

The hepatitis C disaster

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On Mar. 27 Health Minister Allan Rock announced on behalf of the federal, provincial and territorial health ministers an agreement to offer financial assistance to Canadians infected by the hepatitis C virus through the blood system between Jan. 1, 1986, and July 1, 1990. The details of the assistance are still to be determined through negotiation. However, the ministers favoured an initial fixed payment (presumably to all who became infected) and a variable subsequent payment based on the severity of each person's disease.¹

In the weeks following this announcement there has been a steady barrage of criticism, led by the official opposition, supported by some Liberal parliamentarians and by some provinces, and widely echoed in the media. Bewildered Canadians are asking themselves whether this decision taken on their behalf was just, or unduly legalistic and mean, and what, if anything, should be done about it. Events are unfolding so rapidly that the views of today (May 8) are likely to be thoroughly outdated when this article goes to press. Nevertheless, there are some points to bear in mind as we try to make up our minds on this controversial issue.

First, the problem is extremely complex. No solution will be completely "right" for everyone, and any solution will be vulnerable to criticism. Hepatitis C is not a rare disease. According to the Laboratory Centre for Disease Control,² there were 14 070 newly diagnosed cases in 8 reporting provinces and territories in 1995. The majority of infections result from injection drug use, and until 1990 the receipt of blood and blood products was the second most important cause. Rarely, infection may result from transmission from mother to child, needle-stick injury, organ transplantation, unsterile tattooing and, possibly, sexual intercourse with a carrier.² Fifteen percent of people recover completely after an initial acute infection; chronic infection develops in the rest. Of these, up to 20% may become symptomatic.³ By 20 years, cirrhosis may develop in 25% of those with chronic infection; by 30 years, liver cancer may develop in 5%. Interferon therapy is the only established treatment.² Until 1990 there was no sensitive test to detect hepatitis C in donor blood, but a surrogate test has been used since 1986 in the US and for a longer period in some European countries.

The ministers' decision to offer "financial assistance" to the approximately 20 000 Canadians infected by blood and blood products (and those secondarily infected) between 1986 and 1990 recognizes that during this period "some of the infections might have been avoided."¹ Thus it seems to have been decided that the failure to take reasonable care to avoid these infections could amount to legally actionable negligence. By implication, before 1986, when donor blood was not usually screened by any test for hepatitis C in North America and, since 1990, when sensitive screening methods were put in place, infection from blood products was not a result of negligence. To give financial assistance to the unfortunate people who became infected outside of the time window in question would, it is argued, set a precedent that society could ill afford, namely, to provide compensation whenever a therapeutic intervention causes harm.

Was this decision just? If the facts as stated are correct, and if we accept that it is fault, not misfortune, that should be compensated, we must conclude that it was. If there was a failure to meet a reasonable standard of care and, as a consequence, people contracted a potentially lethal infection, compensation based on fault is surely appropriate. But is it also just *not* to compensate those injured with-



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out fault, who became infected before any sort of testing for hepatitis C was accepted practice in North America?

To many of us the answer would be that it is *just*, but hardly *generous*. Even if there is no legal reason to offer compensation to those whose infection was not attributable to fault, many of us would, I suspect, prefer to see them offered some financial assistance should they suffer serious sequelae. The infection of 80 000 people through blood and blood products, even if only a proportion fall ill as a result, is surely a major disaster. We like to feel that we belong to a society that steps in to support those afflicted by disasters such as floods, ice storms or failure of fish stocks. There is, therefore, a feeling that the decision to compensate only those injured through fault does not adequately reflect the caring society we would like to be. However, we are also painfully aware, as hospitals close and waiting lists for health services lengthen, that our means are limited, and that generosity must be paid for.

What is to be done about it? There is clearly a general desire that, whatever we do about the hepatitis C disaster, we should be compassionate as well as just. Our elected health ministers have the unenviable task of deciding how much compassion we can afford. There are 2 courses of action that they might consider.

They might, without admission of guilt or liability, offer "disaster relief" as needed to all those who fall ill, regardless of when they were infected. This need not create a dangerous precedent any more than giving relief to flood or ice storm victims does. Further, there seems little reason (except for the need to settle potential legal claims) to compensate people who became infected but who do not fall ill. The offer would therefore be to help those who suffer financial loss, such as loss of earning capacity

due to hepatitis C induced illness or death, their health costs being already assured. An alternative, and clumsier, option would be to compensate the 1986–1990 cohort and at the same time to offer "disaster relief" for those who suffer the sequelae of infection contracted outside the defined time window. Although the level of relief to the 1986–1990 cohort would take account of the fact that they are suffering from the results of negligence, the level of relief offered to those infected without fault would be determined by compassion. Thus, they would not necessarily be compensated in an identical manner.

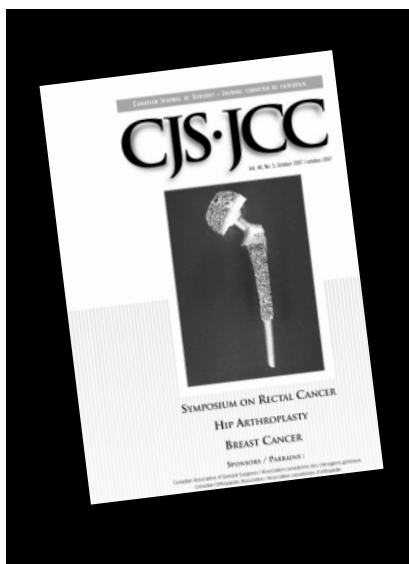
Either course would better reflect the caring society we wish Canada to be than limiting compensation to the 1986–1990 cohort. In any event, it is high time to stop making political capital out of a very real human disaster. Events are evolving so rapidly that by the date of publication of this article a settlement may well have been reached; if so, it is to be hoped that it will be not only fair but also compassionate.

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