Council of Europe. – European Health Committee. 5th meeting 17-21 May 1982

2384

In the discussion which followed, it was generally agreed that the term transfusion-associated hepatitis, suggested by .. (ISBT), was more appropriate to describe this condition which varied in incidence considerably in the member countries.

Committee members reported that it was generally recognised that the frequency of transfusion associated hepatitis was higher when using commercial plasma (which may contain a multiplicity of causative agents.) In order to reduce the risk of such hepatitis, it was again recommended that national blood transfusion services should take steps to ensure that there was an adequate supply of plasma from voluntary, non-remunerated donors in order that national self-sufficiency could be achieved in the production of coagulation factor concentrates (see also Recommendation No. R (80) 5). In the event that importation of products is required, this should preferably be from countries known to have a low incidence of hepatitis. In any case, the committee reiterated the need for implementing Recommendation No. R (80) 14 of the Committee of Ministers with respect to the identification of the source of plasma.

15. Protection of donors and recipients in the national and international exchange of blood and blood products

/SP-HM (82) 28/

The committee examined with interest the survey prepared by (Belgium) on this topic and asked (Belgium) to extend its appreciation to It was decided that this topic would be dealt with under the 1984 Co-ordinated Research Programme (see Item 7.2 and Appendix V).

16. Immunological problems involved in platelet and granulocyte transfusion

/SP-HM (82) 9/

(Netherlands) introduced a short report on the subject. He drew attention to the difficulties encountered in platelet and granulocyte serology due to the presence of immune complexes that may be present in sera under investigation. Platelets and granulocytes carry an Fc-receptor for IgG and the latter also for C4b/C3b and C3bi. Thus immune complexes may adhere to these cells and cause a positive result in techniques - such as the immunofluorescence test - based on the detection of membrane bound immunoglobulins.

This problem is not of importance in the indirect immunofluorescence test on paraformaldehyde fixed platelets, the fixation preventing the adherence of immune complexes to the Fc-recptor, but fixation does not prevent immune complex fixation on granulocytes.

5'

See work on BLC/P.

2155

BPL Development - Financial Appraisal

1. As requested, I set out below the information requirements for a preliminary financial appraisal of the various options arising from the recommendations of the working party on plasma supplies. I must emphasise that if Ministers decide to go ahead with some form of redevelopment at BPL, a much more detailed appraisal will be needed at a later stage, given the large sums of money involved. We cannot hope to carry the Treasury or the NHS with us unless a proper evaluation has been undertaken, based on a detailed costing of all relevant options.

2. First stage: specify options -

(i) no change (allowing for interim expansion at BPL and associated changes at RTCs, as set out in para 2.1 of the working party report. Output level = 200,000 kg plasma).

(ii) 100 per cent self-sufficiency in all products (output level = 500,000 kg plasma).

(iii) self-sufficiency in all products except Factor VIII.

(iv) .....
(v) ..... } HS to specify.

List all relevant non-financial information for each option, eg levels of output, import requirements, number of plasmapheresis centres required etc.

3. Second stage: collect cost information. For each option the following information is required:

(i) BPL capital costs - buildings and equipment (specify costs and lengths of life separately for major items if possible).

(ii) BPL running costs - staff, medical supplies, general services (fuel, transport, estate management, administration etc).

(iii) RTC capital costs - building andequipment for plasmapheresis centres (including information on lengths of life. If buildings are rented or if use is made of existing NHS buildings, please indicate).

(iv) RTC running costs - same categories as under (ii).

(v) import requirements - type and amount of each product + cost per unit.

(vi) sales of surplus products - as for (v).

The appraisal will need to extend over a reasonable time period, say 20 years, but it can be assumed that once maximum output has been achieved under each option, production can be maintained at this level indefinitely. We can then assess each option in relation to total demand of 500,000 kg plasma, with any subsequent shortfall being

[redacted]

met entirely from imports and therefore common to all options. It is, however, unlikely that maximum output can be achieved immediately on completion of capital redevelopments, eg because of constraints on the supply of blood, so you will need to specify the rate of build-up of production under each option in the early years and the associated import requirements. For each cost item, please indicate the price base concerned (Survey 1980, 1980/81 out-turn etc); we can convert these to a common price base at a later stage.

4. Third stage - discounted cash flow analysis. EAO will undertake this part of the exercise on the basis of the information provided above, including sensitivity analysis (ie testing of results according to different assumptions for key variables). Each development option will be assessed in relation to the "no change" option, and we will also show the incremental costs and benefits of differing degrees of self-sufficiency.

5. As agreed at our meeting, you will make a start on doing the work required for stages 1 and 2 as soon as possible. Once the relevant cost information has been collected, we can run through the DCF calculations pretty quickly, but please do not hesitate to contact or myself in the meantime if you would like any further advice on the costings.

17 June 1981

cc

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