Government. It is a very technical matter and I shall give a brief explanation. The amendment would add a reference to two sub-paragraphs from the schedule to the Roads (Scotland) Act 1984. Those two sub-paragraphs need to be repealed because of a prospective repeal that the Government have in mind of Sections 30 and 80 of the Explosives Act 1875. When those sections are repealed, the two sub-paragraphs in question in the 1984 Act will no longer be relevant since they amend those sections in their application to Scotland. The amendment is desirable in order to keep the statute book tidy. I beg to move.

Lord Haskel: It seems sensible that this opportunity be taken to deal with what is a technical matter. The amendment is therefore acceptable to the Government.

On Question, amendment agreed to.

Schedule, as amended, agreed to.

House resumed: Bill reported with amendments.

Haemophiliacs and Hepatitis C

4.31 p.m.

Lord Morris of Manchester rose to ask Her Majesty's Government what new help is intended for people with haemophilia who were infected with hepatitis C in the course of NHS treatment or, in the case of those who have died, for their dependants.

The noble Lord said: My Lords, there is a deep sense of injustice among people with haemophilia and their families, one of the most vulnerable groups in Britain today. The tragic story of three brothers explains why.

All three inherited haemophilia, a life-long bleeding disorder that requires continuous medical treatment. Two of the brothers were infected with HIV by contaminated blood products used in their NHS treatment and died of AIDS-related illnesses. They received financial help from the Macfarlane Trust, funded by the Government, and were able to make provision for their families. The third brother escaped HIV infection but was infected with the hepatitis C virus (HCV), also by contaminated blood products used in his NHS treatment, and died of liver failure. For him there was no financial help. He went to his grave unable to make any provision for his family.

Each of the three brothers had become terminally ill and died from the same cause: contaminated NHS blood products. But one was denied the help given by a government-funded trust to the other two. That contrast in treatment not only suggests but shouts of injustice.

To date the Macfarlane Trust, set up by the last government in 1989, has been given £80 million to disburse in *ex-gratia* lump sum awards, regular monthly payments and one-off grants to 1,200 people with haemophilia who were infected with HIV and their dependants. It was an official acceptance of moral responsibility for their loss and hardship. There was then and is now exactly the same moral responsibility for loss and hardship among those infected with HCV. But nine years on they are still waiting for parity of treatment with other haemophiliacs who were infected at the same time and by the same route. It has been argued that to compensate them would take money away from patient care in the NHS. That is not just to get the wrong end of the stick, but the wrong stick. For the payments made in the HIV cases, including those for the dependants of people who subsequently died of AIDS, came from contingency monies, which is what the Haemophilia Society, on grounds both of equity and social justice, is seeking now for the hepatitis C victims. The society simply wants the terms of reference of the Macfarlane Trust to be extended to include them.

Measured against the pain and suffering endured, help on the scale made available by the Macfarlane Trust is by no means excessive. The HIV and HCV infections among haemophiliacs have been described as the gravest treatment disaster in the history of the NHS. Blood products have been treated against HIV and HCV since 1986; but this came too late for the UK's haemophilia community of 6,000 people, almost all of whom had been infected by then. Some 4,800 were infected with HCV and 1,200 with HIV. Even more sadly, some were infected through their NHS treatment with both.

Hepatitis C attacks the liver and is potentially life-threatening. Current medical opinion is that up to 80 per cent. of people infected will develop chronic liver disease. Of these up to 20 per cent. will develop severe liver problems such as cirrhosis, many of them liver cancer. Based on death certificate information, mortality from liver disease is now 16.7 times higher for haemophiliac males than for the general population and 5.6 times higher for liver cancer. Over 90 haemophiliacs have already died as a result of being infected with hepatitis C. Many others are gravely ill and have lost jobs, homes and sometimes family in consequence of their infection.

To sustain its call for parity, the Haemophilia Society has drawn the attention of the Department of Health to the findings of in-depth research into the problems and needs of people infected with HCV who are not yet seriously ill. The research examined the overall impact of HCV on them and their families. If Ministers have not read its findings, I hope very much that they will do so. It is a most disturbing social document. Families are shown to be trying to cope with sickness, loss of income, loss of jobs and loss of independence, while having to live with what they know may soon prove to be a terminal illness.

The most daunting worry of those infected is not knowing which of them is likely to develop chronic liver disease and perhaps cirrhosis or cancer of the liver. While many will be spared, they all have to face grave uncertainty about their future and to suffer the stress and anxiety it creates. Regardless of their health now, all who are HCV antibody positive will be unable to gain life insurance except at prohibitive rates, while those with young families or other dependants are denied the peace of mind that goes with knowing that, if they become terminally ill, their dependants will be provided for.

[LORD MORRIS OF MANCHESTER]

The research also makes plain the cost, even to those whose health is not yet very seriously affected by the infection, of having to reduce their hours of work, give up opportunities for promotion, take less demanding jobs and give up working altogether.

The enervating effects of hepatitis C make many physical and mental activities impossible. As well as losing income, most of those affected also face increased expenditure on medicine and dietary requirements. The overall impact of being infected varies between individuals, but inevitably many families and relationships are pushed to breaking point. For those whose health becomes progressively worse the problems multiply. Having haemophilia is bad enough; having to cope with another life-threatening disease can be a crushing burden.

Their most urgent need—and urgency was never more urgent, for the death toll rises with every passing month—is for financial help to loosen the vice of reduced income and increased costs. Not to recognise this is to increase their vulnerability and, as one HCV-infected haemophiliac after another has made clear to me since this debate was announced, leaves people who are doubly handicapped and doubly disadvantaged in double despair.

This is well recognised abroad, not least in countries much poorer than ours. Among our closest neighbours here in Europe, in Ireland the government give financial help; so too, among others, do the Italian Government.

It was stated for the Government when the Green Paper on welfare reform was published on 26th March, both in your Lordships' House and in another place, that their

"commitment to the vulnerable is non-negotiable".

That declaration raised hope nowhere more visibly than in the haemophilia community. For no one who speaks to those with HCV infection, more especially those now trying to cope with chronic liver disease, can doubt their vulnerability nor that of their dependents. Of course, they know that new Ministers cannot always act as quickly as they would like—and I am delighted that my noble friend Lady Ramsay is to reply to today's debate, but the declaration of 26th March gave the haemophilia community new hope which I trust will now soon be justified by an end to the cruelly discriminatory treatment of people whose plight the word "vulnerable" might have been invented to describe.

Meanwhile I shall be grateful to my noble friend if, while conveying to Ministers my appreciation of their decision to fund until next April the provision of recombinant Factor VIII, free from the risk of blood-borne viruses, for haemophilia patients under 16 and those newly diagnosed, she will also make plain the deep concern felt on both sides of both Houses of Parliament about the cut of £88,000 in the department's funding of the Haemophilia Society for the current year. Much of that funding was awarded to the society under the previous administration to cover the costs of providing special advice and support services for haemophiliacs with HCV infection. The need for those services is no less today than it was then and I hope a decision that seems totally inexplicable to the haemophilia community will be reversed.

In none of the parliamentary campaigns I have been closely involved in over 34 years in Parliament—even thalidomide and that for statutory recognition of dyslexia—have I had so strong a sense that no campaigning should have been necessary to right so obvious a wrong. Enormous cross-party backing has been given by MPs to Motions calling for parity of treatment. As each successive Motion has shown, the issue is regarded not as one of Right and Left, but of right and wrong. It is just as demonstrable that, given the nod by Ministers, both Houses could end this huge scandal within an hour.

For all of us know that in truth anyone claiming to see any difference in principle between the claims of those infected with HIV and HCV will have no difficulty whatever in spotting from afar the smallest needle in the biggest haystack.

There are many celebrated texts on the undoubted wrong of delaying justice. My choice today is Magna Carta which famously declares,

"To no one will we delay right or justice".

Recognition that justice delayed is justice denied was never more relevant than it is today in the small community for whom I speak in this debate. It hopes profoundly that this opportunity will be taken to justify the new hope given to them as vulnerable people by the ministerial Statements in both Houses of Parliament on the 26th March. But if its campaign has to go on I am in no doubt—nor should anyone else doubt—that go on it will until right is done.

4.45 p.m.

Lord Winston: My Lords, the House will be grateful to my noble friend the Lord Morris of Manchester for introducing this important short debate. I have no wish to detain the House at this late hour this afternoon and I shall be brief. However, one cannot escape the terrible fact that death by liver failure or liver cancer is a particularly horrible end. There is a slow inexorable decline, with severe fatigue and malaise. Patients with these viruses are frightened about their marital relationships. They are concerned about having sex. At the same time, paradoxically and ironically, they suffer loss of libido. They feel sick, have no appetite and lose weight. If they have liver cancer often they have severe pain that is quite intractable. The end is a mixture of a decline, with mental confusion and finally coma. It is true that occasionally there are expensive opportunities for liver transplantation and dialysis, but most of these merely palliate the condition and offer control for a certain time.

As the noble Lord has eloquently pointed out, there is no difference between HIV and hepatitis C that is produced in this way. The cause is the same, a virus, and it comes from the same source, blood products. Yet, sadly and oddly, there is discrimination by the Government. With one exception, there is no logic to it. The exception, sadly, is mere expediency. No government in this situation, quite understandably, want to create a precedent. Therefore, my noble friend who is to reply this afternoon, although an honourable person, sadly is here to defend what is probably indefensible. The precedent is already there. The fact is that patients with HIV have already been compensated to a large extent by government action. A decision on the basis of expediency is not moral.

This Government came to power on a wave of moral feeling and with moral promise. The very National Health Service to which these people owe their treatment, and in this case its unfortunate outcome, is based on a moral promise of which the Government are rightly proud. It was founded on a moral principle. We on this side of the House are proud of the moral principles of this Government. But moral principles not only carry credit and bring public support but impose obligations and responsibilities. There is a price as well as an advantage in taking the moral high ground. The alternative is potentially worse. If these patients eventually resorted to litigation it could prove more expensive; certainly it would be more damaging to them as individuals and potentially more damaging to the Government.

I believe that the Government need to consider more seriously the alternatives for genetic disorders like haemophilia. Here I declare an interest having been involved in genetic disorders and research into their prevention for 10 years. The fact is that it is possible, using modern embryological methods, to screen the families which are at risk and some of whom have been affected with this virus. Undertaking pre-implantation genetic diagnosis is no longer at the research stage. Indeed, in my institution the research approval on the basis of an ethical approval is now withdrawn because it is no longer seen to be a research procedure. It is a clinical procedure. That procedure costs £2,500, and the alternative cost perhaps of treating somebody year after year with hepatitis, or indeed just for haemophilia, and the blood transfusions is around £15,000.

The strange thing is that, although the Government came to power with a promise to abolish the internal market, it is a lottery as to whether these patients are treated by the NHS. In some parts of the country they do and in other parts they do not; but the NHS is not funded through local taxation but through national taxation, and there needs to be a national policy. I understand that the noble Baroness, Lady Ramsay, cannot give us any undertaking this afternoon, but I hope that she will take back this message to the Department of Health and to the Government. I have a suspicion that on all sides of the House there will be unanimous support for a manoeuvre of this kind.

4.51 p.m.

Lord Addington: My Lords, I suspect that in a very straightforward debate on a straightforward problem like this, with so much expertise in front of me, there is little else I can do but agree, so I will proceed as quickly as I can. As has been stated, there is a precedent for this: a treatment for haemophilia has led to a viral infection. As has also been said before, this has happened with the AIDS virus, which may have been the causing virus, if I might try and use the correct term in such learned company. That has led to a variety of illnesses, sometimes resulting in death. With hepatitis C the same principle applies, except that the process is slightly different because the virus is different.

The noble Lord, Lord Winston, has just given us a description of how harrowing and damaging that process is. It might take longer, according to the notes that have been provided for me on this, but the principle is still there; the worry is still there; and ultimately an untimely death is still there. If we could do it once, then we can do it twice. The only real debate that is going on today is as to when compensation will be paid, because the legal precedent is there. Although we do not have our usual battery of heavy guns firing from the legal world, we all know that they will win their case in the end; even if it is not here it will be in another court—perhaps the European Court of Human Rights. It will happen. We must do something. These people are suffering because the system got it wrong. The system which said, "We will look after you" got it wrong. Whether or not the sufferers are taxpayers, they are entitled to expect the system to take care of them. And yet, that is the system which gave them a killing disease. Surely they are entitled to some support.

The Minister may not be able to give us a positive answer today but she knows as well as everybody else that the Government will have to do something. Delay which, because of the dead hand of the Treasury, lies upon this problem as it lies upon everything, will result only in greater suffering for those who have the condition. This is not good enough, and hopefully a new Government with such a huge majority must be able to overrule the Treasury, so that the tail does not wag the dog. That is something which must be reversed in this case and action should be taken as soon as possible. We must not wait until after long and expensive legal cases have taken place. We are speaking not just in terms of money but in terms of people's lives. Ultimately people's lives must be more important.

We have heard that it is comparatively cheap to take action by screening before the condition occurs. A little investment is required. I do not know how many times and on how many issues I have said that we should act now rather than pay later. It is invariably cheaper in the long or even medium term to put a little money up front. I hope that the Government will do something. It may be too much to hope that the Minister can answer now. However, I like to think that hope springs eternal, and that we shall hear something soon. The issue will not go away. The Government will eventually have to give ground, as sure as eggs are eggs. The legal precedents are there. I hope that we shall soon hear some positive information.

4.55 p.m.

Lord Alderdice: My Lords, we are all in the debt of the noble Lord, Lord Morris of Manchester, for introducing the debate. As he rightly and eloquently said, in many ways it is not a complicated argument. It is extraordinarily straightforward and simple. Therefore, I shall not take up much time as the issues have been laid out clearly by my colleague, and the noble Lords, Lord Morris and Lord Winston.

[LORD ALDERDICE]

There are three specific issues. First, there is the moral question. Those of us who come into the caring professions give an undertaking that we shall try to do the best we can for those under our care, but that at the very least we shall not make their situation worse. Sometimes that is a more onerous undertaking than at first appears. Nevertheless it is an entirely proper one. A relatively small group of people, whose care was undertaken in good faith, has suffered terribly. There is a moral question there. Those who undertook the care, out of no real cause of their own, did harm. When we do harm it is incumbent upon us to put the harm right as best we can, or at least make some compensation.

The second issue has been spoken about extensively. I refer to the fact that this group of people is not unique. Others suffer from haemophilia and have already been compensated for contracting HIV in precisely the same circumstances. In that context, it is incomprehensible that at the start of this process the decision did not ensure that those who were infected would be compensated. It is extraordinary that there was a decision to compensate one group and not another.

My noble friend describes hope as springing eternal. I believe that we have gone as far into "eternal" as we should have to do. The hope should not have to spring any longer; it should be responded to.

Thirdly, we should not forget that those who suffer from haemophilia have done so from before birth. They have suffered considerably already, through no fault of their own. To suffer again at the hands of those who were doing their best to care for them is an assault almost too great for anyone to be expected to bear. But to add to that by giving no compensation and steadfastly refusing time after time to recognise their predicament and to give due compensation—while on the other hand doing so for others who suffer the same type of disorder—is quite extraordinary.

We are not talking about large amounts of money in the greater scheme of things. In my own small province of Northern Ireland, we are speaking of some 76 haemophiliacs. Let it be said that probably one-third of those who are suffering from the disorder are suffering from an infection with HCV.

Apart from the issue of compensation, a further problem arises. I raise the issue with the Minister and appreciate that she may be unable to respond immediately. It has been decided that the care of some of the patients will be continued at the Royal Victoria Hospital in Belfast, but that the care of others in a different age group will proceed at the Belfast City Hospital. However, the hepatologist will remain at the Royal Victoria Hospital. Therefore, some of the patients will be cared for partly in one hospital, partly in another and then back to the first.

A small group of people are suffering from a disorder which is not widespread and from an infection which is less likely to be attended to by the media and therefore they find themselves suffering all the more but quietly, painfully and in a very upsetting way. It is the will of your Lordships' House and it appears to be the will of the other place that this matter should be dealt with speedily. I hope that the Minister can give us some reassurance on the matter, if not immediately at least within a timescale when the matter will be acted upon.

5 p.m.

Lord McColl of Dulwich: My Lords, the noble Lord, Lord Morris, brings to your Lordships' House today a cause which he has consistently championed with vigour in another place for many years. For that we must be genuinely grateful. Perhaps surprisingly, the subject of today's debate has not been aired with any regularity in your Lordships' House either in this Parliament or the last. Few who have listened to the noble Lord can fail to be moved by what he said. I agree that Ministers have a duty to consider with the greatest care what options might be available to assist this most unfortunate group of individuals. Those individuals find themselves chronically and sometimes gravely ill as a direct result of treatment they received from the National Health Service.

The noble Lord is right in saying that the case he is advancing is essentially a moral issue. It is not a case which rests on any claim of negligence. The people who received contaminated Factor VIII during the 1970s and early 1980s received the best treatment available in the light of medical knowledge at that time. The techniques followed today to test and screen blood products were not available in those days. Until 1991, there were no tests to detect hepatitis C in blood donations. Indeed, very little was known about hepatitis C. The Department of Health did not know and could not have been expected to know the nature or extent of the hazards in those imported blood products.

In describing this as a moral issue, I must acknowledge—and I hope that I do not anticipate the Minister's remarks too closely—that it is a moral issue of a particularly complex kind. It is a matter with which Ministers in the previous government wrestled for a considerable time. That is why, for all the understandable frustrations felt by those who are looking for answers from the Government, I do not wish to criticise the Minister or her colleagues too harshly for delaying their decisions. The problem as to whether this particular medical accident—namely, the inadvertent transmission of a potentially fatal virus during routine treatment for haemophilia—is of sufficient gravity to merit exceptional recognition by the Government in the form of financial assistance for the victims.

As the noble Lord mentioned, the previous government recognised the exceptional suffering and hardship of the thousand or so haemophiliacs who were accidentally infected with HIV when being treated with Factor VIII blood product. There were at that time very good reasons for regarding that particular group of individuals as being unique and, therefore, worthy of a unique kind of compensation. What possible reason then could there be to withhold financial help from the other 3,000 or so people who contracted hepatitis C under exactly the same circumstances?

We have heard from the noble Lord how devastating can be the effects of hepatitis C on those who succumb to it. Haemophiliacs who succumb to the virus are many times less likely to respond to treatment than non-haemophiliacs; and hence many times more likely to die from the condition. Indeed, some have already died. Like those who have died of AIDS, they have left relatives to cope without them. Others are suffering from the debilitating effects of hepatitis or cirrhosis, unable to work properly or unable to work at all and, indeed, unable to lead anything like a normal life. On the other hand, others have responded to treatment and are able to carry on with daily living in an almost normal fashion, free of all symptoms. The prognosis for these people is good.

One of the considerations which led Ministers in the last government to take the exceptional course of assisting HIV patients was the argument that this would not lead to similar claims from other groups. That in itself is no reason for Ministers not to entertain this further claim. As I have said, they should certainly do so. But it is a fact which serves to flag up a fundamental principle which applies to treatment delivered under the NHS—namely, that when unwanted accidents do happen (and noble Lords should note that I am talking about accidents, not acts of negligence) there has never been any question of this triggering compensation from the Government. Any medical or surgical treatment carries risks and hazards, however expert the level of care. Sometimes things go wrong that are no one's fault. So the question must be asked in relation to victims of hepatitis C: what distinguishes their accident—serious and distressing as it is—from other medical accidents? If compensation were to be paid to them, how could we resist paying compensation to someone who might have contracted a virus during a stay in hospital; or someone who died because an ambulance was unable to reach him quickly enough?

We are into the realms of no-fault compensation—an idea which has been batted around the NHS for a number of years and which, as a concept, appears to be delightfully simple. If something goes wrong, it does not have to be anyone's fault. You do not need to prove negligence. You will be compensated anyway. But if one looks at this idea rather more closely, all manner of anomalies rise to the surface. In practice, we would encounter exactly the same kind of difficulty distinguishing the cases which qualified for compensation from those which did not. Such a scheme would be unworkable and unfair. We would be institutionalising a culture of claim and counter-claim, of finger pointing and finger wagging—a profoundly unhealthy culture which I believe would be deeply damaging to NHS morale.

If there is a genuine case to be made for hepatitis C victims—and there may be—it must be on a basis which distinguishes that group of people pre-eminently from all others. I can think of some good arguments for doing so. Not least is the fact that the infection from which they are suffering arises from a hazard whose very existence was not known about at the time the treatment was administered. It was not, in other words, "one of those accepted risks one took". It marks them out as a discrete, self-contained group. It has resulted, for many of the victims, not in a mildly annoying physical weakness but in a truly terrible deterioration in the quality of life, and sometimes no life at all. Those are the things I ask the Minister to reflect upon.

It should not be a question of money. Whatever the Minister's conclusions on the matter, I hope she will not be side-tracked by worries relating to the erosion of the health budget. Funding for a special payments scheme should come from the contingency fund, which has already been mentioned, exactly on the lines of the Macfarlane Trust for HIV victims. What I hope she will say about the health budget is that substantial, meaningful money is being directed towards research into our understanding of hepatitis C, its transmission, its prevalence and the evaluation of new treatments. There is a compelling need to advance our state of knowledge about this still poorly understood condition.

This has been a useful and timely debate, and I look forward with interest to the Minister's reply.

5.10 p.m.

Baroness Ramsay of Cartvale: My Lords, like other noble Lords who have spoken, I am grateful to my noble friend Lord Morris of Manchester, who has such an outstanding and distinguished record in furthering the cause of the disabled and other groups afflicted by serious health problems, for the opportunity he has given us today to discuss an issue of such importance and concern to those involved.

I express my appreciation to those who have contributed to this debate from such an impressive breadth and depth of professional and personal experience. The Government are, of course, aware of the widespread and deeply felt concern inside and outside this House and another place for the plight of those patients with haemophilia who were inadvertently infected with hepatitis C through blood products prior to the introduction of viral inactivation processes in 1985. It is a concern which we very much share. I can assure my noble friend Lord Morris that Ministers are fully aware of the research reports to which he referred on the effects of HIV infection on haemophiliacs and their families, as well as of the first-hand accounts from sufferers.

The many representations both from those affected, and from others on their behalf, not least the Haemophilia Society, and of course the eloquent accounts given here today by many noble Lords have provided a clear, poignant and harrowing picture of the difficult situation which many of those infected may have to face. Indeed, it would be almost impossible to fail to sympathise with this group, or with the distress of any patients who, already having to cope with one condition, find that the treatment for that disorder has given them another. Many noble Lords have made that point today. I do not believe anyone would disagree with that. The noble Lord, Lord Alderdice, referred to the problem in Northern Ireland. I cannot comment on that because the Department of Health is not responsible for that. However, I shall certainly draw his comments to the notice of the relevant authorities.

Many of the representations which we have received have raised the issue of extra help, mainly in the form of financial assistance, for those directly affected. In some

[BARONESS RAMSAY OF CARTVALE]

cases—as indeed is the case in our discussion today—help has also been requested for the dependants of those who have died.

I am sure all those present are aware that the question of some form of special payments scheme was one of the points raised with my right honourable friend the Secretary of State for Health when he met with the Haemophilia Society last September to hear their first-hand accounts of the effects on the lives of those with haemophilia and their families, of contracting hepatitis C. At that stage my right honourable friend told members of the Haemophilia Society that he would consider the matter very carefully and would write to them.

We know that many of those who have made representations on this subject are disappointed that this has not yet been possible, and that we have not, as yet, been able to announce our conclusions on this matter. The Secretary of State has written to the Haemophilia Society explaining the delay. In those letters, he made clear that the issues involved were very complex—as the noble Lord, Lord McColl, explained eloquently and with authority—and that the emergence of potential problems relating to new variant CJD had made the position even more complicated. Accordingly, the matter was still being considered. That remains the position. I can, however, assure the House that we shall announce the outcome of our deliberations just as soon as we are in a position to do so.

At this point, perhaps I may deal with a point made by my noble friend Lord Morris about the grant to the Haemophilia Society. Section 64 grants are aimed primarily at taking forward the department's objectives through the expertise and initiatives of voluntary organisations supported by time-limited grants. The department is of the view that that is best achieved through project grants. Some £60,000 of the society's grant last year was in respect of the final year of a three-year project. The Haemophilia Society did not submit another project grant application for this year, although we understand that it is currently working on some new proposals. I can assure my noble friend Lord Morris and the House that we shall be happy to consider any new application from the society.

Before looking at one or two of the factors which make this issue such a testing one, I wish to say a few words about the vital importance of blood and blood products to the NHS. First, I should like to stress the fact that, despite the very sad subject of this debate, our UK blood supply is considered one of the very safest in the world. It is important that patients and the wider public know that. It is also very important that donors understand that we need their blood more than ever before. The need for blood for transfusions increases year on year. But that need has now grown even faster, because the NHS is treating more patients than ever before, carrying out more surgery and starting a major drive to reduce waiting lists. I therefore strongly urge those who are able to give blood, to do so, thereby helping the NHS to do its job. Giving blood is a quick and easy way of making an amazing contribution to society—that of helping to save lives.

I hope that patients will also be reassured from recent precautionary steps announced by the Department of Health in relation to the theoretical risk from new variant CJD, that the Government have taken, and will continue to take, all reasonable steps to ensure the safety of blood and blood products.

That applies of course equally to all blood products, including Factor VIII and Factor IX, the clotting agents which many haemophiliacs need to help to control their condition. These products have helped to transform the lives of people with haemophilia by enhancing their quality of life, and also greatly increasing life expectancy. The provision of these products by the NHS has transformed haemophilia care. Greater longevity in the haemophilia community, the increasing use of prophylactic care and new developments—such as the advent of recombinant (synthetic) alternatives to the human plasma-derived clotting agents—together mean that overall spending on haemophilia care is rising at about 10 per cent. per year.

Spending on individual patients will average between £20,000 and £30,000 each year, and for a few patients this may increase to as much as £500,000. I hope that that demonstrates the commitment of the NHS to people with haemophilia. I am grateful to my noble friend Lord Morris of Manchester for his expression of appreciation for the decision made by the Government that recombinant Factor VIII be made available to all children under 16 and to new patients. Sadly, I understand that approximately 80 per cent. of haemophiliacs worldwide have no access to any treatment whatsoever.

My noble friend Lord Morris of Manchester mentioned that the Irish Government pay what he called compensation to those who have contracted hepatitis C. It is for each country to make its own decisions in the light of specific circumstances, but most other countries have decided not to make payments to those who have contracted hepatitis C.

I echo what the noble Lord, Lord McColl of Dulwich, said. Those blood products were undoubtedly the best treatments available for people with haemophilia at the time that those who are infected with hepatitis C contracted the infection. Without those treatments, many people with haemophilia would not be alive today, and, if they survived, it would only be with significant and crippling damage to their health.

At that time, however, all the safety processes currently in operation had not become available. I am thinking specifically of the viral inactivation procedures introduced in 1985. Nor was there, at the time, any test available for detecting hepatitis C in blood donations. Such testing was introduced in 1991 as soon as reliable blood screening tests first became available. These are very important points to bear in mind when considering the issue before us today.

My noble friend Lord Morris and several other noble Lords made the point that this position could be said to apply equally to those who contracted HIV via the same route, and yet there are schemes offering financial support to those people. He and others asked what difference there was between the position of those patients and those who contracted hepatitis C. The special payments scheme for those who contracted HIV in this way, was set up in recognition of the quite exceptional circumstances involved. The unique features of the HIV claim included the stigma attached to HIV and AIDS at the time the decision to compensate was made; the public revulsion surrounding all aspects of the virus at that time; and the fact that the condition was easily transmissible to the spouses of those affected. Many of those infected and their families, including the children, found themselves totally ostracised within their communities.

The progress of the infections also differs. Past reports on clinical aspects of hepatitis C infection indicate that the natural history varies widely. About 20 per cent. of those infected may recover completely; the remainder develop chronic infection. Some of those with chronic infection are asymptomatic, some experience vague symptoms, such as fatigue, and some will have the extreme, horrible end conditions which have been described. These complications may take up to 30 years to develop.

I am pleased to say today that two new types of treatment for hepatitis C have recently become available which are showing impressive results. These are Interferon and effective anti-viral drugs. We understand that the evidence so far suggests that these can virtually suppress the virus in many cases and in a significant proportion of cases eliminate it altogether. These are truly remarkable developments which could change significantly the daily lives and future health and prospects of many of the people whom we are discussing today.

We should also remember that haemophiliacs are not the only patients who, despite receiving the best treatment available at the time, are claiming special help from the Government because of the consequent effects of that treatment. Those groups include non-haemophiliacs who have contracted hepatitis C through blood transfusions. We need to think very carefully whether it would be fair or equitable to introduce new help which was not available to all these groups equally. We also need to consider carefully the best use of resources available to the National Health Service.

I note the point made by my noble friend Lord Winston about the importance of research into genetic disorders and of the need to co-ordinate service provisions. I also note the point made by the noble Lord, Lord McColl, on the question of research into hepatitis C.

Many have indicated that this is a straightforward issue. I hope that what I have said, which is confirmed by what the noble Lord, Lord McColl, so eloquently said, demonstrates that this is by no means a simple or straightforward issue.

I appreciate that the Government's response to the request for help for those infected with blood products is eagerly awaited. As I explained, we will announce our conclusion as soon as we can. I repeat that I am exceedingly grateful to my noble friend Lord Morris in particular and to all noble Lords who contributed to the debate. I can assure them that the Government will consider all their points very carefully.

House adjourned at twenty six minutes past five o'clock.