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ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

1. Ministers will be aware of a great deal of recent press comment about AIDS. As they will know from previous briefing, AIDS carries a high mortality, its cause is not yet fully understood and there is no effective cure. It was always predicted that a rapid growth in the number of cases was likely; such growth is occurring. Nonetheless, up to 28 February there have still been only 132 reported cases in the whole of the United Kingdom (4 of them in Scotland). Even in the United States only a very small proportion of the total population is affected by AIDS, and most cases there are found in the major centres where male homosexuals congregate. The public health hazard does not therefore warrant alarm on the scale manifested in the popular press. However, such alarm undoubtedly exists and it is desirable to take visible steps to reduce it. There are two main issues which call for consideration: first, whether AIDS should be made a notifiable disease; and secondly, what can be done to safeguard the Blood Transfusion Service from the possibility that persons infected by AIDS may donate their blood and so spread the infection.

Notification

2. PS/Mr MacKay's minute of 29 January asked for advice on the question of notification. I am sorry that we have been unable to respond before now, but we have only recently been informed of the action which DHSS Ministers are taking. Three options were identified by DHSS -

(a) to do nothing;

(b) to make the disease notifiable and subject to appropriate provisions;

(c) to lay Regulations for the introduction of hospital detention (and other) powers without making the disease notifiable.

3. Essentially the choice lay between (b) and (c), since the Government could not be seen to be inactive. On the question of notification, the Expert Advisory Group on AIDS, which has been set up to advise the Chief Medical Officers of the Health Departments, identified many problems which would result from making AIDS notifiable and stressed that the benefits to be gained from such a course of action would be limited. While they did not agree that AIDS should be made notifiable, the Group accepted that there was a need for a limited range of powers to be available to deal with particular situations such as had arisen in Wessex (where a patient who was bleeding and thereby might have presented a danger to public health had threatened to discharge himself from a Bournemouth hospital).

4. Notification of an infectious disease has three objectives -

(a) to enable the course and trend of the disease to be studied by identifying cases where and when they occur:

(b) to enable contacts to be traced: this in turn makes it possible in some conditions to prevent further cases (eg by vaccination) or to identify and treat early cases (tuberculosis) or to quarantine contacts during the incubation period to prevent the spread of infection (smallpox);

(c) to take power to limit movement of a patient (eg by detention in hospital).

As far as (a) and (b) are concerned, the present voluntary arrangements by which cases of AIDS are reported to the Communicable Disease Centres in England and Scotland are a satisfactory means of clinical surveillance. In conjunction with the laboratory reporting of positive antibody tests to the causal virus, these arrangements provide an effective overall surveillance which is as good as, if not indeed better than could be achieved by statutory notification of the disease.

5. All the experts agree that on the basis of present knowledge there is no point in limiting the freedom of an individual suffering from AIDS other than in the exceptional circumstances where there is risk of the spread of infection by blood. Limitation of sexual activities by statute is of course impracticable. It is against this background that DHSS Ministers have decided that they should adopt the third option referred to in paragraph 4 above and should lay Regulations attracting certain specific statutory powers, eg hospital detention, without making the disease notifiable. We consider that the course of action being taken by DHSS is the correct one in the circumstances and we propose to ensure as far as practicable that a similar result is achieved in Scotland. However Scottish legislation in this area is significantly different from that which applies in England. In England the statutory provisions which their proposed Regulations would attract do not at present apply to AIDS since it is not one of the statutorily defined diseases which such provisions cover. In Scotland however the equivalent statutory provisions with regard to hospital detention etc apply generally to all infectious diseases without any limiting definition of that term, and so may be regarded as already applying to AIDS. A letter explaining this will be sent to the Chief Administrative Medical Officers of Health Boards and the Chief Executives of District and Island Councils on 22 March, the day DHSS issue a circular drawing attention to their new Regulations. These letters will be copied to SIO so that they can respond to any inquiries prompted by the DHSS action.

Blood Transfusion

6. It is known that AIDS can be transmitted through transfusions of blood or blood products from an infected donor. Ministers will recall the discovery of antibodies to HTLV III, the virus implicated in AIDS, in a number of Scottish haemophiliacs towards the end of last year. All Scottish produced Factor VIII, in which Scotland is self-sufficient, is now heat treated to counter HTLV III and hence greatly reduce the risk of transmission to haemophiliacs.

7. Tests are becoming commercially available for the screening of blood donations for the presence of HTLV III antibodies. The first of these tests, from the USA, was marketed in the UK at the beginning of March. DHSS Ministers have agreed in principle that, in England, all blood donations should be screened and that Regional Health Authorities should meet the cost of this. Regional Blood Transfusion Directors throughout the UK have written to the Lancet (copy attached) strongly supporting the screening of all blood donors, but advising that such a screening programme should be delayed until the available test systems have been evaluated and until alternative testing facilities are made available to individuals who may be at high risk of transmitting AIDS.

8. We consider these views of the Transfusion Directors to be sensible and responsible, and support them, particularly in the Scottish context. As noted above, all Scottish Factor VIII is heat treated; the risk from ordinary blood transfusions is believed to be very small; as far as is known, in Scotland where 280,000 donations are collected each year, there has only been one infected donation of blood (the one which contaminated the batch of Factor VIII); there is other evidence that blood donated in Scotland is "clean"; and donors are now required before giving blood to sign a statement that they are not in a group at risk of contracting AIDS.

9. The tests becoming available from United States companies are likely to give a high rate of false positive results - maybe 4%. On that basis about 10,000 Scottish blood donors could be identified as having antibodies to HTLV III who are in fact quite free of them. The implications for the individuals concerned, and for the resources required for further testing and counselling, would be profound and substantial. The tests also have an unpredictable false negative rate, so that an infected person might not be identified; and since the test is for antibody and not antigen it will not in any case identify a person who has been infected with the antigen but not yet developed antibodies.

10. Antibody testing is at present expensive, at approximately £2 per test. This figure, which would suggest an overall annual expenditure on such testing of about £600,000 in Scotland, has to be set against a total cost per donation for all other tests, including blood grouping, also of £2. Nevertheless, we should not wish to stand in the way of testing solely on financial grounds. However a test is being developed in England, partially using NHS resources, which it is hoped will be cheaper and more accurate. A UK Evaluation Panel has been set up to test the validity and reliability of the commercial test kits coming on to the market, and the English test will be included in these evaluations.

11. A further problem has been highlighted by recent experience of a pilot testing facility for AIDS associated with a regional transfusion centre in England, to which homosexual men travelled, ostensibly to give blood but really to determine their antibody status. Thus, having regard to the possibility of false negative tests, the risk of infected blood being donated could be increased rather than the reverse. We therefore propose that testing facilities should be made available by the Health Service, possibly associated with sexually-transmitted disease (STD) clinics, prior to the introduction of general screening by the transfusion service, so that people considering themselves to be at risk to AIDS can have access to the antibody test without presenting themselves as blood donors.

12. No doubt there will be public pressure for routine screening of blood donations once it is known that commercial tests are readily available. However having regard to:

(a) the limitations of currently available tests;

(b) the disproportionate effects of a high rate of false positive findings; and

(c) the need to provide alternative screening facilities to divert "at risk" individuals from the Blood Transfusion Service,

we recommend the adoption of a phased policy leading to the routine screening of blood donors, which would take into account a comparative evaluation of the tests available, the need for ready access to testing facilities outwith the transfusion service and a recognition of the considerable requirement for additional testing, monitoring and counselling of donors with positive tests. We should be glad to know whether Ministers agree that we should proceed in this way.

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