worst case is as above.**
	Lump sums to all – no distinction for debility status	100%	11.6m per £10k awarded	Virtually immediate	
↑ (See notes column)	Lump sums to all with symptoms	100%	7m per £10k awarded	Virtually immediate	Assumes 60% have symptoms. Could rise to 80% if the 20% who *may never develop symptoms* invented some – increasing cost to £9.2m per £10k awarded.

[redacted] Health Planning & Quality [redacted] 8 January 2003

[2] Assumes that (for those not in the '568 group') 75% of the 20% who '*may never develop liver damage or physical symptoms*' never become aware of their infection; 100% take up by the remainder.