Previous Section Index Home Page

14 Nov 2001 : Column 270WH

Hepatitis C

11 am

Dr. Brian Iddon (Bolton, South-East): I am pleased to have secured this important debate, in which I wish to draw the attention of Parliament and the people to hepatitis C, a serious condition that affects the health of hundreds of thousands of our fellow citizens and is likely to become at least as serious as the onset of HIV/AIDS a few years ago. The Government do not appear to regard the situation as that serious; this is an opportunity for the Minister to clarify their position.

It was not deliberately planned, but yesterday the Haemophilia Society and the all-party group on haemophilia held a reception in the House, and today they are holding a photo call on College green to mark their "carpet of lilies" campaign. That is why some of us are wearing lilies on our lapels to represent the fact that more than 1,000 haemophiliacs have died as a result of contracting the HIV and/or hepatitis C viruses, through receiving contaminated blood during national health service blood transfusions. I shall not say much about that issue, but I am sure that other hon. Members will cover it adequately.

The hepatitis C virus, HCV, was first identified as recently as 1989. It infects the liver but it can also cause damage to kidneys and white blood cells. HCV is an enveloped ribonucleic acid of the flaviviride family, which is believed to have a narrow host range. It is incredibly resilient, being capable of surviving in dried blood for long periods. The incubation period for the virus is commonly six to nine weeks, although it is frequently longer. It can lie in the body without causing obvious disease for a lifetime, and infected people can put others at risk without realising the dangers. HCV has a high mutation rate and it is thought that six common strains exist, each with many sub-strains. It is possible for a person to be infected by more than one strain at the same time. The strains have the ability to mutate spontaneously, which is partly why it has not been possible to develop vaccines to combat the virus.

The World Health Organisation estimates that about 170 million people worldwide are infected with the HCV virus. However, the epidemic is fairly new to the United Kingdom. It probably began in the late 1960s, but a large cohort of people is believed to have become infected in the early and late 1980s before needle exchange schemes and other interventions to reduce transmission of the virus became widely available. The official figure for the number of infected people in the UK was recently given in a parliamentary answer in the other place, which stated that there were 300,000 people with chronic carriage of the virus. However, specialists working in the field believe that the true figure may be much higher--possibly 500,000. That figure was quoted in an article in *The Independent* in July 2000. In the same article, the former Surgeon-General of the United States, Everett Koop, said:

> "We stand on the precipice of a great threat to our public health . . . It affects people in all walks of life, in all states, in every country . . . and, unless we do something soon, it will kill more people than AIDS."

HCV is a growing concern, as its transmission through contaminated blood is incredibly common. Misconceptions, rumours and misinformation are the greatest allies of HCV infection because, like the AIDS virus, it carries a stigma.

14 Nov 2001 : Column 271WH

In 1999, HCV killed 743 people in England. The provisional figure for 2000 is 1,042, but most deaths from HCV-related complications are not recorded with HCV as the cause, so the true figure for deaths caused directly or indirectly by the virus must be much higher.

In 15 per cent. of cases HCV disappears spontaneously, but the other 85 per cent. of those infected will proceed to develop a long-term chronic illness. HCV is the biggest cause of chronic liver disease in the western world and is known to exacerbate the severity of underlying liver disease when it co-exists with other hepatic conditions. Some 30 per cent. of victims will contract cirrhosis of the liver over a 30-year period, and of those some 5 per cent. every year will develop liver cancer and 2 per cent. will suffer liver failure. Even among those less severely affected the symptoms, which include fatigue, depression and lethargy, can be debilitating and all lead to a poor quality of life.

As a result of HCV infection, over the next 10 years 30,000 to 60,000 people in the UK are expected to die from cirrhosis of the liver and 15,000 to 30,000 are expected to die from primary liver cancer. Heavy drinkers, especially alcoholics, who are unaware of their HCV infection are putting themselves at particularly great risk.

HCV is incredibly difficult to treat owing to its high mutation rates. Indeed, viral infections in general are notoriously difficult to treat with known drugs. The most successful treatment that is currently available, which is approved by the National Institute for Clinical Excellence, is a combination therapy of ribavirin and alpha interferon. However, it is extremely expensive--it costs about £8,000 per patient per annum.

Until now a few, but not all, health authorities have commissioned treatment from their central budgets. Knowledge of the advent of primary care trusts in April 2002 has made specialists working in the field fearful that far fewer patients than at present will receive the combination therapy. I put it to the Minister that it might be preferable to commission expensive treatment of that sort from a centralised regional budget--after all, liver transplants are funded in that way--and I look forward to his response.

Significantly, the combination therapy, which is successful in curing approximately 40 per cent. of those infected, is cost-effective, according to consultants. Moreover, it reduces the eventual need for long-term care and the demand for liver transplants. Apart from the fact that transplant operations cost about £50,000 each, the recent organ retention scandals have severely reduced the supply of livers for such operations.

The most common cause of HCV transmission is injecting drug use--specifically, the sharing of injecting paraphernalia. It is estimated that, on average, 30 to 40 per cent. of current and former injecting drug users may have the virus, and the figure can be as high as 60 per cent. for long-term injectors. More males than females are infected because the former are more likely to inject drugs. Four out of five deaths from HCV infection may be categorised as drug-related.

It is believed that one in 11 injecting drug users who began injecting in the past three years have the hepatitis C infection. Occasional users are more likely to share

14 Nov 2001 : Column 272WH

equipment. Their drug use is often unplanned and their first experiences of injecting are nearly always with borrowed equipment. HCV can be transmitted by using any injecting equipment that has been in contact with an infected person's blood. The lending and borrowing of injecting paraphernalia is common. In 1999, direct sharing of needles and syringes was reported by 32 per cent. of drug users who had injected in the previous month.

Dangerous sharing practices include not only syringes, but spoons and other containers used for mixing drugs, water, swabs, filters, tourniquets and utensils such as lighters and knives. There is also a growing concern that sharing straws to snort cocaine may be a route of infection through weakened nasal membranes.

Although there is strong evidence that needle exchange facilities significantly reduce the incidence of HCV, no formal assessment of the availability of such schemes throughout the UK has ever been carried out. There is a wide disparity in the distribution and quality of such services.

Some 27 million syringes are distributed every year for harm reduction. Assuming that there are 100,000 regular injectors, which is probably an underestimate, that provision represents less than one clean syringe a day for each injecting drug user. No wonder injectors are forced to share syringes.

NICE and the British Society of Gastroenterology have advised treatment providers against generally giving treatment to current drug injectors. That advice is apparently based on problems of compliance and re-infection. An article in the 19 July 2001 edition of the *New England Journal of Medicine* examined the rationale for excluding drug users with chronic HCV from treatment and rejected the NICE advice. I hope, therefore, that the Minister will re-examine the advice.

I also draw the Minister's attention to an article that appeared recently in the 2001, volume 34, issue 1 edition of "Hepatology", beginning on page 188. It shows that prejudicial statements about poor compliance are inaccurate and that injecting drug users with chronic HCV can be treated successfully with combination therapy.

It is thought that the risk of newly acquired HCV is highest among prisoners, and that transmission in prisons occurs through not only the re-use of needles but the sharing of other items, and through piercing and tattooing. The Prison Service already has a strategy for preventing the spread of communicable diseases in prisons, involving training, education, prevention, risk reduction and harm minimisation. It is necessary for that best practice to be spread nationally throughout the community, which calls for the development of a national strategy.

My final remarks are about such a strategy. In the 1980s, the Department of Health responded to the growing threat of the HIV virus with national advertising campaigns informing the general public. They were coupled with more detailed information made available to groups at the highest risk. There is a growing concern among specialists working on HCV that if some form of information is not soon made available, it will become more widespread than HIV has ever been. Although programmes such as needle

14 Nov 2001 : Column 273WH

exchange schemes have been implemented in most parts of the country, they are patchy and the current situation is inadequate. Unfortunately, many who use needle exchanges still regularly share equipment.

Although many injecting drug users are aware of HCV, not all are familiar with the ways in which it can be contracted. A national strategy to inform and educate the public would reduce the number of people contracting it and that would reduce the money that the NHS spends on treatment. Without adequate information, HCV prevalence is likely to rise further. It is vital that those at risk are informed and helped to avoid contracting the disease. The Prison Service already has a system of education and risk reduction, but why is the giving of information confined to prison inmates? Could the DOH modify the information programme used in the Prison Service and use it to spread awareness throughout high-risk groups of the general public?

It cannot be denied that the strategy against HIV and AIDS significantly reduced the numbers becoming infected. It is hoped that a similar national strategy against HCV, if and when it is launched, will reduce the incidence of that infection in the same way. I look forward to hearing the views of my parliamentary colleagues and the Minister's response.

11.14 am

Dr. Ian Gibson (Norwich, North): I congratulate my hon. Friend the Member for Bolton, South-East (Dr. Iddon) on raising an issue that is a medical time-bomb waiting to explode, and taking on a subject that has still to penetrate the public consciousness. I shall try to cover in more detail some of the points that he raised.

I am aware of the situation because of my contact with the Bure drugs centre in Norwich, Norfolk, which has helpfully provided local information. In a quiet city, which, the newspapers tell us, is a city of the future, the problem is just as deep-seated as anywhere else in the country. The problem is worldwide and global, but it is also found in our cities--quiet, nice and productive of a good quality of life though they are--and throughout the country. I therefore congratulate my hon. Friend again on raising the issue.

The help that I received from the Bure centre came via Paul Brierley, who, as the harm minimisation nurse in the community drug team there, is at the coal face of the problems. His role at the centre is to operate a confidential advice and testing service for bloodborne viruses, including hepatitis C, hepatitis B and HIV. He participates in the surveys of the Public Health Laboratory Service, and in a 2000 survey testing for hepatitis C antibodies in individuals, from a sample base of 211 people in Norwich and Norfolk, 42 per cent. responded positively. The sample base was representative of Norwich and the old East Norfolk health authority.

There is no accurate figure for the number of individuals that that percentage would translate into in Norfolk because, as my hon. Friend pointed out, many injectors are invisible to that, or any other, form of survey. We are aware that there is in Norfolk a significant number of dependent opiate injectors who never access any form of treatment, as well as a probably larger group of non-dependent opiate and stimulant

14 Nov 2001 : Column 274WH

injectors, and several who may have injected a few times, or a long time ago. The Bure centre currently has 700 open cases and in excess of 3,000 closed cases. The vast majority of them are at some risk of infection. The medics who operate at the Bure centre think it reasonable to conclude that the numbers infected in Norfolk are in the thousands, many of them unaware of their status, or even of the existence of the virus.

On testing, there is no routine antenatal hepatitis C screening, although it is actively encouraged when a pregnant woman reports past or current intravenous drug usage. It is often available on the request of general practitioners, and some of them encourage it. It is unlikely, however, to include significant counselling before or after the test, or to alter a client's risk behaviour. All local prisons offer some access to counselling and testing, and vaccination for, at least, hepatitis B.

On prevention, there is evidence, courtesy of the local Public Health Laboratory Service, that rates of new infection have slowed during the past few years. That may reflect a growing awareness of risk. The Bure centre is often approached by statutory and non-statutory agencies seeking training for staff and service users. That reflects the level of local concern and the increasing number of people considering the risk because of their occupation or lifestyle.

All work on hepatitis C in Norfolk is conducted within existing budgets. That point is strongly made and amplified by all those who carry out front-line work.

On treatment, I am indebted to my ex-colleague Dr. Hugh Kennedy for providing information about the gastroenterology unit at Norfolk and Norwich hospital and the problems in the hospital environment. NICE guidelines recommend funding for treatment, but whether it is provided seems to vary across the country, as is the case with funding for many drugs. I shall say a little more about the NICE recommendations in a minute.

The needle and syringe exchange scheme provides comprehensive coverage of Norfolk, on a rather nine-to-five basis. With some forethought it is possible to have a clean needle and syringe for every injection, but whether that happens is another matter. In the prison in Norwich, a course of training has been run for 50 staff, including a morning on viral infection. It highlighted clients' remarks on the availability of drugs in prisons and on the lack of injecting equipment. Sharing such equipment is a widespread practice in prisons, and must play a significant part in spreading hepatitis C. The prison gives inmates access to sterilising tablets, ostensibly for disinfecting cutlery, but they have not been demonstrated to inactivate the virus, even when soaked for the recommended 30 minutes--probably considerably longer than the average user is likely to wait. If virus transmission in prisons is not addressed, the overall infection rate is expected to remain high.

There are other routes of infection, although they are perhaps not as significant. Contact with contaminated blood and blood products, and non-hygienic tattooing or body piercing are among the myriad of ways in which bloodborne viruses can infect the population. They are detected only when patients present in general practice with obvious and often advanced liver disease.

14 Nov 2001 : Column 275WH

The level of knowledge gained over the years by the Bure clinic means that most current intravenous opiate-dependent users have some idea of the risk of infection with the virus, although local myth and misinformation plays a part. The clinic also fosters knowledge among those working with or caring for intravenous drug users, although the demand for information is in danger of outstripping the supply of people to provide that information.

Confidential advice and testing is also available at the Bure centre, as advised by the young person's capacity to give informal consent--the so-called Gillick competency. Early reports that HCV infections frequently occur within the first year of injecting have been borne out only partly. Awareness of risk ordinarily postdates the commencement of injecting behaviour.

As my hon. Friend said, the true prevalence of hepatitis C in the United Kingdom is unknown and there is no accurate information about the infected population. Basic information relating to the age of those infected, the duration of the infection, the risk factors for infection and the distribution of infection in the different regions of the UK is not available. It is therefore impossible to determine what services are required, where they should be established and which client groups should be targeted. Appropriate epidemiological studies are urgently required to determine how best to tackle the hepatitis C problem.

The National Institute for Clinical Excellence reviewed drug therapy for hepatitis C in the final quarter of 2000. As my hon. Friend said, it concluded that therapy with current drugs such as interferon and ribavirin cures up to 40 per cent. of infected individuals and that, although it is expensive, it is cost-effective and should be provided. At present, therapy for the virus is funded by local health authorities. I have already pointed out that a postcode lottery operates, and I hope that the Government will address that with all the other drug problems, including cancer.

Much concern has been expressed about funding, and many centres have featured in campaigns to try to obtain sufficient money to provide effective drug treatments. It is clear that the current system for implementing the NICE guidelines for hepatitis C is unsatisfactory, and that central, ring-fenced funding will be required to allow all patients to receive appropriate therapy. That is the only conclusion that one can draw from the available information.

A targeted testing and information campaign is needed. The Department's current policy is to test only those patients who ask to be tested for hepatitis C, but hepatitis C can, for many years, be a silent disease, and probably about 500,000 people in the UK have been infected. However, they are unaware that they are at risk, and are thus unlikely to ask to be tested. If they were aware of the diagnosis, many people could limit the progression of their disease--for example, simply by stopping drinking alcohol. Others could be prevented from developing serious disease by appropriate treatment.

A public information campaign could be undertaken at a cost equal to that of treating three or four people with interferon or ribavirin. Symptomatic illness and

14 Nov 2001 : Column 276WH

liver failure could be prevented in many people. Indeed, the correlation between hepatitis C and liver cancer is well proven. Every undergraduate medical student knows that, and it is one of the few cases where a virus is involved in the development of a cancer. Targeted testing and a public information campaign are essential.

There is evidence that some groups are disadvantaged. However, the subject has not been studied in detail, and only anecdotal evidence is available. It is common in patients of non-European descent, in those who misuse drugs and among prisoners. Those vulnerable groups have poor access to healthcare, and there are no plans to facilitate treatment for them. Unless services are developed to address their healthcare needs, a substantial reservoir of untreated hepatitis C will persist, which will place an increasing demand on healthcare services and cause new infections.

As my hon. Friend said, the costs of treating individuals with chronic hepatitis C are high, and it is disappointing to note that no cohesive policy is in place to prevent transmission. There is clear evidence that effective health promotion aimed at reducing needle sharing among those who inject drugs reduces the risk of infection with HCV.

The Medical Research Council facilitates research funding for medically related problems, but its strategies document does not mention hepatitis C. Priority is given to research into spongiform encephalopathies, such as BSE, and the epidemiology of HIV. Given the size of the current hepatitis C epidemic, those research priorities seem completely out of balance.

Mention has been made of compensation for haemophiliacs who have contracted HIV. It is perverse that many patients with haemophilia who are now dying as a result of infection with hepatitis C should be denied similar compensation. I suggest a possible solution. Current systems for dealing with the problems are clearly failing. The epidemic is not being properly monitored, patients are being denied the information needed to reduce the risk of infection and those who are infected are being denied therapy.

To resolve those problems, central funding is required to provide a full range of services for people who have chronic hepatitis C or who are at risk of being infected with it. Improving services for such patients will require the co-ordinated efforts of a large group of different healthcare groups. Regional anti-viral centres that are responsible for preventing, managing and monitoring the epidemic in their area need to be set up with central funding. Without some form of centralised funding, ad hoc arrangements will persist and the epidemic will continue to absorb precious healthcare resources for many years to come. We can take action now to forestall the consequences of the disease by reducing transmission, preventing deterioration and eliminating the virus from those who are currently infected.

11.26 am

Brian Cotter (Weston-super-Mare): I shall raise the subject of those haemophiliacs who contracted hepatitis C as a result of blood transfusion and who suffer in many ways as a result. For example, they are unable to obtain life insurance, and many have had to give up their jobs. Such people require proper financial help. It is not simply a moral obligation; we have a financial obligation to

14 Nov 2001 : Column 277WH

provide for them and their families, so that they can be financially secure and enjoy as full a life as possible. In that connection, I must point out that help has been provided for HIV sufferers. Hepatitis C is just as devastating a disease and it involves just as much loss and hardship. Why should the two be treated differently?

A step has been made in the right direction. In March, in a landmark High Court case, Mr. Justice Burton found that the national health service had a legal duty to supply clean blood for transfusion. Significant compensation was awarded to 114 non-haemophiliacs who had suffered blood transfusions and who had been infected as a result. That case was brought under the Consumer Protection Act 1987, but those provisions apply only to cases that arose after the Act came into force. However, if the principle of compensation was accepted in that case, it is surely grossly unfair to deny the same rights to haemophilia sufferers who have hepatitis C.

The Government have said that they are considering the implications of that verdict, but it seems that they will not provide further compensation. However, the Health and Community Care Committee of the Scottish Parliament recently recommended that financial assistance be given to haemophilia sufferers infected with hepatitis C as a result of having been given contaminated blood. If the Scottish Executive can do it, I hope that the Government will move in the same direction.

I asked the Minister a question on that subject on Monday 12 November. His response was that he would let me have a reply as soon as possible. I hope that the reason for the delay is that the Government are considering what to do. The Scottish Executive does not provide the only example. Many other countries, such as Ireland, have accepted responsibility and provide compensation for haemophiliacs.

Arguments have been advanced against compensation or financial help; there is concern that that would open the floodgates in respect of other issues. However, I do not accept that argument. The Government have said that benefit payments are the way to help. That is not enough. I hope that they will change their mind.

The matter was raised many years ago. When he was Under-Secretary of State at the Department of Health and Social Security in 1974, David Owen--now Lord Owen--asked departmental officials to put money aside for that very purpose. It has been a tremendous shock to him and to others that that money was not, seemingly, put aside. Certainly it was not used, yet it was already an issue all those years ago.

The present and previous Labour Governments have not uniformly insisted on proof of medical negligence before compensating national health service patients. The Callaghan Government increased payments under the vaccine damage payment scheme, and payments have been increased by the present Labour Government under the Macfarlane trust fund.

Compensation is provided in other areas, such as for criminal injuries, but that is not dependent on the Government's being seen to be at fault. Financial assistance is required, and haemophilia victims want and deserve an inquiry into how their plight has been allowed to happen. There has been an internal inquiry,

14 Nov 2001 : Column 278WH

but it was not considered that it got to the root of the matter. Supporters have pointed out that haemophilia victims who received transfusions in the 1970s and 1980s did not have any of the risks that we now know exist explained to them, although scientific knowledge available to Whitehall at that time suggested that hepatitis C could be transmitted through blood. In addition, money has never been forthcoming, despite the fact that a previous Minister with responsibility for health--Lord Owen--considered the issue important enough to say that it was required.

A debate was initiated by Lord Morris in the other place. He made it clear that almost everyone with haemophilia who is now over the age of 15 was infected with HIV and HCV by unclean blood. Of some 6,000 haemophiliacs, about 1,000 have already died of one or both of those diseases. If there have been inquiries about the Marchioness and about Paddington, surely there can be one into this disaster.

I hope that this is a constructive contribution.

Dr. Iddon : The hon. Gentleman has mentioned the Scottish Parliament. Is he aware that the Haemophilia Society petitioned it? Although most of the reasons for its petitioning were rejected, the Scottish Parliament's Health and Community Care Committee reached the following conclusion:

> "financial and other practical assistance, awarded on a no-fault basis, is the clearest solution to the issues raised in these petitions."

Brian Cotter : I very much appreciate that contribution, which helps to advance the case that I have been trying to make. I hope that we are not putting up the ramparts on the issue, and that the Government are considering it and will shortly come forward with what is needed: an inquiry and financial support to put right this clear injustice.

11.35 am

Mr. Neil Gerrard (Walthamstow): I am grateful for the opportunity to contribute to the debate. It concerns a serious public health issue, on which discussion is long overdue. My hon. Friend the Member for Bolton, South-East (Dr. Iddon) has spelled out questions about the levels of infection, the consequences for the people who are infected, the costs of treatment and the need for a national strategy to deal with hepatitis C. Work is being done on that, but rather belatedly.

I agree with what the hon. Member for Weston-super-Mare (Brian Cotter) said about haemophilia. There is a need for compensation. We should recognise that need and act on it. We should also conduct an inquiry into what has gone on, so that we can be clear in our mind about the history, the causes and the problems. Without one, we can never be absolutely sure that we have dealt with all the problems, however much we might feel that we have.

The major route of transmission for hepatitis C has been injecting drugs. I suspect that that is one of the reasons why the issue has not received the attention that it should have received. Injecting drug users are not popular causes. It is not difficult to see a connection between the fact that that is the major route of transmission and the lack of attention that has been given to the subject, the feeling being perhaps that the

14 Nov 2001 : Column 279WH

victims of hepatitis C have brought it on themselves. As my hon. Friend the Member for Bolton, South-East said, the disease is transmitted not just through the sharing of syringes, but via other drug-injecting paraphernalia and possibly through household contacts such as shared razors.

There is no doubt that we are behind other countries when it comes to a national strategy to cope with hepatitis C. Most other European countries have one. The Australians have had one for several years and are on their second or third revision of it. If we do not have a national strategy, we shall not know the true prevalence of the disease, monitor the epidemic or be able to establish the most effective ways to deal with it. Nor shall we be able to ensure that all those who need treatment get it--the problem of prescription by postcode has been mentioned. There are questions about the accuracy of the data. The Advisory Council on the Misuse of Drugs said in one of its reports:

> "It is regrettable that the country is encountering an immensely threatening public health problem without the data with which to monitor population trends and the effectiveness of policies."

That is the situation.

I am also concerned about treatment. What will happen when we move to commissioning by primary care trusts? My hon. Friend the Member for Bolton, South-East described clearly his views on the need for centralised funding. Two or three weeks ago, I was in this Chamber for a debate on HIV funding, and the same questions arose about what would happen when commissioning took place under primary care trusts.

Dr. Iddon : Does my hon. Friend agree that those questions apply to syringe exchange schemes, as well as to combination therapy? Such schemes would be low on the agenda of most primary care trusts.

Mr. Gerrard : I agree. There is a difference between what is happening in relation to hepatitis C and HIV. On HIV, many health authorities have a history of specialised commissioning and have people with expertise. I am worried about what will happen to that expertise when commissioning takes place at primary care trust level. On hepatitis C, we have not had specialised commissioning and no expertise has been developed in most health authorities.

Dr. Gibson : In Norfolk, money that was requested from the local health authority for a hepatitis C nurse was put towards a bowel cancer nurse. Priorities such as hepatitis C nurses are stuck low on the agenda time and again, which is why we need the money to be put towards what the Government mean it to be put towards and not diverted to other causes. Sometimes the money is even spent on car parks instead of staff to help the likes of drug abuse units.

Mr. Gerrard : My hon. Friend's example illustrates the problems, which I fear will worsen when the change is made and specialised commissioning takes place at primary care trust level. What happens to public health-related work generally, as a result of the change to primary care trust commissioning, is a serious issue. In

14 Nov 2001 : Column 280WH

many health authorities, only a few people have any expertise in public health. We must ensure that they continue their work. In my area, workers in the health authorities who are unsure about their future, especially those who work on narrow and specialised subjects, are disappearing as the change to primary care trusts occurs. They are taking the opportunity to find jobs elsewhere due to their uncertainty.

We certainly should consider public information campaigns. I have no doubt that such a campaign on hepatitis C could be cost-effective. The costs of treatment are so large that the prevention of even a small number of infections represents a significant saving. We must improve accessibility to treatment--a subject that has been covered by my hon. Friends the Members for Bolton, South-East and for Norwich, North. Access to the treatment that one should receive for a hepatitis C infection must not continue to depend on where one lives. We need national guidelines for treatment and clear agreement on who should receive therapies.

We also need to tackle the subject of testing facilities. One can be tested at a drugs service or a genito-urinary medicine clinic, but many people do not like going to such places, so we must think about where testing should be provided and how people should be directed to it.

The subject is a major one in public health terms. The figures--the number of infections, the likely number of deaths--speak for themselves about what will happen if we do not get to grips with the problem. It has been ignored for far too long. I am grateful to my hon. Friend the Member for Bolton, South-East for securing the debate. I hope that we shall hear proposals for action from the Government to start to tackle this public health issue.

11.45 am

Sandra Gidley (Romsey): I congratulate the hon. Member for Bolton, South-East (Dr. Iddon) on securing the debate. He has been trying to do so for a considerable time; his e-mails requesting me to try to secure a debate on this important subject might now stop. I pay tribute to his work with the Haemophilia Society. My hon. Friend the Member for Weston-super-Mare (Brian Cotter) has spoken about haemophilia.

We should take note of the interesting comments made by the hon. Member for Walthamstow (Mr. Gerrard), as he has done plenty of work on HIV. He must have learned lessons from the way in which HIV has been tackled, and must have used that knowledge to highlight many of the problems of hepatitis C.

The hon. Member for Norwich, North (Dr. Gibson) stole my opening line. I was going to start by saying that hepatitis C was a medical time-bomb, so I agreed when he said something similar.

I should like to query the figures. We do not know the number of people infected with the disease. The Department of Health estimates that 300,000 people in the United Kingdom have a chronic infection, but its figures are flawed because they are based solely on mathematical projections. Those projections are based on known prevalence rates in antenatal clinics, and that information is patchy at best. The rate varies from 0.8 per cent. to 0.2 per cent., and is regarded as 0.5 per cent. of the population overall.

14 Nov 2001 : Column 281WH

Hepatalogists are concerned that that figure is falsely low. As we heard, 80 per cent. of hepatitis C transmission is associated with injecting drug use, but figures from antenatal clinics suggest that female drug users have reduced fertility. Comparison of drug users with non-drug users among females of childbearing age shows that drug users have half the normal fertility rate. That creates a significant flaw in the mathematics. Much evidence shows that fewer women inject drugs and consequently share equipment than men, so it is apparent that a sample of antenatal clinic attendees has a lower prevalence of hepatitis C than the general population.

A general population survey is urgently needed, to give us a clear idea of the scale of the problem and enable us to plan accordingly. A survey in the United States of America showed that the rate there was not 0.5 per cent., but 1.8 per cent. If the same rate occurred in the UK--there is doubt that it would--more than 1 million people would be infected, as opposed to 500,000. We urgently need information. The financial impact of the problem would differ considerably depending on whether 300,000, 500,000 or 1 million people were affected. Will the Minister, instead of relying on a poor estimate, make a commitment to fund a study so that a clear picture of prevalence is known?

A big problem of hepatitis C is that most people do not know that they have been infected until many years later--possibly, 20 or 30 years. Some people go to the doctor and their condition is diagnosed when the next step of their liver failure could be liver cancer.

Testing is not widely available in the UK. It has been said that people can go to genito-urinary medicine clinics, but they cannot always do so. Many such clinics do not regard hepatitis C as a sexually transmitted disease, so it does not fall within their remit. People have problems accessing such services. Although 80 per cent. of transmission is through injecting drug use, a significant proportion--about 15 per cent.--of those infected have probably acquired the infection via sexual intercourse, and they still cannot get tested. Many drug services are not allowed or cannot afford to provide testing, and accessibility varies widely around the country. The postcode element of testing has been mentioned many times.

Figures from the Public Health Laboratory Service show that in 1999, 13,272 cases were diagnosed. That shows that at least 95 per cent. of the people in this country who already carry the hepatitis C virus are unaware that they have the disease and that they are sitting on a medical time-bomb. I want to reaffirm that a widely publicised campaign is needed to make people aware of the issue. If they find that they are potentially at risk, they can be tested. We also need to make testing easier and more available, so that appropriate early treatment can be given. Will the Government commit to providing such testing? People may take the view that if they do not know that they are ill, they have no reason to worry, but I shall explain later why it is important to know.

Many people who suddenly find that they are living with the hepatitis C virus are from a generation who probably dabbled briefly with injecting drugs in their teenage years. Some 20 or 30 years ago, the need for clean needles and the dangers of sharing were still not widely known or acknowledged. If the problem was known, it was not being tackled. Injecting drug use was rare before the late 1960s but has increased steadily ever since. That is why the full effects of the epidemic have yet to hit us. Most people with hepatitis C have probably forgotten that they ever took drugs.

14 Nov 2001 : Column 282WH

Needle exchange schemes have probably helped to reduce the incidence of infection, which probably accounts for the fact that the UK incidence will be lower than that of the United States. Such schemes are designed to limit the spread of HIV. However, HIV prevention advice is confined to not sharing needles and syringes. For HIV that is good enough, but for HCV it is not because, as has been outlined, there is much evidence to show that the sharing of other drug paraphernalia such as spoons and filters may ease transmission. It is thought that although people do not share syringes they do re-use their own syringe, and when they do so the contaminated blood is transferred to the paraphernalia, which may be used by someone else.

In Holland, needle exchange kits include single-use filters such as steri-cups. That would be a good move in the UK if we had the funding. However, it is currently illegal to supply such paraphernalia. Will the Minister consult the Home Secretary and push for the repeal of section 9 of the Misuse of Drugs Act 1971? That would go a long way to help with HCV strategy. That simple act would save lives, as studies have shown that sharing spoons and filters causes a fourfold increase in the risk of infection.

Dr. Iddon : Does not section 9 of that Act also preclude the provision of syringes with sterilising liquids of any kind, and would it not be sensible to provide the two things together in one pack?

Sandra Gidley : The hon. Gentleman is right. Also, sterilising liquids are currently prescription-only medicines, which is another problem that needs to be solved urgently.

To return to the disease itself, 85 per cent. of those infected develop chronic disease. If they remain untreated, 30 per cent. will die from the disease in 30 years. During the chronic phase, many people suffer from depression and fatigue. That has a significant impact on what society has to pay out--people may be unable to work, increasing the strain on the benefits system. There is a stage when drug treatment is appropriate. If people are tested at the right time, drug treatment can be given. As has been pointed out, the next step is a liver transplant. The difference in costs is clear. The drug costs vary from £12,000 to £15,000 a year, but a liver transplant costs roughly £36,000, so there are cost savings to be made by identifying the problem early.

I support the views expressed by the hon. Member for Bolton, South-East. He has pointed out that the system discriminates against infected current drug users, who are simply denied treatment. There is now evidence that the exclusion of injecting drug users from treatment is ill-founded. There is no evidence that they go on to re-infect if a proper education programme is supplied.

As usual, Britain appears to be lagging behind the rest of the world. In the USA, concerted efforts are being made to highlight the problem. Information campaigns

14 Nov 2001 : Column 283WH

are being targeted at the casual drug users of the 1960s, so that those people can be tested and treated at the optimum stage. There are numerous websites and charities highlighting the issue, and activities include awareness rallies and something called a hepfest--I hate to think what that was, but it received a lot of publicity. A large quantity of public awareness material and plenty of medical information is being distributed, because parts of the medical profession are still not up to speed with the full implications of hepatitis C.

Prisons were mentioned. More prisoners are injecting drug users than are not. Will the Minister consult with the Home Secretary so that we have a proper trial of needle exchange facilities? Some things are being done on an ad hoc basis, but provision is patchy around the country. Pilots have been tried in Switzerland, Germany and Spain and many of the fears, such as the fear that inmates would tackle prison officers with syringes, have proved to be unfounded, provided an education programme is in place.

The problem is real and it is no good to adopt an ostrich-like stance--we must face reality. Will the Minister establish the true prevalence of HCV, monitor the epidemic and plan for the future, establish ways of preventing further infections--such as the repeal of the drug paraphernalia laws--and ensure timely, appropriate treatment for all? Like many hon. Members in the Chamber today, I am suggesting a national strategy.

11.58 am

Mr. Simon Burns (West Chelmsford): I add my congratulations to the hon. Member for Bolton, South-East (Dr. Iddon) on securing this debate and on choosing this important subject. Almost every hon. Member who has taken part has described the problems facing us with regard to hepatitis C as a time-bomb ticking away. That is the most accurate description, given that hundreds of thousands of people in the country may carry the disease without even knowing it. No one quite knows how many people in the community are carrying the disease undiagnosed. It is clear from a number of contributions made this morning that there have been guesstimates and estimates, but the bottom line is that we do not know the exact or even the semi-precise figures on the extent of the problem, particularly as the incubation period of the disease is so long--in many cases up to 20 years.

We can expect an explosion in newly identified cases in the forthcoming decade. Even if all the routes of transmission were somehow blocked or closed today, there is still the prospect of a very large number of cases emerging over the next 10 to 20 years. Some medical authorities have suggested that hepatitis C has the potential to be an even greater killer in the long term than AIDS. That is extremely alarming. The fact that so many people are undiagnosed and unaware of the disease that they carry makes it even more alarming. Of the 80 per cent. of cases in which the virus makes itself felt, the vast majority will develop into a chronic illness. Some 20 per cent. of the people concerned will contract cirrhosis of the liver, and of those half will develop liver cancer.

14 Nov 2001 : Column 284WH

Even among those less severely affected, the disease can be debilitating, with symptoms that include fatigue, depression, lethargy and a resultant poor quality of life. Furthermore, if as many people develop the illness as has been predicted, the number needing treatment for HCV in the next decade will dramatically increase. That will impose significant costs on the national health service. As several other hon. Members have pointed out, planning and preparation are necessary, so that the national health service will be able to do what is needed in the coming decade.

I would like reassurance from the Minister that the Government are prepared to tackle several issues that are significant for people suffering from the disease. The current lottery for treatment, dependent on where one lives, which has been mentioned by hon. Members on both sides of the Chamber, must be grappled with and ended immediately. It is unacceptable that one's postcode or address should determine the standard of treatment that one receives.

Treatment for hepatitis C, a combination therapy involving interferon and ribavirin, costs £9,600 per annum per patient. However, although it can cure up to 40 per cent. of patients with HCV, the majority of health authorities either do not provide it or provide it on a limited and inadequate scale. In a survey conducted by the British Liver Trust in 1998, it was found that only a fifth of health authorities had any sort of strategy for tackling HCV and that fewer than one third had a budget for treating it.

Although the National Institute for Clinical Excellence recommended in October 2000 that patients suffering from moderate or severe hepatitis C should be given combination therapy-- interferon alpha and ribavirin--I fear that that will not be enough to solve the postcode lottery. Health authorities will still have to prioritise funding to meet the cost of treatment. The costs have been estimated by NICE at £18 million per annum initially, yet that figure excludes the associated costs of pathology, virology, radiology and specialist nursing.

The verdict of every reputable HCV specialist is that spending money early will save a great deal of money later. However, it is questionable what incentive health authorities have to invest those considerable sums. I believe that the barrier to funding relatively expensive drug therapies such as the combination therapy in question could be largely eliminated by the creation of a central funding mechanism for such exceptional medicines, separate from health authority budgets. Such an initiative would go a long way towards ending the lottery that is blighting the distribution of treatment for those suffering from hepatitis C.

As many other hon. Members have mentioned, another fundamental problem is the lack of proper facilities in many areas for the testing and counselling of HCV patients. Moreover, there is no common protocol to which health authorities work in looking after and managing such patients, before and after testing. The way in which patients are presented with their test results is too often insensitive and ill thought out in the extreme. A great many receive no advance preparation for what they are to hear, and no advice about it afterwards.

14 Nov 2001 : Column 285WH

According to a recommendation by NICE:

> "Confidential HCV testing and counselling should be made available whether or not treatment is initiated."

The Government should urgently heed that advice. Confidential testing facilities of the type that exist for HIV would encourage many to undergo an HCV test. Presently, many people are deterred, partly through ignorance, but also, more worryingly and sadly, from fear that the information will feature on their medical records and, in turn, have a stigmatising effect on their prospects of obtaining employment, life insurance or a mortgage. It could also affect personal relationships. As a result, it is likely that many people whose condition could otherwise be treated are not even being diagnosed.

The far-reaching effects of stigmatisation of the disease are particularly worrying. Miss GRO-A GRO-A is a constituent of my hon. Friend the Member for South-West Bedfordshire (Andrew Selous), who wanted to attend the debate but was prevented from doing so by his duties as a member of the Select Committee on Work and Pensions. The tragedy for Miss GRO-A is not confined to the problems of suffering from the illness; it extends to problems in seeking employment. She applied for a job with Bedfordshire police, and when it became known to them that she suffered from hepatitis C they refused to employ her. Those attitudes should not be acceptable among employers and in society today.

More needs to be done to provide funding for research. Much about hepatitis C remains unknown. The hon. Member for Norwich, North (Dr. Gibson) mentioned how he tried to discover the priorities in research into hepatitis. He was dismayed at the lack of such research. Sadly, he is right. We need more research to help us to cope with the problem. It is crucial, as there are apparently at least six strains of the virus, each with about 40 sub-strains. Over time those strains may change spontaneously. It is partly for that reason that no vaccine for hepatitis C has yet been developed.

Some aspects of the pathogenesis of HCV are still hidden and the precise mechanisms by which HCV causes liver cancer have not yet been identified. We therefore need a simple, cost-effective and reliable diagnostic test, both for the initial detection of HCV and for monitoring the disease as it progresses. There are still no firm data on the susceptibility of HCV to disinfecting agents, which is important bearing it in mind that the virus, unlike HIV, for example, can survive for many hours outside the body.

It is not only the treatment of hepatitis C that is a matter of concern. More needs to be done to tackle some of the problems of sufferers--not just haemophiliacs, although it is indeed tragic and appalling that those people have contracted HCV, but people who are not haemophiliacs and who have contracted it. I naturally feel deep horror at the fact that far too many people have been infected by the disease while giving medical treatment.

I urge the Minister to attend carefully to points that have been made repeatedly in this debate by hon. Members on both sides of the Chamber. Unanimity strengthens the case that has been put. I ask the Minister to take positive action to enhance and improve research, diagnosis and treatment, and to attend to the ancillary issues such as needle exchange that hon. Members have eloquently explained.

14 Nov 2001 : Column 286WH

12.9 pm

The Minister of State, Department of Health (Mr. John Hutton) : I join hon. Members in congratulating my hon. Friend the Member for Bolton, South-East (Dr. Iddon) on giving us the opportunity to discuss what are by common consent important public health issues, which affect many thousands of people. Like many hon. Members, I have constituents who have been caught up in this terrible tragedy. I am always struck by the dignity and forcefulness of the arguments that they present to me about how we can move on from the present situation.

This morning's contributions have been carefully presented and the arguments well marshalled. As the hon. Member for West Chelmsford (Mr. Burns) said, there is substantial consensus about some of the major issues with which the Government must deal. In the course of my remarks, I shall mention what the Government are doing to deal with some of the concerns that have been voiced. The hon. Member for Romsey (Sandra Gidley) accused the Government of taking an ostrich-like stance over hepatitis C, but that is absolutely untrue, and I shall explain why in a second.

My hon. Friend the Member for Bolton, South-East spoke eloquently about the scale of the problem that we must deal with, and I shall spell out precisely how we intend to take our work forward. I strongly agree with my hon. Friend the Member for Norwich, North (Dr. Gibson) that we need to penetrate public consciousness as regards the danger of hepatitis C. I shall set out how we shall do that in a minute.

Hon. Members have referred to the problems of postcode prescribing. It is important that the Government tackle that issue, and we now have the means in place to do so. The National Institute for Clinical Excellence is the first body in the world to advise advanced health care systems about the cost-effectiveness and value of new drug treatments. That approach is being widely mirrored, and many other countries are, as we speak, examining how to tackle such issues. Extra investment is going into the NHS to allow health authorities to take important steps in procuring new drug treatments, which are expensive, as all hon. Members have acknowledged.

It is entirely reasonable to express concern about postcode prescribing, but we should not lose sight of or fail to chalk up our successes in the battle against that problem. We tend to discount our successes as we move on to the next set of issues that hon. Members and people outside the House want us to deal with. It is important that we take stock of some of our successes, such as the availability of taxanes, of new drugs to treat Alzheimer's and of statins, the anti-cholesterol drugs.

We are making progress, although there is more to do. However, it ill behoves hon. Members--particularly those who were once responsible for dealing with such issues--to draw a polite veil over their record. The hon. Member for West Chelmsford conveniently failed to describe the measures that the last Conservative Government put in place to deal with the postcode prescribing against which he railed today. Perhaps other hon. Members share my impression that there is a dangerous tendency among some to suggest that the postcode prescribing that we are tackling appeared only on 1 May 1997 and that there was no such thing in the

14 Nov 2001 : Column 287WH

NHS before then. I was a Member of Parliament during the last Conservative Administration and for the life of me I cannot remember them taking a single opportunity to outline a coherent strategy for dealing with the issue. We are putting a strategy in place.

The hon. Member for West Chelmsford made some important points, and I shall deal with those. I strongly agree with my hon. Friend the Member for Walthamstow (Mr. Gerrard) that hepatitis C is a serious public health issue, which we must urgently address. I also agree with him that we need a national strategy, and I shall say more about our work to prepare and develop one in a second.

The hon. Member for Romsey wanted me to open a relationship with my right hon. Friend the Home Secretary to discuss several issues. I have a very good relationship with him. She asked me specifically about section 9 of the Misuse of Drugs Act 1971, as did my hon. Friend the Member for Bolton, South-East. She will be aware that the Advisory Council on the Misuse of Drugs has been considering the relevance of section 9 and is advising us on possible changes to deal with the concerns. She will understand that I cannot make a definitive statement about the future of section 9 today, but it is certainly being considered.

Dr. Iddon : Is the Minister prepared to ask NICE to reconsider its advice not to give injecting drug users combination therapy because of the problems of reinfection and compliance that I mentioned?

Mr. Hutton : I shall certainly deal with the issue, if my hon. Friend will be patient. The problem is that there has been some misunderstanding about NICE's recommendations, but it is the institute's job to deal with those, not mine. There is an appeals process, and decisions are subject to judicial review. There has, however, been a problem understanding NICE's comments on the issue, and I want to clear that up.

Hon. Members have referred throughout to three common elements: better prevention, better testing and better treatment for those who carry the virus. Those form the core of the Government's approach.

The virus was first identified in 1989, but the significance of its association with chronic liver disease and the number of people infected were not initially appreciated. As my hon. Friend the Member for Bolton, South-East rightly said, hepatitis C is now justly recognised as a global public health issue. As he and others said, the World Health Organisation estimates that there might be as many as 170 million chronic carriers around the world. Subject to the caveats that must be made about such data, studies suggest that England has a relatively low prevalence of hepatitis C. The best estimate of the number likely to have been infected and become chronic carriers is about 250,000. I accept what the hon. Member for Romsey said about the accuracy of that data, but it is a fact of life that we must work on the basis of best estimates. I shall say in a second how we might improve data collection systems.

I accept, as the hon. Member for West Chelmsford said, that there is likely to be an increase in the diagnosis of hepatitis C in the next 10 years as individuals who

14 Nov 2001 : Column 288WH

have carried the virus for some time without symptoms are identified through wider testing of groups that have been at risk. It is worth bearing it in mind that the figure is nearly 10 times that for people who have been infected with HIV. In contrast with HIV, however, we have an effective drug treatment for hepatitis C in many cases of infection. There is, however, no room for complacency.

In most cases, hepatitis C is spread by contact with the blood of someone who is infected. Injecting drug misusers and those who received blood transfusions or blood products before screening and viral inactivation processes were introduced have been the main at-risk groups. Data from the unlinked anonymous surveys show that the prevalence among injecting drug users in contact with treatment and support agencies is about 33 per cent. Hepatitis C may be spread to a much lesser extent between sexual partners and from mother to baby. As many hon. Members said, health care workers are at particular risk from occupational exposure.

Once transmitted, the virus can quickly cause inflammation of the liver. That may become apparent as jaundice, which is an acute illness, but, fortunately, one from which people recover. For about 80 per cent. of people, however, the infection becomes chronic and has longer-term health implications.

Unfortunately, there is evidence that some people with hepatitis C experience social prejudice and discrimination; the hon. Member for West Chelmsford referred to a particularly shocking case. It is not easy to deal with that issue, and I look forward to receiving advice about how we might do so from the national steering group that we set up. In part, such behaviour may represent a lack of public knowledge about the disease. It must be tackled as we improve patient care. The group that we set up earlier this year to develop a national strategy for hepatitis C will discuss the problem.

People with chronic HCV infection can remain virtually symptomless for many years. However, individuals may suffer more general debilitating effects that can affect their quality of life and, in a proportion of cases, the liver may become progressively inflamed and damaged. If not treated, that may eventually progress, over a number of years, to severe liver disease. Routine death statistics are difficult to interpret, and we have had some discussion about how many people are dying from hepatitis C.

Hepatitis C has been identified by the Public Health Laboratory Service as the contributory cause of around 200 deaths every year in the United Kingdom, so I cannot confirm the statistics given by my hon. Friend the Member for Bolton, South-East. It is clear that hepatitis C infection contributes to deaths from the complications of chronic liver disease, including cirrhosis and hepatocellular cancer. I accept that there is likely to be some under-reporting--that is obviously the case. We need to improve the surveillance of serious liver disease associated with hepatitis C. I will say more about that in a moment.

Many hon. Members have referred to the National Institute for Clinical Excellence, which assessed the use of a drug combination therapy involving ribavirin and interferon for treating hepatitis C and published its recommendations last October. The therapy has been shown to be twice as effective as any previous treatment.

14 Nov 2001 : Column 289WH

NICE's recommendations provide clear and authoritative advice for clinicians and health care providers, which should ensure that patients receive effective treatment, and were welcomed by patient groups, including the Haemophilia Society.

Sandra Gidley : The problem is not so much with NICE, whose guidance one may or may not question. We are all agreed that its guidance is timely, but the local health authorities are not given extra funding to afford those guidelines, and are forced to make decisions to stop giving other treatments. Authorities may have to ration patients on the basis that they can afford to take on only 10 a year for a particular treatment. Some hon. Members have called for a central budget. Would that not be a better way of tackling the problem, when we know the extent of it?

Mr. Hutton : I was just coming to that. The hon. Lady is not right in saying that health authorities and trusts are not given additional resources to manage the additional costs associated with implementing NICE recommendations. It is true that there is no dedicated pot of money for that, but we must bear in mind the unprecedented increase in overall NHS resources that has taken place this year and will take place in the next two years. In this financial year, for example, health authorities received an 8.9 per cent. increase in resources. Of course, decisions must then be made, and no one is disputing that authorities may have to make hard judgment calls.

Others have suggested that we should have a ring-fenced budget for hepatitis C treatment. I am not convinced about that, although I understand the view of my hon. Friend the Member for Bolton, South-East and others. We all want patients to be properly supported and provided for, but mainstreaming of funding ensures that local providers of care have more say in the priorities that they fix for their local populations. That is the underlying principle behind shifting the balance of power. Hypothecating funding for this treatment would raise obvious questions about consistency in the way we provide for people with other illnesses.

My hon. Friend the Member for Bolton, South-East asked me to consider the question of specialised commissioning of services for people with hepatitis C. I will come back to that question in a moment.

There are grounds for optimism that further improvements in treatment will follow. The modified slow-release form of interferon--pegylated interferon--became available this year and appears to be more effective than conventional interferon. I understand that NICE is considering that new drug as a topic of future appraisal. The Department is funding research to establish the effectiveness of the early treatment of chronic hepatitis C with interferon alpha, or a combination of interferon and ribavirin.

Several hon. Members referred generally to the issue of research; the hon. Member for West Chelmsford called for more research, as did others. I agree that that is necessary, which is why, last November, the Medical Research Council spent £1.8 million in developing new and further research proposals for hepatitis C. In the past four years, the Department has spent a further £1.5 million on hepatitis C research.

14 Nov 2001 : Column 290WH

Concern has been expressed that NICE guidelines seem to exclude injecting drug users from hepatitis C treatment, but that is not the case. General advice recognises potential difficulties in treating injecting drug misusers, but NICE recommends that, if a prescribing clinician is reliably assured that reinfection, compliance and drug interactions pose no problems, a person in that group should be considered for combination therapy. In line with good medical practice, the emphasis should be on the clinician assessing each case in conjunction with the patient. As my hon. Friend the Member for Bolton, South-East said, some evidence exists that injecting drug users may be successfully treated for hepatitis C.

We also heard calls for new guidelines for hepatitis C treatment, to which we have tried to respond. The Royal College of Physicians, the British Society of Gastroenterology and the British Association for the Study of the Liver published evidence-based clinical guidelines in July that will provide a framework for patients with hepatitis C to receive high-quality treatment and care. That work has the full support of the Department of Health.

We recognise, too, the increasing importance of hepatology, not only for patients with hepatitis C but for those with other complex liver diseases, who should have access to specialist hepatology units with the necessary knowledge and expertise. We have worked on a commissioning framework to ensure that specialised hepatology services are developed to uniform standards throughout the country. That may go some way to meeting the concerns expressed by my hon. Friend the Member for Bolton, South-East. The Department is due to publish the national specialised services definition set later this month, which will be used as the basis for identifying those specialised services that require some form of collaborative commissioning. Hepatology, which includes specialised services for the treatment of patients with viral hepatitis, is part of that set. I will ensure that my hon. Friend and other hon. Members who have taken part in the debate are kept fully informed of developments.

Unfortunately, time always runs out during debates such as this. Hon. Members asked me to respond to several issues, which I will try to move on to quickly because time is of the essence.

The issue of compensation was raised. I, personally, found that the most difficult decision of all. We have listened carefully to arguments for a special payments scheme for people with haemophilia and hepatitis C similar to that in place for HIV. After a long and difficult consideration, we came to the same conclusion as the previous Government, that such a scheme should not be established. That was not a view we came to lightly. I assure my hon. Friend the Member for Bolton, South-East that every one of my colleagues who considered the issue and met individuals affected by this tragedy found it a difficult decision to make. As I said earlier, as soon as technology became available to render blood products safe, it was introduced. The policy of successive Governments has been that compensation, or other financial help to patients, is paid only when the NHS or individuals working in it are at fault. I do not believe that the NHS has been at fault in this case.

Brian Cotter : Will the Minister give way?

14 Nov 2001 : Column 291WH

Mr. Hutton : With great respect, I will not, as I have only a couple more minutes left and want to respond to all the points that were made.

The issue of compensation has been widely debated in the House. I know that some hon. Members take a different view, which I respect, but it is not the view that the Government have come to. However, we intend to develop options for reforming the system for dealing with clinical negligence claims. As my right hon. Friend the Secretary of State for Health announced on 10 July, we will produce a White Paper on that subject early next year. The chief medical officer is chairing an expert advisory committee to explore the issues and options, one of which is whether no-fault compensation for NHS patients may be appropriate in future.

The other issue that was discussed at some length today was the need for a national strategy, which I agree is necessary. We fully recognise the importance of hepatitis C as a public health issue and the need to have in place effective prevention, testing and treatment services. To assist us in developing our strategy, we recently established a multi-disciplinary steering group to consider the issues. The steering group is chaired by Professor Howard Thomas of Imperial College School of Medicine, who is a world authority in the field, and comprises health professionals, academics and voluntary and community sector members. I hope that hon. Members are reassured by the fact that the group not only is a collection of experienced medical practitioners but has a strong lay involvement, including Manlio Fahmi, chair of Re-act and vice-chair of the recently launched national forum, the UK Assembly on Hepatitis C; Lorraine Hewitt from Action on Hepatitis C and a member of the Advisory Council on the Misuse of Drugs; Tania Machell, head of the National Hepatitis C Resource Centre and Grant McNally of the National Drug Users Development Agency.

The steering group is considering the scope and effectiveness of current measures to tackle hepatitis C in several different settings, including the prison environment. It will advise us on any gaps or areas for improvement, including prevention activities and provision of needle exchange schemes--issues that were widely discussed today. The group has already identified that improvements in surveillance are necessary, which was a concern of the hon. Member for Romsey. It is also necessary to raise awareness for health professionals in general and to inform the public about hepatitis C.

Mr. Nicholas Winterton (in the Chair): Order. I regret that time is up. I thank the Minister for his reply.

Next Section Index Home Page