

[Mr. Gavin Strang]

National Blood Transfusion Service began screening donations in October 1985, although at least two have become infected since then owing to the window period between infection and sero conversion.

The House will remember that in December 1990 the Government finally took the decision to make provision for 1,217 haemophiliacs infected with HIV through the blood product factor 8. An out-of-court settlement was made, bringing the total sums provided to £76 million. It took five long years of campaigning for haemophiliacs to see justice done, though many people were not convinced of the adequacy even of that settlement.

We are now asking for equal treatment for non-haemophiliacs infected with HIV as the result of an NHS blood transfusion or tissue transfer. As this group of people is much smaller than the number of haemophiliacs, the sum required would be correspondingly less, perhaps £4 million.

The Government have given a number of reasons so far for not providing compensation for non-haemophiliacs. They say that they cannot distinguish between infected non-haemophiliacs and other victims of medical accidents and that making provision for them would set a precedent for the piecemeal introduction of no-fault compensation. That is an irrelevant distraction. We are not arguing about no-fault compensation, but that non-haemophiliacs and haemophiliacs should be given equal treatment.

Last year, the Government were careful to insist that they were not providing compensation to haemophiliacs but simply making *ex gratia*, out-of-court settlements. In that way, they avoided setting precedents for no-fault compensation. We demand the same for non-haemophiliacs, which would also not set such precedents. One respect in which infected non-haemophiliacs differ from other victims of medical accidents is precisely that a precedent has been set for making provisions for people infected with HIV through NHS blood and tissue transfers.

The Government have given many reasons for distinguishing between haemophiliacs and non-haemophiliacs, but they are all totally unconvincing. They have argued that haemophiliacs were seriously ill before they became infected, but, by definition, many non-haemophiliacs were also ill before they became infected. Some of them received tissue transfers—those are rather exceptional—and blood transfusions precisely because they were ill with diseases such as leukaemia. The Government's arguments are nonsense, because there is no reason to make a distinction on that ground. What does it matter whether a person receives a blood transfusion because he has leukaemia or because he has had a car accident?

Secondly, the Government have argued that there is likely to be more than one infected haemophiliac in a family. Haemophilia is genetic and, as a result there may be more than one in a family. Although HIV is not genetic, it can be transmitted from mother to child and certainly between partners, so there is a real risk that there may be more than one HIV-positive non-haemophiliac in a family as a result of a contaminated blood transfusion.

Thirdly, the Government have argued that a distinction between haemophiliacs can be made on the ground that, because of a haemophiliac's illness or condition, he or she

is unlikely to have a well-paid job and therefore be able to afford adequate insurance. Again, a substantial proportion of non-haemophiliacs who received compensation were not in highly paid jobs and did not have insurance to protect them against the prospect of eventually developing AIDS as a result of a blood transfusion contaminated by HIV.

Those arguments are totally spurious. There is no valid, logical ground for distinguishing between infected haemophiliacs and non-haemophiliacs. That has been accepted by other Governments, such as those of Canada, France, Denmark and Western Australia. Although it may have taken them a little while to get there, they have all recognised that a distinction between infected haemophiliacs and non-haemophiliacs cannot be justified. The Haemophilia Society has also made that point.

One of the reasons why the haemophiliacs achieved success was that they were organised and had a society to campaign on their behalf. The society never intended to succeed to the exclusion of non-haemophiliacs. There is no justification for drawing a ring fence—to use the technical jargon—around the haemophiliacs. We have to draw a ring fence, but it must be drawn around everybody—non-haemophiliacs and haemophiliacs—who has become infected as a result of a blood transfusion under the national health service.

No amount of compensation can make up for the enormity of the personal and family tragedies involved, but the money can help to make life easier and more comfortable for those who are still alive. The money can help the families, especially the children, of those who have died as a result of AIDS.

There are good reasons for pursuing the issue until the Government recognise the justice of the case. I tabled an early-day motion which has all-party support and I emphasise that this is an all-party campaign. The motion now has 234 signatures and is a powerful demonstration of the support by Parliament for non-haemophiliacs. Hon. Members are overwhelmingly of the view that the Government's position is untenable and that they need to think again. There is no justification for continuing to distinguish between haemophiliacs and non-haemophiliacs.

The Minister has a chance this afternoon to rectify the mistake made last December when the Government announced that they would provide compensation for haemophiliacs. That was an error of judgment because the announcement should have included non-haemophiliacs. I have given the figure for the number affected. The Government figure may include one or two more people, but even if there are a few more, the total number is substantially lower than the number of haemophiliacs affected. There can be no ground for resisting the argument on the basis of financial considerations, as the Minister knows.

I have sought to demonstrate that the grounds for the Government's argument are entirely spurious. I hope that the Minister will take the opportunity to put the matter right. The issue will not go away and the sooner that we get an announcement that justice will be provided for the non-haemophiliacs the better.



1.13 pm

The Minister for Health (Mrs. Virginia Bottomley): I congratulate the hon. Member for Edinburgh, East (Mr. Strang) on seeking this opportunity to raise a subject of understandable concern which undoubtedly arouses deep sympathy in all of us. It is a tragedy that people have become infected with HIV through blood transfusions or through tissue transfer. I join the hon. Gentleman in expressing my sympathy for those affected by this unfortunate tragedy which has blighted the lives of those infected and the lives of their families.

I recognise that the hon. Gentleman has a long-standing and special concern about the whole question of HIV and AIDS. He spoke particularly of the situation in Edinburgh. He will know that the prevalence of HIV and AIDS varies in different parts of the country. I visited Edinburgh earlier this year to meet Dr. Mok and many others involved in the provision of services. I visited the new hospice in the centre of Edinburgh and saw much of the medical treatment available for those suffering from HIV and AIDS, whatever the cause.

In a sense, the hon. Gentleman's debate is about how people contracted HIV and AIDS. That is the point that he seeks to make, but he, of all people, will also be aware that the development of appropriate services, support and care for those suffering from this fatal disease has been a major challenge and a major priority for us all.

The Government's response to the hon. Gentleman's comments cannot just be a matter of sympathetic words. We are taking steps to ensure that appropriate services and treatment are available to those with HIV and AIDS and that appropriate services and treatment are available to the blood transfusion and tissue recipients and to all others who are infected.

We are seeking as far as possible to alleviate and delay the effects of the infection. We continue to support research and that support amounts to about £31 million during the past five years; about £500 million has been put by the Government into the development of services and treatment for people with HIV and AIDS. This year, the substantial ring-fenced funds of £160 million for the national health service and other organisations are the Government's contribution to preventing the further spread of HIV and providing diagnosis, treatment, care and support services.

Next year those resources are being increased to almost £200 million. That shows a clear commitment to the development of services in this country, which leads the world in the provision of care, support and treatment for those suffering from HIV and AIDS.

As I say, the hon. Gentleman has long identified the threat to public health and the enormous difficulty facing individuals and families. He sponsored the AIDS (Control) Act 1987 which, through its reports, gives the Government and health authorities a strong strategic tool with which to monitor the progress and effectiveness of their prevention and treatment efforts in the area of AIDS and the use of the earmarked money.

Earlier this year I was also able to give the initial results of the anonymised HIV sero-surveys. Hon. Members will be aware that fact is much better than fantasy in the area of HIV and AIDS. It was essential in terms of the development and planning of services, particularly in the

light of the large ring-fenced sums of money available for the work, that we should have a better estimate of the prevalence and spread of the disease.

The hon. Gentleman referred to the situation in Edinburgh. Our figures demonstrated that the prevalence of HIV infection among women attending ante-natal clinics in certain parts of inner London was 1 in 500. As a result of those figures, I established the AIDS action group, which I chair. The group is studying ways of reaching key population groups and ways of co-ordinating work across a number of sectors. It will enable us to build on and to make widely known the tremendous amount of effective work already being carried forward locally. The task is urgent and we are making rapid progress. The hon. Gentleman will be aware that there are similar developments in Scotland.

The time has come with the development of services, prevention and support for those with HIV and AIDS to ensure that we have an effective way of ensuring that all those who are infected or increasingly affected by HIV and AIDS receive the support and care that they deserve.

The debate concerns those infected through blood transfusion and tissue transfer. I can assure the House that all practical steps are being taken to safeguard our blood supply, of which we are justly proud. Those engaging in high-risk activities associated with HIV are not accepted as blood donors and all donations are tested for HIV antibodies. Tissue donors are also tested and by such means we seek to prevent a recurrence of this appalling and unforeseen tragedy.

I hope that the hon. Gentleman and other hon. Members will acknowledge the substantial measures taken by the Government to ensure that appropriate treatment, care and support are provided for those with HIV and to protect against any recurrence of this tragedy. Difficulties have arisen on the issue of compensation and are of concern to the hon. Gentleman. Governments of all parties accept that when there has been negligence in treatment the national health service should compensate those who have been damaged. It is for individuals to decide whether to pursue such cases and, until now, the main avenue of redress has been the courts.

As the hon. Gentleman may know, we are consulting on proposals for an arbitration scheme in respect of claims for negligence against the health service. That follows a suggestion by Lord Griffiths in his address to the annual conference of the Law Society in October 1990 that claims for compensation could, with the agreement of both parties, be considered by a small panel of medical and legal experts working on paper and applying the normal principles of negligence under common law. Any damages awarded would not be limited and would be calculated according to established guidelines. Such a system might provide a simpler, quicker and cheaper route for those who opted to use it in preference to the courts. If the suggestion meets with general support, perhaps we could develop a pilot trial in one or two regional health authorities.

Of course, the avenue of legal action is open to blood transfusion recipients infected with HIV. The hon. Gentleman sought to argue that for this group the Government should go further and provide compensation without any need to show negligence—that we should compensate effectively on a no-fault basis.

Earlier this year the House carefully considered the merits and demerits of a no-fault compensation scheme



[Mrs. Virginia Bottomley]

when the hon. Member for Greenwich (Mrs. Barnes) presented her NHS (Compensation) Bill for Second Reading. On a free vote, the Government and the House rejected that Bill. That was certainly not because we lacked sympathy for the victims of medical accidents. As I hope we have shown, the contrary is the case. It is the duty of government to consider the wider implications for policy of any such major proposals. Any workable scheme of no-fault compensation would be enormously costly, and in attempting to solve one set of problems it would create another. Inevitably, there would be unfairness because those injured through NHS treatment would be compensated, while those injured or disabled through natural causes would not. Severe difficulties over causation would remain. The accountability of those providing treatment could also be reduced. There could be substantial cost implications if the awards were not to be unacceptably small, which is the case in some countries that have adopted such a scheme.

The proposals that I have mentioned offer a much better hope of finding a workable way forward for our current system. Following the full debate on 1 February when the Secretary of State for Health addressed the House, the House decisively rejected the principle of no-fault compensation for those injured because of NHS treatment when no negligence had been demonstrated. No one can underestimate the difficulties of these questions and of the decisions involved. Inevitably, there will be further demands on finite NHS resources. I have spoken about the way in which we have deliberately and determinedly invested additional resources in the development of services for those with HIV and AIDS.

**Mr. Strang:** The Minister's comments about no-fault compensation are interesting, but the crunch issue is about how the Government justify making a distinction between haemophiliacs and non-haemophiliacs. That is the issue that I covered in my speech and I trust that the Minister will reply to it. Surely they can provide compensation for non-haemophiliacs in the same way as for haemophiliacs. It is simply a matter of erecting the ring fence in a logical place. I do not want to get involved in the argument about no-fault compensation. I hope that the hon. Lady will address the issue that I have raised.

**Mrs. Bottomley:** I hope that explaining the various ways in which we are tackling the problem will help the hon. Gentleman to understand why we reached the decision that we did. It is important to consider that group in the context of the larger group of HIV and AIDS sufferers, to make it clear that—whatever the causation—they are suffering from a disease for which there is no known cure and to which we and the hon. Gentleman have sought to give priority.

It is important to establish the arguments in respect of no-fault compensation. Although it may initially seem superficially appealing, its long-term implications for the health service would be very serious. In reaching the decision a year ago that the haemophiliacs in question should be offered financial assistance because they were a special and specific group, the Government considered carefully the various factors involved. We took the view that because they already suffered from health, social, and

financial disadvantages associated with their lifelong condition, an exceptional decision should be made in their case.

The hon. Gentleman argued that the payments made to HIV-infected haemophiliacs should be considered as a precedent for blood transfusion cases. There is hardly any need for me to remind the House of the lengthy campaign on behalf of haemophiliacs—supported by many right hon. and hon. Members, the public and the media—whose advocates reiterated that haemophiliacs were an exceptional and specific group who merited exceptional treatment. The Government remain convinced that their case is exceptional.

It is always extremely difficult to draw distinctions. It is likely that there will always be a group who will feel unfairly treated, seek to have the limits redrawn and the boundary altered, and argue that they should be incorporated rather than excluded. That will be the case whenever such a decision is made.

The Government recognised the arguments forcefully put to us that HIV-infected haemophiliacs were a special case. I repeat that, their lifelong condition of haemophilia—which had already adversely affected their health, social, employment, insurance, and mortgage prospects—was further exacerbated by the onset of HIV.

**Mr. Strang:** Does the Minister agree that those haemophiliacs were deemed to be a special case precisely because they were infected by contaminated blood from the national health service? But is it not the case that only haemophiliacs infected in that way were compensated—not those infected in any other way?

**Mrs. Bottomley:** The hon. Gentleman is correct. The haemophiliacs in question were given contaminated blood products by those who sought to treat them. The particular arguments and considerations given to their particular case have been much rehearsed.

No one can argue effectively that a line can be drawn anywhere and be left unchallenged. It is inherent in such an initiative that there will always be some who are on the other side of that line who were contaminated through no fault of their own—or even through some fault of their own—and who will argue that they also ought to receive financial recompense. It is naive to believe other than that there will always be some groups on the other side of the line who will seek to argue that it should be moved. That must be so wherever financial decisions are involved.

In the case of the haemophiliacs, the Government responded generously, making available more than £76 million to help the 1,200 individuals affected with HIV and their families. A haemophiliac with dependants will receive around £80,000 from that sum, and those with particular needs can receive additional help from the Macfarlane Trust, which has been further funded with Government money. The support that has been provided by the Government for this specific group compares favourably with state help that is provided elsewhere for haemophiliacs with HIV. The House will be aware that the Governments of about half the EC countries have made no recognition of the plight of this group.

Those advocating help for HIV-infected blood transfusion and tissue recipients argue, as has the hon. Gentleman, that the cost would be relatively small. Thankfully the numbers suffering as a result of the tragedy are relatively small. We know of 62 reported cases where



treatment was given in the United Kingdom. We estimate that the cost of extending the recent settlement for haemophiliacs to transfusion or tissue cases treated here could be about £10 million. That is not an insignificant amount. It equates with the cost of 1,000 kidney transplants or 500 bone marrow transplants or 500 heart transplants.

In short, we share the great sympathy that the hon. Gentleman feels for this particular group of patients. We are committed to developing first-rate, effective and supportive services for the treatment and care of those with HIV and AIDS. The Government have not been persuaded, however, that blood transfusion and tissue recipients constitute a special case. We shall, of course, consider carefully the views which have been expressed by the hon. Gentleman. We have great sympathy for these tragic cases and for their families.

## Schools (Berkshire)

1.30 pm

**Sir Anthony Durant (Reading, West):** I am delighted to have the opportunity to raise this matter. It has come about because one of my colleagues cancelled his debate. That gave me the opportunity to introduce this subject. I came in, as it were, at a rather late stage.

The two schools that are mentioned on the Order Paper are of the highest standard in Berkshire. Little Heath school, in my constituency, is one of the two. Ryeish Green school is in the constituency of my hon. Friend the Member for Reading, East (Sir G. Vaughan). I hope, Madam Deputy Speaker, that you will allow my hon. Friend to intervene briefly as we proceed.

Incidentally, the headmaster of Little Heath school taught my daughter in another school in Berkshire. I have, therefore, a close interest in the school.

The history is that four parents with four children applied for entry into Little Heath school in the normal way. Their children were due to start at the school in September 1991. They were refused entry on the ground that the school was full. The parents went through the appeals procedure and were refused again. The appeal committee upheld the decision of the local education authority. The four parents were not satisfied with the decision. They refused to send their children to any other school. I should say that one parent sent his child to Meadway school but still wishes to transfer to Little Heath.

The parents wrote to my right hon. and learned Friend the Secretary of State for Education and Science and he replied to the effect that he could not intervene because the LEA had not acted unreasonably. I feel strongly that the Government's policy of open enrolment is being flouted. The LEA continues to say that the school is full.

Little Heath school was first measured in 1979. It was decided then that the maximum intake was 239. The actual intake between 1983 and 1989 was 210. The school was remeasured in 1990, and the intake that year was 253. In 1991, the year in question, the intake was 239. There were six successful appeals, so 245 became the final figure. In August 1991, three children withdrew, which meant that 242 became the final figure. Three places became available. The number of admissions the previous year was 11 more than the total number of entrants in 1991.

My hon. Friend the Under-Secretary of State for Education and Science has to decide whether the LEA has acted unreasonably. I believe that there are grounds for intervention. During the appeals the parents were not given full information. For example, the catchment map was not produced. There are arguments in the county about whether there is a catchment map. In some letters it is referred to as being in existence and in others it is not. The parents' representations were not circulated to the appeals committee and only one parent's preference was allowed by the local education authority, which is contrary to the Department of Education and Science circular 11/88 and contrary to the Act.

Two stages of the appeal do not appear to have been followed. The first part of an appeal is to consider whether the entry will cause the school to suffer because of having too many children. The appeals committee then has to decide whether, if it supports the local education authority, the children's needs and the parents' preference