put forthwith, and then put the Main Question or the Main Question as amended; or

(b) if the Question last proposed from the Chair is for the amendment of the Motion, put that Question and then proceed as aforesaid; and

(2) in relation to any further such Motions as may then be made, put forthwith any questions necessary to dispose of proceedings thereon, including the Questions on any amendments thereto which he may have selected and which may then be moved. —*[Mr. Greg Knight.]*

Blood Transfusions (HIV Infection)

Motion made, and Question proposed, That this House do now adjourn.—*[Mr. Greg Knight.]*

11.56 pm

Mr. Robin Cook (Livingston): I speak to this Adjournment from the Back Benches partly to signal that I regard this as a non-party political issue for which there is considerable cross-party feeling. I do so also because, on this occasion, I speak as a constituency Member. It is unusual for a member of the shadow Cabinet to retire to the Back Benches willingly, and it requires unusual circumstances to persuade me to do so. On this occasion, there are unusual circumstances, which I have observed at first hand and have left me with a strong feeling that an injustice is being done.

I represent two constituents who are both HIV-infected as a result of blood transfusions in the Health Service. Neither is a haemophiliac—that is a relevant and important point which I will develop later. I suspect that my case is unique because there are only 19 such patients alive in Britain. I know that my hon. Friend the Member for Birmingham, Ladywood (Ms. Short), who will intervene in the debate with my permission, has one other case in her constituency.

The facts are quickly rehearsed, and I do not think that they are in dispute. As the Secretary of State said in his letter of 12 February, 32 such cases are known to have occurred from transfusions that took place in Britain. Of those 32, 13 have since died. Those figures give rise to two observations relevant to my case.

First, we are dealing with a small number. It is probable that there are still some in our community who have not yet been diagnosed, although they may have been infected from blood transfusion before 1985. It is equally probable that there will be few of them. Even if there were as many again as are at present alive and diagnosed, we are talking about a total number throughout Britain of some 50 people.

Secondly, not only is that number small, but it is not getting any larger. There is no known case of a patient who has been infected with HIV as a result of blood transfusion since 1985. So we can tackle the public policy questions that arise from this group confident that they are few and that they are not getting larger.

The key issue of public policy to which I wish to address the mind of the House tonight, is the discrimination against this handful who are excluded from the special financial support that the Government have created for those haemophiliacs who are HIV-infected through blood products.

It is no part of my purpose tonight to debate those arrangements. I shall content myself with two brief observations. First, I welcome the fact that Ministers have created those special arrangements and, secondly, for balance, I express no view tonight on whether those arrangements are adequate or inadequate. But whichever view is taken on how adequate are the arrangements that have been made for haemophiliacs, the purpose of my Adjournment debate tonight is to query how on earth the Government can justify excluding from those arrangements this small handful of people who have also been infected as a result of treatment within the NHS but who happen not to be haemophiliacs.

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As the Minister will be aware, as I have no doubt that he has seen the file, I have had correspondence over two years with two successive Secretaries of State on this issue. I have repeatedly asked how they can justify leaving that tiny group of infected patients out in the cold. The attempts in the replies that I have received to make a logical defence of the arrangement are so threadbare that they have a hint of desperation. They have not convinced me, and I am authorised to say that they have not convinced the hon. Member for Eastleigh (Sir D. Price) who was offered the same explanation in a parliamentary answer last month.

Briefly, three grounds are advanced by the Government for justifying the exclusion of those who are infected but are not haemophiliacs. First, they say that haemophiliacs were already disabled at the time of infection. All those people who have become infected through whole blood transfusion were so infected as a result of undergoing treatment within the NHS. By definition, at the time of that treatment they may well have been less fit than many haemophiliacs.

I put it to the Minister that the defence that is being arranged by the NHS throughout Britain against legal action being taken by those people is that, at the time of the transfusion, they were in a life-threatening condition and the risk from transfusion was substantially less than the probability of death without transfusion. In those circumstances, it is difficult now to tell those people that they should be excluded from the special arrangements because they were not disabled at the time of infection.

Secondly, it is argued that haemophiliacs were already financially disadvantaged by their condition and were barred from taking out life insurance. The relative financial security of the patients with whom we are concerned varies from circumstance to circumstance and from individual to individual. I would be interested to hear from the Minister whether any data have been collected by or are available to the Department to suggest that the financial background of haemophiliacs is worse than the financial circumstances of the small group whom we are debating tonight.

One of my constituents, whose financial circumstances I know in detail, was a single parent who for many years lived on benefit and had been on social security for some time before she became infected through blood transfusion. She very reasonably made the point to me that, when one is living on the extremely tight budget of social security for many years, the very last priority one is likely to have is paying the premiums on a life insurance policy. She has always been in financial difficulty and now has to subsist on £26 a week disablement benefit, quite unable to supplement that from earnings because it is now increasingly rare for her to be able to leave the house, far less obtain employment.

The third justification advanced by Ministers as to why the scheme should be confined to haemophiliacs is that haemophilia is hereditary, so more than one person may be infected in a family. That undoubtedly is the case, but it has rightly not stopped Ministers making payment to those families in which there is only one infected member. They make up the great majority of cases where payment has been made.

Not only is haemophilia hereditary—so is HIV infection. If there is no example of two such infected cases in the households of the small handful of people that we are discussing tonight, it is entirely fortuitous, and it does not exclude the possibility that such a case may be discovered in the future. We know that one patient was infected by a whole blood transfusion while giving birth, and in those circumstances it is as much a matter of luck as of anything else that there are not two infected people in that household.

The more one contemplates the cases of those who are haemophiliac and those who are not, the more difficult it becomes to see the basis for the distinction. Indeed, it becomes more obvious that there are greater similarities between the two groups than there are differences. The most obvious similarity is the financial pressure. Both groups face the same extra expenses for being HIV-infected. Both groups have a reduced opportunity to earn as a result of the infection, and both may be unable to discharge family responsibilities. In those circumstances, it is natural to find that many haemophiliacs strongly support the case of those who are infected as a result of NHS blood transfusions, although they are not haemophiliacs.

I understand that those who administer the Macfarlane Trust, funded by the Government to assist cases of hardship among haemophiliacs, would be willing to consider extending the trust to include those who are not haemophiliacs but who are infected through NHS treatment, provided that the Government also act to widen the terms of reference of the trust and to provide the additional modest amounts of money necessary to meet that additional responsibility.

Money cannot be the reason why the Government resist the case, because it is a very modest sum. The Government have already provided £34 million for special arrangements for ex gratia payments to those haemophiliacs who have been infected. The sum of money required to meet all the cases that we are discussing tonight would be less than an additional £1 million.

The real reason why the Government resist extension of the scheme is not revealed in the letters or the parliamentary answers on the matter. However, I have glimpsed in conversations with Ministers that the real reason that they are reluctant to extend the scheme to embrace those people who are not haemophiliac is the stark terror of their advisers at the precedent that such a payment would cause for other NHS patients.

I understand that a genuine problem exists, and I appreciate that a condition of the special scheme for haemophiliacs was that it was capable of being ring-fenced so as to protect the Department of Health against other patients who might make parallel claims on the back of that precedent. The problem is that the ring fence, important though it is, has been drawn in the wrong place. It should have included and not excluded those other patients who are HIV-infected as a result of blood transfusions.

I suggest to the Minister and to his advisers that, if they amend that obvious weakness in the ring fence, they will have a much more logical case to defend and it will be much easier for them to protect the integrity of the ring fence. I understand that in Canada, where they have adopted similar ex gratia payments for people infected through treatment within the health service, they have not made any distinction between those who are haemophiliac and those who are not, for precisely that reason.

In one respect, there is a distinction between the two groups. In talking to a constituent who has been to see me about her own problems, what came across most strongly

[Mr. Robin Cook]

was her sense of isolation. Because she does not belong to one of the normal risk groups, there is no support group with whom she can readily identify. I recently forwarded to the Secretary of State a letter from her which spelled out that sense of isolation. She asked why she was any different from any of the haemophiliacs.

I leave that question with the Minister. I know that he is an honest man and that he has a clear mind. He must be troubled to know that he can advance with a good face no logical reason for excluding this group of people from ex gratia payments that are already available to a much larger group.

I hope that the hon. Gentleman will be able to respond positively to the debate. If he cannot do so, I beg him at least not to dig himself further into the morass of logical inconsistencies by trying to defend the present position. I ask him to return to his Department and to say to his advisers, "You do not have to go out there and defend the present position. We cannot hold this line any longer. Let's get rid of this piece of petty discrimination, which is as much of a nonsense in logic as it is unjust in equity." Were he to convey that message to his advisers in his Department, I assure him that he would be speaking for almost all hon. Members.

12.10 am

Ms. Clare Short (Birmingham, Ladywood): I am grateful to my hon. Friend the Member for Livingston (Mr. Cook) for allowing me to speak in the debate.

I had a constituent who was in this position. She died just before Christmas. She was a lone parent—the mother of four children. I got to know her and the children extremely well during the time that she was ill. I have written to the Department of Health. I met the previous Secretary of State and got nowhere. I confirm what my hon. Friend said: that the reason is terror of future infection through needles, or whatever, not concern about justice for this small group of people.

My constituent, whose life was taken from her by the National Health Service through a blood transfusion, lived out her remaining years in poverty. She was unable to afford the kind of food that would have made the quality of her life better. She was unable to give the kind of treats to her children that she wished to give them. It is insufferable that she was treated in that way by the Government and the country. It is unsufferable, too, that her children have been left with absolutely nothing. She died in poverty and left nothing to them.

The Government will say that there is the possibility of legal action and compensation. If that ever comes to anything, it will be too late for my constituent. It may help her children, but she is dead. The quality of her life was massively diminished because she lived her remaining years in poverty. That is not good enough. I appeal to the Minister to do better than that for other people who are in the same position.

12.11 am

The Parliamentary Under-Secretary of State for Health (Mr. Roger Freeman): I am sure that I speak for the whole House in extending heartfelt sympathy to all those who have suffered by contracting HIV and AIDS through blood transfusions—not necessarily whole blood transfusions; in some cases it has been through partial blood transfusion. Those comments are not trite; they are deeply felt and I am sure that all hon. Members, certainly on the side of the House, feel exactly the same.

The hon. Members for Birmingham, Ladywood (Ms. Short) and for Livingston (Mr. Cook) eloquently expressed their views. The hon. Member for Livingston has campaigned long and consistently for the inclusion of the group that he has described within the provisions that have been made for haemophiliacs. I know that I shall not convince him tonight of the Government's position. His campaign will continue.

I am a great believer in debate being a process of discovery. All sides learn something from parliamentary debate. I do not relish ever being put in an invidious position by having to place too much reliance on logic, thus excluding ex gratia payments to a certain group of individuals when such payments have been made to other groups.

The position was set out by my right hon. Friend the Member for Braintree (Mr. Newton) when he was Minister of State for Health, by my right hon. Friend the Member for Croydon, Central (Mr. Moore) when he was Secretary of State for Social Services and, most recently, by my right hon. and learned Friend the Secretary of State for Health. That was during the period from 1987 to 1990. The hon. Gentleman was right to raise the issue. It always deserves careful attention. I do not believe that additional payments to haemophiliacs—a second payment from the Macfarlane Trust—necessarily change the position, but they prod careful thought again about their predicament. It is tragic that a number of people have HIV infection as a result of receiving blood transfusions, and that some have developed AIDS and have died.

HIV was identified in 1984 and since 1985 we have screened blood in the United Kingdom. We all have great sympathy, of course, for those people and their families—indeed, for all people who have HIV and AIDS. It is estimated that 113 people in the United Kingdom have been infected with HIV through blood transfusions. Of those, 17 were transfused, we know, in the United Kingdom, 35 were transfused abroad, and for the remaining 61 the place of transfusion is unknown. According to a completely different source of statistics, including some overlap, the numbers of reported AIDS cases among transfusion recipients are 21 transfused in the United Kingdom, of whom 15 have died, and 26 transfused elsewhere, of whom 17 have died. It may be that some of the deaths are attributable to the patient's original illness and not to AIDS.

Fortunately, as medical and scientific knowledge about the screening of donors and testing donations has increased, the risks of HIV being acquired from blood transfusion in this country have been reduced considerably. I understand that the risk is now very remote indeed—about one in 1 million. However, we should not pretend that we shall ever get to a stage at which there is no risk from medical procedures.

The hon. Gentleman referred to haemophiliacs. The Government and the whole House acknowledge the tragedy of those who received infected blood products prior to 1985. Some 1,200 haemophiliacs were affected. I hope that the hon. Gentleman agrees with me that there is no doubt that, to an extent, haemophiliacs suffered a double tragedy. They had a disadvantage—there is no

denying that—before the accidents occurred. The establishment of the first and second Macfarlane Trusts acknowledged the tragedy of this group. Both, of course, were ex gratia payments: they were not compensation payments in the strict sense of the term. They were not in lieu of the legal right to sue. Indeed, that right remains.

The Department of Health maintains that there was no negligence. One is not denying the consequences, but I stress again that the Department of Health believed that it was offering the best available treatment, in good faith, at the time. Tragically, we know now that, prior to 1985, the consequences were not what was desired.

I presume that, although he did not say so, the hon. Member for Livingston would naturally extend his argument about blood transfussions to whether the transfusion occurred in the United Kingdom or abroad. It is interesting to note that the majority of cases in which we know where the transfusion occurred were abroad. Secondly, he would presumably extend his argument to all those who are living here. Thirdly, he would extend the provision without relying on exhaustive proof of the cause of HIV—it is very difficult to prove; and he would also extend his argument without seeking to ascertain if the death would have occurred anyway—again, something that is very difficult to prove.

So one assumes that the group to which the hon. Gentleman is referring is a comprehensive one. I do not think that the hon. Gentleman would seek to subdivide that group in—to use his own expression—any logical way, so I think that one must cast doubt on an estimate of £1 million. I do not seek this evening to debate the cost of any settlement in relation to this group; I simply put it to the hon. Gentleman that, even among those who have suffered through transfusion, it is very difficult to divide and subdivide, using his criteria, into categories which are or are not deserving.

I believe that it is very difficult for the hon. Gentleman honestly and logically to find any resting place in his argument. In terms of what he is essentially arguing for —his universal no-fault scheme, whether there is negligence or not, for medical accidents—I do not believe that there is any comfortable resting place for the hon. Gentleman. I put four examples to him. There are clearly cases that fall into the category of those who acquired HIV through skin grafts or organ transplants; the tragic cases of those who suffer serious side effects from the treatment of leukaemia; those who suffer brain damage as a result of anaesthesia during operations; and those who suffer post-operative complications having undergone neuro-surgery. I could go through a long list of categories for which other Members of Parliament would argue lucidly that there was real disadvantage and financial hardship as a result of an accident whether or not there was negligence.

Although he has argued his case very coherently, in his heart of hearts I am sure that the hon. Gentleman would not wish to draw a hard and fast line and say that we are dealing only with one particular group of individuals. If he were standing at this Dispatch Box, he would then be faced with exactly the same arguments from other hon. Members, arguing just as eloquently, to extend to the final resting place the argument he has put tonight, which is that there should be a universal no-fault scheme, whatever the cause and whether or not there was negligence.

I have looked at the vaccine damage compensation scheme again, anticipating that the hon. Gentleman might raise it—and he would have been right to do so. That scheme, which provides autom families whose children have suffe damage, is justifiable because it interest that all children should small but significant risk is a pr taxpayer should bear to ensure and acceptance of our vaccinatio

The argument for no-fault preserved right to sue—I understa a Committee in the House the argued the case for no-fault compe sue—would have the benefit of s to relieve financial pressures. I st system, which is the only logical r Gentleman's argument, would lea and bureaucratic tariff, which wou or discouragement to suit.

In cases of admitted negligen erapy where, sadly, there have l recent years—the better system is by the health authority concerned, ultimate out-of-court settlement That would be a fairer and more

In cases of no or disputed negli have to rely on our free National social security system for suppor affected party to sue. That is a gene as I am sure do all right hon. and h will soon be an effective treatment

Mr. Robin Cook: First, the diff courts as a means of recompense a the time scale of the court synchronisation with the time s sufferers—13 out of 32 people have although I am tempted to follow t about no-fault compensation, let Government, in their wisdom, hav haemophiliacs who are infected thr the NHS. The point of the deba should be a no-fault compensatic who suffer cryogenic diseases or NHS, but about how, having crea Government can exclude from it numbers.

Mr. Freeman: I accept that time have HIV, although there is n sentence hanging over them. That it is one of the pressing arg compensating the haemophiliac infected. It is a difficult issue, as on behalf of the taxpayer an act of charity to one group of suffere however logically the hon. Gentlem cause—and the common cause is l

The hon. Gentleman will conced place for a Minister in terms of dr if he were to move the line case by c already been drawn to relieve the f group which has suffered doul disadvantage, as it were. There is n until we have a relatively genero compensation scheme, and I do not be in the best interests of the Nati

[Mr. Freeman]

I genuinely meant what I said at the outset: I do not believe that these debates are merely a pro forma exercise to enable an hon. Member to raise a constituency matter for the benefit of the media. There is a process of discovery in all these debates, because thought goes into their preparation and answer. I shall study the *Official Report* of the debate and bring the matter to the attention of Ministers at the Department of Health. It is only fair that I should do that, the hon. Gentleman having asked me to do so.

I cannot give him the assurance for which he asked, and he would not expect me to do so, but I join him again in expressing sympathy to those who have suffered. They have the sympathy of the
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However, it would be
the hon. Gentleman's fac
no prospect of any hop
individuals. Of course we
the arguments, and I
sympathetically as I can

Question put and agre

Adjourned accordingly
o'clock.

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