OFFICIAL REPORT
AITHISG OIFIGEIL

Meeting of the Parliament

Tuesday 18 April 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 18 April 2017

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Scottish Parliament

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[The Presiding Officer opened the meeting at 14:00]

Time for Reflection

The Presiding Officer (Ken Macintosh): Good afternoon. The first item of business this afternoon is time for reflection. Our time for reflection leader today is the Very Reverend Andrew Swift DL, dean of Argyll and the Isles, rector of Holy Trinity, Dunoon and rector of St Paul's, Rothesay.

The Very Rev Andrew Swift DL (Dean of Argyll and the Isles, Rector of Holy Trinity, Dunoon and Rector of St Paul's, Rothesay): Presiding Officer, members of the Scottish Parliament, thank you for the invitation to speak to you today, as you come back to work after your Easter recess.

The Scottish Episcopal Church and most of the churches in Scotland have just celebrated holy week and Easter, remembering a story that takes us into the black depths of despair with Jesus' death on Good Friday and up to the indescribable joys of the empty tomb on that Easter morning. Today, two days later, we are all, I am sure, joined as we contemplate that most important of things—not snap general elections, but chocolate.

I was in a local primary school, over on the Cowal peninsula in Argyll, talking to the children about Lent, holy week and Easter, and chocolate had more than a little to do with their excitement at the celebrations to come. What did they tell me about? Chocolate eggs, which remind us of the stone that rolled away from the tomb's door; and chocolate bunnies, which are a sign of new life and new beginnings—for the sake of the primary 1s, we did not discuss exactly why bunnies are a seen as a sign of new life. In fact, any kind of chocolate, which many people give up for Lent, is a delicious and welcome part of the new beginnings that we celebrate this week. As a cleric, I have noticed that chocolate can have the strange side-effect of shrinking one's cassock, but chocolate remains pretty central to the celebrations that we have been holding. However, we came through that harrowing holy week—through betrayal, torture and death—to let us come, blinking, out into the new light of Easter day and the rewards of the chocolate offerings placed before us.

As Christians, we believe that God's love is shown through Easter. The new beginning that churches celebrate is a new beginning where every single human being is of infinite value and worthy of respect, love and the chance to flourish.

Those values are the values that I see all around us in Scotland. We are a nation of people who, whether with faith or not, are willing to see the humanity in all, to work towards a common good, to protect the weak and to welcome the refugee and vulnerable migrant.

So, may you start your sitting with my blessings and my good wishes, and I thank you for all that you do as our representatives and our Government.

Topical Question Time

14:03

Benefits and Welfare Eligibility (Reforms)

1. **Gillian Martin (Aberdeenshire East) (SNP):** To ask the Scottish Government what its response is to reports that United Kingdom Government reforms of benefits and welfare eligibility are unfairly impacting on women. (S5T-00509)

The Cabinet Secretary for Communities, Social Security and Equalities (Angela Constance): The UK Government's welfare cuts are fundamentally unfair and are having a hugely damaging and disproportionate impact on women. Women are twice as dependent on social security as men are, and 75 per cent of the cuts since 2010 have come from the pockets of women.

New cuts that will come into force this month are all the more concerning because, in many households, women are the primary, or even sole, carers of children. Of in-work families receiving child tax credits, 87 per cent are women, and of all the single-parent in-work families receiving child tax credits, 94 per cent are women. Therefore, these cuts represent a massive step backwards for equality for women right across the UK.

Gillian Martin: When it comes to the Tories' appalling policy of limiting child tax credit support for children unless a woman can prove that she was raped, does the cabinet secretary agree with the position of Rape Crisis Scotland and Scottish Women's Aid, which have refused to be third-party assessors for that vile policy, along with many other organisations in Scotland and Northern Ireland that have roundly called for it to be scrapped?

Angela Constance: The heinous policy to limit child tax credit support for children, particularly the exemption that requires a woman to prove that she was raped, is completely unacceptable, deeply harmful to women and their children, and a fundamental violation of women's humans rights. There are no circumstances under which it can be acceptable for a woman to have to disclose that she has been raped in order to access social security for her child. The UK Government must scrap the policy as a matter of urgency. It is anti-women, anti-family and fundamentally wicked. I totally understand the position of the many organisations that have refused to support the policy. I very much agree with the joint statement by Rape Crisis Scotland and Scottish Women's Aid that

"the problem is not that organisations are unwilling to change their service to help operate the family cap and rape clause ... The problem is the policy, and this is what must change."

Gillian Martin: Before I ask my next supplementary question, I pay tribute to Alison Thewliss, who has campaigned on the issue for the past two years. Suddenly, everyone else seems to be waking up to the fact that this is going on. Given that tax credits are provided to working families who are on low incomes, will the cabinet secretary estimate the effect that the policy might have on child poverty in Scotland and on the in-work poverty of women with children?

Angela Constance: I, too, pay tribute to Alison Thewliss MP, who has worked hard across the political divide to build as much consensus as possible on this much-hated policy.

At the end of the day, it is the children who will be most affected. Our efforts to reduce child poverty across Scotland will be made all the harder as the Tories in Westminster continue their assault on the poor. It now seems as though Theresa May wants to continue that assault for another five years.

By 2021, about £1 billion will be cut each and every year from welfare spend in Scotland, with a £0.2 billion cut coming from the changes introduced this month alone. The respected Institute for Fiscal Studies estimates that a three-child family will lose on average £2,500 a year; that families with four children or more will lose £7,000 a year; and that 4 million families across the UK will see their entitlements fall. By 2021, 50,000 households in Scotland will be impacted by the two-child cap on child tax credits.

The impact is massive; the reach is far and wide. There is no doubt that Tory policies will push families into poverty and crisis, so it is no wonder that they have scrapped their child poverty targets.

Adam Tomkins (Glasgow) (Con): What exactly is the decision here that the cabinet secretary dislikes? Is it the decision to restrict child tax credits—a decision that is widely supported by taxpayers across the country, as I think that we will see in the forthcoming general election—or is it the decision to make a number of exemptions to that policy? If it is the former, the Scotland Act 2016 ensures that this Parliament has the power to do something about it, either through the top-up power or through the power to create new benefits. Does the cabinet secretary intend to use either of those powers? If not, why not, given her rhetoric on the matter?

Angela Constance: There is nothing like a bit of rhetoric from the Tories or a bit of deflection from a policy that is anti-women, anti-family and fundamentally wicked. The policy violates women's human rights. It is interesting that, rather than uniting with other parties in the Parliament to

oppose a much-hated policy that is anti-women, anti-family and fundamentally wicked, the Tories would prefer to be apologists for and to defend that policy. Mr Tomkins always expects the women in the Scottish Parliament and the Scottish Government to clear up his Government's mess. As well as expecting the Scottish Government to mitigate his Government's mistakes, he expects this Government, this Parliament and the people of Scotland to pay twice. Whether we are talking about the 15 per cent of social security spend that is in the process of being devolved to Scotland or the 85 per cent of the social security system that will remain reserved, we are all entitled to expect to have a social security system that is fair and which does not penalise women and children.

The policy is wrong not just for women and children in Scotland but for women and children right across the United Kingdom. If the Tories intend to save £12 billion from the cuts, they should pass on to Scotland our share of those savings so that we can make different choices—choices that are based on dignity, fairness and respect.

Claire Baker (Mid Scotland and Fife) (Lab): The family cap will push more women and children into poverty, and the rape clause is an indefensible policy that does not belong in a civilised society. The strong opposition that we are seeing to the reforms reflects the anger that exists to the changes.

Gillian Martin talked about the role of third parties and the strong stance that has been taken by women's organisations. Will guidance be issued to the public sector? What is the expectation in terms of compliance in Scotland?

Angela Constance: Claire Baker probably knows from what the Cabinet Secretary for Health and Sport said on the radio this morning that we are opposed to healthcare and other staff and specialist organisations being used by the Department for Work and Pensions to implement its policy. For the reasons that I have outlined already, we are concerned about the proposed third-party assessment model. We have grave concerns that no suitable infrastructure or training to support the implementation of the policy has been put in place by the UK Government, and none appears to be forthcoming.

It is extremely important that we do not expect our healthcare professionals to act as gatekeepers to the benefits system. The chief medical officer for Scotland has advised that she cannot agree to disseminate guidance, because she wants to seek the views of the professionals who are expected to act as approved bodies. She wants to get further information about unintended consequences. In addition, the widely publicised letter from the Royal College of Nursing to Alison Thewliss has raised many concerns.

Children (Physical Punishment)

2. **Liam McArthur (Orkney Islands) (LD):** To ask the Scottish Government what its response is to recent comments by the Children and Young People's Commissioner Scotland on protecting children from physical punishment. (S5T-00516)

The Minister for Childcare and Early Years (Mark McDonald): The Scottish Government does not support physical punishment of children. We have no current plans to introduce Government legislation in the area, but we will consider carefully the member's bill that we understand John Finnie intends to introduce.

We continue to support positive parenting and we recognise that physical punishment can set children the wrong example and is not an effective way to teach children discipline.

Liam McArthur: It is perhaps worth reminding members what Tam Baillie said at the weekend. He told *The Herald* that his failure to see the law on justifiable assault of children being changed is

"the biggest regret of his eight years as children's commissioner."

It sets us apart from practice in most civilised countries and has led to sharp criticism from the United Nations.

We all share the ambition for Scotland to be the best country in the world in which to bring up children. Does the minister believe that we can justifiably claim such an ambition as long as we maintain the practice of physical punishment?

Mark McDonald: As I have stated, the Government does not support physical punishment of children. We take an approach that is about positive parenting and about ensuring that parents feel confident and empowered to take other approaches to disciplining their children. Evidence from the growing up in Scotland longitudinal study that the Government is carrying out demonstrates among parents in Scotland a significant shift in the attitude to physical punishment.

As I said, the Government does not have current plans to introduce legislation in the area, but we are aware that John Finnie will introduce a member's bill on the matter, to which the Government will give careful consideration when the bill comes before Parliament.

Liam McArthur: I thank the minister for that further clarification. One of the criticisms of the proposed legislation is that it may seek to criminalise parents or to interfere unduly with family life. I believe that that criticism is misguided.

As with the ban on smoking in public places and in cars when children are present—the legislation on which was introduced by my former colleague Jim Hume—this is about changing culture and practice. Does the minister agree that when Ireland recently introduced a similar change in its law, it did not result in parents being criminalised or being unable to control their children, and does he also accept that introducing equal protection against assault could help to reduce physical abuse of children in this country?

Mark McDonald: In Scotland, the area of legislation to which Liam McArthur refers predates both his and my time in Parliament. I believe that the legislation was piloted through Parliament by Jim Wallace, who was the Minister for Justice at the time. There was much debate in Parliament around the position that the Scottish Executive of the time took. We will always pay close attention to international examples and the experiences of other countries. As I have said already, the Government will give consideration to John Finnie's bill when he introduces it to Parliament.

John Finnie (Highlands and Islands) (Green): I hear everything that the minister has said, and Mr Baillie's comments are a welcome contribution to our debate. The minister will be aware of growing support for equal protection from assault for children. I note the detailed comments that he made to Liam McArthur, and his reference to international examples. Is the minister able to indicate what priority the Scottish Government gives to the very clear position that the UN has taken on ending physical punishment of children?

Mark McDonald: The Government considers the findings in terms of the United Nations Convention on the Rights of the Child. Work is taking place across all portfolios in the Government, including mine, looking at how we can ensure that the principles that sit behind the UNCRC are taken forward in the Scottish context.

John Mason (Glasgow Shettleston) (SNP): Can the minister reassure families that they are the key part of our society and that parents are the key part of their children's lives? Can he give examples of what the Government is doing to support families, parents and children?

Mark McDonald: The Government's aspiration is that all Scotland's children have the best possible start in life. As I said to Liam McArthur, we believe that the way to do that is to have parents who feel empowered and confident to support their children as they grow up. The Government is taking forward a number of different strategies in that respect—the national parenting strategy being the most obvious.

Also, as part of our children, young people and families early intervention fund, we have awarded £14 million to 116 organisations that support children, families and communities across Scotland. Within that, around £4 million has been allocated to organisations that work specifically in parenting and family support. The Government is committed to ensuring that parents across Scotland have the support and advice that are required to ensure that they can make positive impacts on the lives of their children and be a positive support to them as they grow up.

Douglas Ross (Highlands and Islands) (Con): The minister will know that, in the past, the Scottish Conservatives have raised concerns that a smacking ban would criminalise parents. It seems that the ban that was introduced in New Zealand has not been wholly successful. In his response to Liam McArthur, the minister said that the Scottish Government is considering international examples, so can he advise Parliament what lessons the Scottish Government has drawn from the smacking ban in New Zealand, in particular in relation to false allegations and the risk of criminalising parents?

Mark McDonald: I would not single out any one example as being indicative of what may or may not occur in the Scottish context. Liam McArthur cited Ireland and Douglas Ross cited New Zealand. We can look broadly at international examples and determine what will be the right approach for Scotland. The Government currently takes the position that its approach is to promote positive parenting strategies, although we are nonetheless aware that Mr Finnie intends to introduce legislation to which we will, as a Government, give careful consideration when we see its detail.

Monica Lennon (Central Scotland) (Lab): Given the convincing body of evidence that shows that physical punishment can have a long-term negative impact on a young person's mental health and wellbeing, can the minister tell me how he plans to work with the Minister for Mental Health to address that issue, and what action he is taking to ensure that the long-term impacts of physical punishment will be considered as a factor in the roll-out of the 10-year mental health strategy?

Mark McDonald: As I mentioned, we take a cross-portfolio approach to our responsibilities under the United Nations Convention on the Rights of the Child by looking at how each portfolio interacts with the convention's requirements.

On Monica Lennon's specific question about the mental health strategy, we will also be taking forward a child and adolescent health and wellbeing strategy, which will very much tie in with the mental health strategy and its long-term aspirations.

As I said in my initial answer to Liam McArthur, we recognise the negative impact that physical punishment can have, which is why we, as a Government, take the very firm position that we do not support it. The approach that we take is around promoting positive parenting, which we seek to advance through the work that we are progressing and the funding that we allocate.

Preventative Health Agenda

The Presiding Officer (Ken Macintosh): The next item of business is a debate on motion S5M-04948, in the name of Neil Findlay, on behalf of the Health and Sport Committee, on its inquiry into the preventative health agenda.

14:21

Neil Findlay (Lothian) (Lab): It is a great honour for me to chair the Parliament's Health and Sport Committee and to open this debate on the committee's on-going work on the preventative agenda. Members might be wondering where our report on the subject is. The fact is that our inquiry is at a very early stage and we asked for this debate in order that all members could participate from the outset and contribute to this piece of work. The Health and Sport Committee may be leading today, but the inquiry affects all members, most of the Parliament's committees and every sector of Government. The preventative health agenda is a cross-cutting issue that involves education, justice, transport, housing, the environment, social security, culture and many other areas of Government.

When I was appointed as convener of the Health and Sport Committee, I made it clear that I wanted to run a very democratic and open committee and one that listened to real people. Over the past nine months, we have worked directly with patients, staff, carers and health professionals, not just lobbyists, policy officers and the politically connected. At our business planning event, we agreed a strategic plan for the committee that not only covers the current session but takes a much longer view of health and care. The overriding aim of the plan, which is short, concise and highly relevant to this debate, is:

"In all our actions ... to improve the health of the people of Scotland."

That is fundamentally what this debate is about—improving the health of the people of Scotland. It is a matter not solely for the Health and Sport Committee, the Cabinet Secretary for Health and Sport or health professionals; as the motion makes clear, it concerns us all, whichever area we operate in.

Modern medicine is overwhelmingly reactive rather than proactive. People get sick, they seek medical assistance and—we hope—they are cured or made better. What is less common is the overarching community and national planning that focuses on prevention and early intervention, which is as much about housing, jobs, economic policy and environmental policy as it is about health and social care policy. The first paragraph of the Government's "Health and Social Care

Delivery Plan", which was published in December, makes that very point, but that plan relates entirely to health services. I gently say to the cabinet secretary that that is a great pity, as the opportunity was missed to include other areas that, between them, hold the key to reducing demand on our health services while closing the inequality gap. Health inequality is a manifestation of social and economic inequality, and we will never tackle it from a health perspective alone. We have to take a whole-Government, cross-society approach.

A focus on prevention is not new but goes back through time, coming in different guises. The introduction of sanitation and clean water, slum clearance, council housing and the national health service are some of the most successful examples. That makes the point that the state has a very important role to play, and witnesses that we have heard from have been quick to point to the effectiveness of measures that use fiscal, regulatory and legislative levers to reduce exposure to harm and address inequality.

Such levers impact the whole population, rather than focusing on individual behaviours. Measures such as those that cover the sale and distribution of tobacco and alcohol, taxation of those products and other restrictions introduced to restrict smoking in public places are good examples. We need a dual strategy that includes treatment—yes—but has active prevention running alongside it.

The Christie commission on the future delivery of public services in 2011 did not believe that there was a "magic solution" to the current problem of resources being tied up in dealing with short-term problems to the exclusion of efforts to improve outcomes in the longer term. The commission saw no alternative but to switch to preventative action to avoid what it called "demand failure" swamping the capacity of our public services to achieve outcomes. It noted that it was imperative that public services adopt a much more preventative approach and address the persistent problem of the multiple negative outcomes and inequalities that are faced by far too many.

Also in 2011, the Finance Committee of this Parliament identified that all public spending could be classified as in some way preventative, and it sought from the Scottish Government a robust and measurable definition of preventative spending to be used across the public sector. It would be helpful if, in her contribution, the Cabinet Secretary for Health and Sport could cover that aspect and assist the committee with a working definition.

Moving forward to 2016, I note that in its report, "Changing models of health and social care", Audit Scotland acknowledged what it called the "ambitious vision" that has been set by Government, but had as its key message the fact that the shift to new models of care is not happening fast enough to meet growing need. New models are generally small in scale and not widespread. Audit Scotland called for strong leadership and identification of measures of success, models of new investment and new ways of working. It called for a clear framework by the end of 2016 for how that ambitious vision was to be met.

The "Health and Social Care Delivery Plan" was the Government's response. It aimed for high-quality services with a focus on prevention and early intervention. Prevention is mentioned frequently as a focus in the document, which speaks of a "lifetime-wide approach to prevention". However, I say again that an opportunity is missed in the plan to think beyond the boundaries of health services.

A central part of meeting the vision is the national clinical strategy, with its focus on realistic medicine. The problems that we have in committee in scrutinising prevention remain the same as those highlighted by the Finance Committee in 2011—understanding how the shift to prevention is to be defined, how it is being planned and funded and how it can be measured.

That takes me to the committee's work to date. In January, we agreed that we needed to understand what we were dealing with—what exactly preventative spend and preventative expenditure are. The Scottish Parliament information centre told us that those terms are both vague and conceptual and that all public expenditure could be argued to be preventative. It warned us that because of a lack of definition, public services can be fitted retrospectively under those headings. It also warned us that it is difficult to attribute outcomes to any one policy. We also noted another Audit Scotland report, "Changing Models of Care", which urged effort to address the gap in cost information and to evidence the impact of new models.

We put out a call for views on the definitional question and on how such spending could be identified and tracked. We also asked how spending could be shifted from the reactive, on acute services, to the preventative, in primary services, and how that shift could be speeded up and incentivised. We received nearly 70 comprehensive and thoughtful responses.

In March, we explored those issues further with a group of expert practitioners in the public health field, with integration joint boards and with eminent academics. They confirmed difficulties with definitions and warned us about what they called "counterfactuals"—what would have happened anyway without interventions. We heard about false dichotomies when considering the relative

merits of addressing social determinants of health versus carrying out more specific interventions. We were also told that shifting the balance of care does not mean the same as shifting resource. Community-based care will not necessarily save money, even if all the work to shift the balance is successful. We were warned of the need to compress mortality, to reduce the time people spend in ill health and to keep people healthier for longer.

Overall, however, most of them were saying the same thing to us—that we need a whole-system approach and joined-up government with a focus on reducing the shocking levels of health inequalities that we see in Scotland today. Fundamentally, we all need to agree what actions on the ground will make a difference and how the existing barriers to the use of resources can be tackled. I guess that we also need to know how we can measure the outcomes that are achieved—a subject that, I am sure, my colleague Ivan McKee will cover later in the debate. The committee was also told that the necessary evidence, information and data are available but that we need to get better at measuring them from the outset and interpreting them before using them. There is, however, a need to avoid the danger of paralysis by examination, modelling and testing.

We heard from the Midlothian integration joint board about work that it is undertaking to better understand its communities and about how it is using that knowledge to design new targeted, holistic interventions that look at the social determinants of people's issues. It is measuring improvements or changes using gap indicators, which are, in effect, the measures that are being taken to close the gap. However, that work needs a long-term view and the conclusions are not always clear—we heard about the difficulty in making linkages between a single intervention and an impact—which may take us back to counterfactuals.

My time is not sufficient for me to fully cover our inquiry, but I have tried to give a flavour of what the Health and Sport Committee is looking to consider. Our next steps will be determined partly by what we hear today and partly by what members say. Should we look at discrete initiatives and evaluate how successful or otherwise they have been, trying to read their outcomes across into other areas, or should we focus on how improvement, outcomes and benefits are being evaluated? Could or should we do both? On our strategic plan and its focus on health inequality, should the committee focus on health inequalities and measures to address those only through the prism of health interventions?

I and the committee would really value members' thoughts today. My one plea is that we all endeavour to take a longer-term view of the issue and to resist viewing the next election as the horizon. It seems as though we are having an election every five minutes just now, but the committee's strategic plan commits us to at least a 15-year view.

We will see meaningful progress only with a concerted cross-governmental approach that is properly resourced, and it is absolutely appropriate that the issue is being discussed early in our work. Only by joint and joined-up action will progress be possible towards taking a preventative approach and tackling the root causes of health inequality.

On behalf of the Health and Sport Committee, I move,

That the Parliament recognises the importance of the work of the Health and Sport Committee in its inquiry into the preventative health agenda; welcomes its examination of policies and actions, which prioritise and build in actions to reduce demand on health in the longer term following on the work of the Christie Commission on the Future Delivery of Public Services, and the Finance Committee in 2010; notes that the cross-cutting nature of health inequalities also encompasses housing, education, justice, transport, the environment and other portfolios, and welcomes attempts to meet the growing demand for public services by preventing health problems before they occur by early interventions and by tackling causes as well as their effects.

14:32

The Cabinet Secretary for Health and Sport (Shona Robison): I welcome the debate, which has been initiated by the Health and Sport Committee, and I look forward to seeing the committee's final report. As Neil Findlay highlighted, the Health and Sport Committee's inquiry is building on the recommendations of the Christie commission and the work of the Parliament's Finance Committee in the previous session, which took evidence on prevention from the finance secretary. Neil Findlay is right in saying that the debate needs to look beyond the confines of the NHS and be cross-governmental in nature. It is a very broad topic, so I will try to focus my remarks on some strategic priorities.

The hallmark of Scotland's Parliament and Government has been their willingness to innovate and try new ideas. Two examples that are relevant to the present debate come to mind: first, our pursuit of minimum pricing of alcohol; and, secondly, the introduction of the early years collaborative. Both those preventative measures not only demonstrate our willingness to try new and challenging ideas but highlight the complexity of what we mean when we talk about prevention.

Neil Findlay asked for the Scottish Government's definition of preventative spending. Our preventative approaches are many and diverse, and any definition must give us flexibility

to address different challenges across a range of policy and delivery contexts. We therefore believe that prevention should be defined in broad terms as activity that maintains positive outcomes and breaks cycles of negative outcomes, helping to tackle persistent inequalities for people and communities.

Over the long term, that activity will reshape services and demand, and contribute to the long-term vitality of communities and the sustainability of public services. In that way, we will look beyond preventative spending decisions alone to consider how we can make best use of the totality of resource available—our people and other assets—as that is key to enabling a fully preventative public service culture.

High-quality public services play a crucial role in shaping our economy and society; they also play a role in primary prevention. Our ambitious programme of reform in Scotland, with its emphasis on prevention, integration and empowerment, provides the means to reshape services and demand in a way that contributes to the long-term vitality of communities and the sustainability of public services. Building on the foundations that were established in the Christie commission report, our approach to public service reform is underpinned by the principles of democracy and reform. We see prevention as the route to tackling the most difficult and entrenched problems that people in our communities face, and to achieving our goals of reducing inequalities and driving inclusive growth.

We believe that collaborative partnership working across the public, private and third sectors can enable us to deal with that complexity in a more joined-up way, and to make the best use of the total resource that is available to us. By focusing on outcomes, we aim to develop and deploy resources in a way that establishes a truly preventative culture that forges deeper relationships with local people and is more open and responsive to what communities most value. That was the premise that the Christie commission's report set out, and it is the vision that we are continuing to progress towards, building on the pillars of prevention, partnership, people and performance.

Alex Cole-Hamilton (Edinburgh Western) (LD): I absolutely endorse the cabinet secretary's remarks about collaborative working across the third and public sectors to reduce negative social outcomes in our communities. However, how does that marry up with the cut that represents nearly a quarter of the budget for alcohol and drug partnerships?

Shona Robison: As I just said, we need to focus on outcomes. Since 2008, the Scottish Government has invested more than £630 million to tackle problem alcohol and drug use. The outcomes for 2016-17 show that the standards that were set in the local development plans have been met—in fact, the three-week target for access to alcohol and drug treatment has actually exceeded the 90 per cent target and is at 94 per cent. We need to focus more on the outcomes, and we will shortly set out indicative allocations and expectations in respect of ministerial priorities and outcomes that are to be achieved by boards and other partners. We expect that, in addition to Scottish Government money, our health boards and local authorities will work together, using their resources, to ensure that they deliver on those priorities and, importantly, those outcomes.

We are making a significant investment and engaging in structural reform with the aim of prevention. Again, I will cite some examples. There is the early years framework, and the children and young people improvement collaborative is crucially important. We also have the reducing reoffending change fund, the Scottish attainment challenge and, importantly, the integration of health and social care.

I will draw on one or two of those examples to illustrate that work. This Government's defining mission is to deliver excellence and equity in education, and we want to see the poverty-related attainment gap in Scotland closed, wherever, whenever and however it is measured. That is why we have committed £750 million during this session of Parliament, through the attainment Scotland fund, to target resources at the children, schools and communities most in need. Through the Scottish attainment challenge, we want to break the cycle by improving literacy, numeracy and health and wellbeing; raising educational attainment; and increasing positive destinations for our most disadvantaged children. It is a good example of primary prevention, alongside the fairer Scotland action plan, which sets out 50 concrete actions that we will take over the current session of Parliament to tackle inequality.

Given my own portfolio interests, I turn to one of the biggest structural changes that we have initiated: the most ambitious reform of health and social care services in Scotland since the creation of the NHS in 1948. That has brought about a fundamental realignment of resources that will build the capacity and strengthen the preventative action of our community-based services. It is clear that making a decisive shift towards prevention requires a fundamental change in the relationship between people and public services. Modern healthcare means embracing the public as partners rather than as passive recipients; it is about realistic medicine.

Dr Christie got it right when he said that we have to consider our structural systems to ensure

that they are better aligned to help deliver our preventative agenda. With that in mind, I cannot not mention the work that is under way with local government to agree a set of national public health priorities that will inform local, regional and national action. Our aim is for public health thinking to be embedded in all parts of the public sector. Our shared priorities will be the activities that have the greatest potential to make a significant improvement to health gain, tackling inequalities and promoting inclusive growth over the next 10 years. Work has already started to develop those priorities. Over the spring and summer, I will be engaging widely to build consensus and momentum ahead of publishing priorities at the end of the year.

We can all agree that prevention has the potential to reduce demand for services arising from poor health. I hope that we can also all agree that there are many aspects to a preventative approach that impact at different points in people's lives—sometimes at a population level and sometimes directly with individuals. I hope that we can further agree that the prevention of poor health outcomes is not just a matter for the NHS and its professionals but encompasses the activity of the whole of government and the whole of our public services. If we get our public services better aligned and working more closely with the people they serve, we will make progress, but, to do so, we also need to develop and promote a strong shared narrative and show continued collective leadership on the issue. Within the existing structures, we have seen real successes in tackling the burdens of preventable disease. Life expectancy and healthy life expectancy have both improved significantly in Scotland over the past decade. We need to move that on. By shifting our focus to prevention, we can make a further difference to the lives of people living in Scotland. I am sure that the Health and Sport Committee of this Parliament will help us in that endeavour.

14:41

Donald Cameron (Highlands and Islands) (Con): I am delighted to open for the Scottish Conservatives in this Health and Sport Committee debate on preventative spending. It raises issues that require urgent attention as we consider the health of Scotland's population and the consequences that that has for our NHS—not just in the next five years, but in the next 15, 25 or even 50 years.

The issue of preventative health was brought into sharp focus for me very early on in my time as a member of the Scottish Parliament, when I met two charities on the same day. The charities dealt with two wholly distinct health conditions: diabetes and liver disease. When they were asked about the solutions needed to make lasting inroads into those conditions, they gave the same answer: we need people to have healthier and more active lifestyles.

We spend a lot of time talking about the state of our nation's health, and I have personally participated in a variety of debates in the chamber—both members' business debates and general debates—in which major health issues have been discussed at great length. However, issues surrounding the root causes of so many of Scotland's ills have rarely been laid bare, nor have we debated how we in this Parliament can focus resources on prevention rather than just treatment.

Of course, there a lot of varying opinions when it comes to Scotland's health: that is the nature of politics. First, we must be honest about the situation before we can act. It is clear that Scotland is in a desperate situation, and we need to act now so that future generations will not suffer in such significant numbers from the big health problems that we see today. As the motion states, it is also clear that we need to bridge the gap between the wealthiest and the poorest in terms of health inequalities. As well as being on the Health and Sport Committee, I am delighted to co-convene the cross-party group on health inequalities, along with Anas Sarwar and Clare Haughey. A number of other MSPs play an active role in that group, in which we discuss health inequalities with professionals and interested parties.

Scotland is highly unequal; it has the widest mortality inequalities in western Europe. The poorest Scots are three times more likely to commit suicide, and are more likely to die of cancer, to suffer from a stroke and to die as a result of an alcohol-related condition than those in the most affluent parts of Scotland. Almost a third of our adult population is obese, costing our health service up to £600 million per year. Scotland continues to have the worst weight outcomes of any of the United Kingdom nations and is among the worst Organisation for Economic Co-operation and Development nations. Around one in three children in Scotland lives with at least one binge-drinking parent. No one political party, professional or individual is to blame. This is a cross-party and cross-society issue, and we must all be prepared to be honest about the state of Scotland's health. Only then can we move forward and tackle the challenges head on. We must also be mindful of the fact that a range of social factors feed into poor health outcomes, and we must consider them.

Educational inequality is a significant factor, with Scotland's poorest children on average 31 months behind children from wealthier backgrounds in sciences and reading, and on average 26 months

behind in mathematics. Similarly, affluent pupils are four times more likely to attend university than deprived pupils.

We cannot expect to reduce the health inequality gap without closing the education attainment gap. I acknowledge that the Cabinet Secretary for Health and Sport mentioned that in her speech.

To turn to the Health and Sport Committee's work in this area, I pay tribute to my fellow committee members and the committee clerks for their initial work in placing preventative health at the forefront of what the committee has done in the first year of this parliamentary session. I think that we all recognise the importance of highlighting the radical action that is required if we are to avoid significant issues in terms of chronic conditions that may arise in the future unless focused preventative spending is undertaken now to deliver a more active and healthier population.

I understand that this is a complex area, given that the success of any prevention strategy is never really known for some time. It requires time and input from members of all parties in the chamber and beyond so that we get it right. When the Health and Sport Committee called for written submissions from organisations and individuals on the preventative agenda, it received 67 responses from a range of charities, governmental organisations and professionals, detailing innumerable statistics on and analysis of the poor state of Scotland's health.

I would like to concentrate on two areas where the committee has been active, even prior to its inquiry. First, we undertook a report on increasing participation in sport. Some members of the committee visited Aviemore and Kingussie in my Highlands and Islands region to look at the work of High Life Highland and the role of community sport hubs in a rural setting. It was hugely instructive to see, at a community level, the degree of engagement and co-ordination among a variety of organisations, from schools to rambling clubs, which have come together with the sole aim of achieving greater participation in sport, as well as the role of senior pupils in the school setting providing leadership to younger pupils.

Secondly, the committee evidence sessions on obesity at the end of last year were very illuminating. One specific issue, which was also covered in my members' business debate in January, was the link between obesity and cancer. As I noted in that debate,

"It is estimated that around four in every 10 cancer diagnoses are preventable".—[*Official Report*, 24 January 2017; c 89.]

Cancer Research UK has noted that obesity is the single biggest cause of preventable cancer after smoking, and is linked to 13 different types of cancer. We also know that about 10 per cent of bowel, breast and womb cancers in the UK can be prevented if people are physically active for at least 30 minutes a day, five days a week.

I hope that I have provided a brief overview of the immense challenges that Scotland faces, and I know that my colleagues and others in the chamber will go into greater detail about specific areas of preventative health that we must explore.

It is also incumbent on us to challenge established orthodoxies. We all accept the role of the preventative agenda and the principles behind it. We must also be able to have a frank and candid discussion about where and how money is spent. There may be some programmes that we have supported in the past but which we need to give up because other avenues would provide better results. The committee's inquiry must be alive to radical and innovative thinking, given the scale of the challenge before the country. I again note what the cabinet secretary said about identifying new and challenging areas.

There are a lot of people counting on us to explore this topic, identify solutions and implement change. Only with open discussion will that occur, and I am delighted to offer the support of my party for the motion and for the on-going work of the committee in this area.

14:49

Colin Smyth (South Scotland) (Lab): It is a privilege to open on behalf of the Labour Party on an issue that I know is very important to all members of the Health and Sport Committee.

When Labour created the NHS in 1948, life expectancy in Scotland was 64 years for men and 69 years for women. Today, it is now around 77 years for men and 81 years for women. That shows the success of Britain's greatest achievement—our NHS. However, we all know that for far too many Scots today, from the very moment they are born and simply because of where they are born, life expectancy of 77 or 81 is something that they are unlikely to achieve.

The first paragraph of the session 4 Health and Sport Committee's "Report on Health Inequalities" in 2015 summed up the situation when it said, chillingly:

"A boy born today in Lenzie, East Dunbartonshire, can expect to live until he is 82. Yet for a boy born only eight miles away in Carlton, in the east end of Glasgow, life expectancy may be as low as 54 years, a difference of 28 years or almost half as long again as his whole life."

This is not about only life expectancy. In the most deprived areas, males spend 22.7 years not in good health, compared with 11.9 years in the least deprived areas. The figures show that

tackling health inequalities has to be at the heart of the debate on preventative health. They are inextricably linked: if we want to prevent ill health, we need to tackle health inequalities, and if we want to tackle health inequalities, we need to tackle inequalities in wealth, education, transport and housing. For example, we know that being in work and a person's income are fundamentally associated with their health.

In Scotland today, we suffer from record levels of underemployment, from job insecurity, from zero-hours contracts and from low pay, which means that taking action on the real living wage, showing ambition and using our tax powers, and how we manage our new social security system will all have a major impact on inequality and, therefore, on our health. Indeed, following the publication of a Scottish public health observatory report in 2014 entitled "Informing investment to reduce health inequalities in Scotland", Dr Gerry McCartney, head of the public health observatory at NHS Health Scotland, said:

"Whilst ... tax options may not seem to be directly health related, they will save lives, and ultimately save the NHS precious money and resources. Interventions that redistribute income, such as increasing the standard rate of income tax or implementation of a living wage, are among the most effective interventions for reducing inequalities and improving health."

It is clear that the solutions to health inequalities cannot simply be tucked away within policies on health and social care. As Neil Findlay has highlighted, the Scottish Government's recently published "Health and Social Care Delivery Plan" has, disappointingly, little to say about tackling health inequalities. It fails to acknowledge the notion that health should be in all policies, which is highlighted by a number of submissions so far to the Health and Sport Committee's inquiry.

The importance of a cross-departmental approach to health was highlighted by the Christie commission in its report, which it published in 2011. It stressed the need for community planning partnerships to understand that health inequalities are not purely the concern of the national health service. Christie called for strengthening of democratic accountability, for a joined-up public sector leadership approach and for public sector staff being given the freedom to develop approaches in accordance with local circumstances, rather than there being a top-down approach. The extent to which that has happened is debatable, given that the most significant reform that we have seen in management of public services in recent years has been the establishment of centralised police and fire and rescue services.

The reality is that tackling health inequalities has to be at the centre of all Government policy development, including the carrying out of health inequality impact assessments for all policies and plans. All Government departments and public services must play key roles in reducing inequality through delivering accessible public transport, affordable sport and leisure facilities, through providing decent damp-free social housing and through providing properly funded local services. There is a need to get serious about taking a more joined-up approach to delivery of services, and the pace of change needs to be increased.

In the short time that I have, let me give one brief and simple example, which is co-location of money advisers in general practice surgeries. We know that primary care is, for the majority of people, the access point to the NHS, but not everyone needs to see a general practitioner. Locating additional services in GP surgeries helps to take pressure off our already overstretched GPs. With £2 billion-worth of benefits being unclaimed in Scotland, and with the cost of co-locating a money advice specialist in a GP surgery being just £11,500, with an estimated return on investment of £39 for every £1 spent, such co-location is exactly the type of practical measure that recognises the clear link between inequality, poverty and health.

Crucially, as is clear in evidence that has so far been submitted to the health committee, there is also a need for a relentless focus on the early years, from pre-birth onwards. Stimulating learning in very young children and preparing them for primary school is essential in helping to break the cycle of health inequality. Although tackling health inequalities and, therefore, preventative health, are cross-cutting issues, there is still, very much, a direct role for health and social care.

In public health, we know that Scotland faces an obesity crisis, with two thirds of adults and almost a third of children being classed as overweight or obese. The current obesity framework is not working, so if the Government, when refreshing that strategy, proposes a bolder and more radical replacement that includes tougher regulation of current promotion of unhealthy food over healthy options, it will get Labour's backing.

There is also a need for a revised and tougher tobacco strategy that sets out the priority actions and clear targets along the way to measure progress towards the Government's welcome ultimate aim to have smoking prevalence below 5 per cent by 2034. With Scotland continuing to have the highest levels of alcohol consumption and harm in the United Kingdom, the need for a new alcohol strategy is also clear.

In all those areas—obesity, smoking and alcohol-related harm—there are inequalities, with people who live in the most deprived areas being most likely to be affected. Ultimately, as with any strategy, implementation and resourcing are

crucial, which is why the issue that Alex Cole-Hamilton highlighted—namely, the Government's recent decision to reduce funding for alcohol and drug use prevention services—is deeply regrettable.

We need to have an honest debate about how we resource our NHS. We all accept that we have an ageing population and more people with more complex needs. However, despite the growing demand for services, health boards are being hit by significant savings targets amounting to £1 billion over the next four years. Those savings come at a time when the NHS is struggling to recruit and retain staff—a problem that is exacerbated by the number of unfilled trainee and specialist posts. One in four of our general practices reports a vacancy, and there are 350 consultant vacancies and more than 2,500 nursing and midwifery vacancies, including more than 300 unfilled mental health nurse posts. If we do not stop the cuts and ensure that we have sufficient staff, it will be all the more challenging for health boards and integration joint boards to shift the balance of resources from reactive to preventative spend, and to focus resources and priorities better on health inequalities.

Parliament has the powers to stop those cuts, to make different choices and to be progressive. If we want decent health and social care, we need to ensure that we fund them properly, which means being honest with the public and saying that those who have the broadest shoulders should pay that bit more.

The Presiding Officer: We move to the open debate. I suggest to members that we have plenty of time to take and make interventions.

14:56

Emma Harper (South Scotland) (SNP): I remind members of my interests: I am a registered nurse and co-convener of the cross-party group on lung health. I also participate in other health-related cross-party groups.

I, too, recognise the importance of the work that the Health and Sport Committee is undertaking in its inquiry into the preventative health agenda. I thank the convener, other members of the committee and the clerks for their hard work.

The local health delivery plan guidance says that

"the nature and scale of the challenges that our NHS faces"—

in particular, the challenges of an ageing population and of dealing with health inequalities—

"mean that we need to change the way that our NHS delivers care."

The delivery plans recognise that we must prioritise the actions that have the greatest impact on service delivery, and so focus on three areas, which are often referred to as the triple aim—better care, better health and better value.

The Christie commission estimated that 40 per cent of all health spending was on interventions that could have been prevented. The commission insisted that focusing resources on prevention measures must be a key objective. Obesity, diabetes, coronary heart disease, stroke, cancer, mental health issues, dementia and alcohol-related disease are major issues that affect people in Scotland—more so in the lower socioeconomic groups. We are already seeing a reduction in mortality from the big three—non-respiratory cancer, coronary heart disease and stroke—due to the targeted multidisciplinary teamwork that has been implemented across Scotland. The chief medical officer's annual report, "Realising Realistic Medicine", shows that, between 1994 and 2015 there was a 36 per cent reduction in all causes of premature mortality. A graph on page 48 clearly shows the reduction in mortality from the big three. NHS boards and teams of professionals working together have been able to achieve that.

I would like to focus on Scotland's lung health. It has been 11 years since the ban on smoking came into force, in March 2006. The recent ban on smoking in cars in which children are passengers has been commended by health professionals across Scotland, including my former colleagues in the respiratory team at NHS Dumfries and Galloway. However, the number of deaths that are attributed to respiratory disease has flatlined, with little change over the past 20 years.

The fall in mortality in the other groups is due to a concerted effort, with Government support, to target the big three. At the cross-party group on lung health, I have the privilege of meeting specialist doctors and other multidisciplinary professionals whose prime directive is to improve lung health in Scotland. Representatives from the British Lung Foundation, Chest Heart & Stroke Scotland and Asthma UK also attend. The BLF published "The Battle for Breath: The impact of lung disease in the UK", which examines lung health across the UK. The big picture is that UK lung disease mortality is among the highest in Europe. The overall cost for bad lung health in the UK is £11 billion a year, and £1 billion in Scotland. The BLF paper recommends levels of investment and attention that are similar to those for cancer and cardiovascular disease.

Across Scotland, there are wide variations in the care that is given to people with lung conditions including asthma, lung cancer, chronic obstructive pulmonary disease, idiopathic pulmonary fibrosis and mesothelioma. However, great work is already

being done. Action is in place to prevent unscheduled hospital admissions, which contribute significantly to the higher overall costs of care. Patients are taught to self-monitor their vital signs and to use a scoring system that triggers action based on the severity of the score. They recognise the symptoms of exacerbation of their lung conditions and can act by, for example, getting an antibiotic prescription instead of a hospital admission. NHS Lothian has a light-touch telehealth and person-centred approach to preventing or reducing unscheduled admissions, and NHS Dumfries and Galloway's multidisciplinary team is testing a community respiratory early warning score—or CREWS.

Fewer exacerbations lead to fewer admissions and a reduction in costs, but more could be done. We have a respiratory national advisory group that is chaired by Dr Iain Small and is working on a respiratory health quality improvement plan with the intention that it will be delivered throughout Scotland. The document that the NAG is creating is based on the Welsh and Northern Irish respiratory improvement plans.

I suggest that the respiratory experts need Government support and assistance to implement a national respiratory quality improvement plan—RQUIP—with co-ordination and support, so that deaths from lung disease and even hospital admissions can be reduced. I ask the Scottish Government to consider supporting the respiratory NAG to create a short-life working group or task force to agree on a national RQUIP and then to help to roll it out. I also call on the Scottish Government to consider supporting the next steps for healthier lungs for people who are affected. The work for the group would not be an uphill battle: the template has been created and the battle for breath has already begun.

15:02

Brian Whittle (South Scotland) (Con): I thank the Health and Sport Committee for its work to date on the preventative health agenda, and for bringing the subject to the chamber for debate and discussion. As most members are aware, I have a particular passion for it.

In the short time that I have, I will focus on the relationship between physical activity and food and nutrition, and how they can contribute to the preventative health agenda, especially when early intervention is possible. It is widely acknowledged that a healthy diet and an active lifestyle stack the cards in a person's favour when it comes to preventing many conditions including cardiovascular diseases, stroke, type 2 diabetes, degenerative musculoskeletal issues, certain cancers and heart disease.

We must also include poor mental health as a condition that can, in many cases, be prevented by an active, healthy and inclusive lifestyle. Such a lifestyle is certainly useful in treatment of mental health issues. The Scottish Association for Mental Health has stated that prevention and treatment of poor mental health should involve inclusivity and physical activity. In fact, so sure is it that it is helping to fund the jog Scotland programme.

The fact is that general lack of physical activity and poor diet are leading to an obesity epidemic, with many of the conditions that I have mentioned appearing increasingly as co-morbidity problems—disproportionately so in the more challenging areas. Access to opportunity is one of the main areas that we need to explore. We need to ensure that the opportunity to participate is available to all, irrespective of background or personal circumstances.

Incidentally, we must also understand the differences between physical education, activity and sport. All are intrinsically linked and crucial, but they are all different.

Getting active as early as possible should be the goal. With the advent of 30 hours of free pre-school childcare, we have the opportunity to use those hours constructively through an active-play framework. As I have said many times, the physical and mental pathways for life are mostly set at the pre-school age, so our focus should be on that age group. An active and healthy lifestyle in the early years is likely to set the foundation for an active and healthy lifestyle for the rest of a child's life. Following on from that, we need to ensure that when children reach primary school the active framework continues into active games and on into activity and sport in secondary school.

Access is the key—we must tackle barriers to participation in order to give opportunity for all. One solution is surely to keep schools open after 4 pm. If children need to go home from school and then go somewhere else, the drop-off rate will be high. While they are in school they are a captive audience and, with the right opportunities and encouragement, uptake of physical activity will be likely to increase.

A Child Poverty Action Group Scotland report has suggested that some children from families who are in more challenging circumstances are, rather than asking their parents whether they can take part, saying that they are not interested in participating in sports and activities because they know that they are likely to be told that they cannot. Surely, by opening up extracurricular activities at school, we can begin to address that barrier.

The other issue that I would like to raise in relation to participation is the need to have enough

appropriate teachers and coaches to ensure access to opportunity. That is borne out by the increasing waiting lists at clubs in many sports. There are solutions. Perhaps we should be looking at the section of the population that has life and work experience aplenty—people who are approaching retirement or who are already retired. When I was manager of the Glasgow athletics development scheme, we had on a rota 43 coaches working with schoolchildren who came from all over Glasgow to the Kelvin Hall, and all those coaches were retired people. Having retired coaches ticks quite a few boxes, including intergenerational social interaction, purpose and activity. There are always options worth exploring.

Poor diet is an area that the Scottish Government has a direct input to, from nursery education right through to primary and secondary schools, in our hospitals and in our prison service. I discovered when investigating public food-procurement policy through the Scottish Government's Scotland Excel that a sizeable proportion of food that could be procured from our farmers is, in fact, sourced from outside Scotland and the UK—much of it of lower quality than what is produced locally. I welcome the decision by the Deputy First Minister and Cabinet Secretary for Education and Skills to investigate, as a result of that report, the nutritional quality of food that is served in schools. I encourage the Cabinet Secretary for Health and Sport and the Cabinet Secretary for Justice to do the same for hospital food and food that is served in prisons. By ensuring that the highest-quality food, sourced locally, is available from nursery education onwards, the Scottish Government can have a significant impact on diet, especially in the earliest years.

Neil Findlay: We are debating a whole-Government and whole-society approach to improving health—in particular, the health of children. How does the UK Government's social security policy contribute to that?

Brian Whittle: I think that Mr Findlay is alluding to inequality of income, which obviously has a bearing, but we must acknowledge that participation has a cost as well as an impact, so we must be careful because the two are intrinsically linked. Although I recognise Mr Findlay's desire to tackle the issue, having been at committee meetings where he has addressed it, I believe that he has an answer that he wants to get to, and that he is trying to find a question that will get him there. We need a more open-minded discussion because the issue is wide, as has been stated today.

I repeat: by ensuring that the highest-quality food, sourced locally, is available from nursery education onwards, the Scottish Government can have a significant impact on diet, especially in the earliest years, when intervention will have the greatest long-term impact.

It is also important to note the part that good nutrition plays in mental health, as well as on physical health. According to the report by the Mental Health Foundation, "Food for thought: mental health and nutrition briefing", nutrition is a factor in mental health, just as it is for physical health, and plays

"an important role in the prevention, development and management of diagnosed mental health problems including depression, anxiety ... Attention Deficit Hyperactivity Disorder (ADHD) and dementia."

In establishing the activity levels of Scotland and the potential impact of top-level sport on increased participation levels, it is important to note that, within the figures, the increased waiting lists for sports clubs are not included, nor are the numbers of people who are inactive and would like to be active but do not know how to or do not have the means to do so.

I ask people not to throw the baby out with the bath water. Investment in physical education, physical activity and sport at all levels is crucial if we are seriously to tackle health inequality. The truth is that the preventative health agenda is primarily an educational intervention and not a health portfolio intervention. Once again, I thank the Health and Sport Committee for giving us the opportunity to debate the subject in the chamber.

15:10

Bob Doris (Glasgow Maryhill and Springburn) (SNP): I am delighted to speak in the debate and I commend the Health and Sport Committee for its constructive and proactive approach to its inquiry. I was a deputy convener of the committee in the previous session and I know that Labour's Duncan McNeil, who was the then convener, would be pleased about the approach that the current committee is taking. I have a strong interest in the issue, too.

As I tend to do in such situations, I will talk about how, by getting cross-party and cross-Parliament support, we can drive change. The previous committee brought about significant change on new medicines, medicines for rarer conditions and the regulation of care for older people. We achieved that not in a tribal way but by coming together in a cross-party, constructive and proactive way. That was a real achievement. We sometimes get such a cross-party approach in committees, but it does not always happen in the chamber. It is good to see it transfer to the chamber from time to time.

I now have the privilege of convening the Local Government and Communities Committee.

Housing is a huge part of the committee's remit and I am pleased that housing is mentioned in the motion, because it has a key role to play in preventative spend. As we have heard, health and social care integration is a significant step forward in efforts to join up services locally. In Glasgow, for instance, significant progress has been made in tackling delayed discharge from hospital. However, pressures still exist, and additional progress is needed to support vulnerable residents in their own homes or in the most appropriate homely setting.

I commend Glasgow for including housing representation in its integration joint board. That is a positive step and the right thing to do. I would be keen to know how many integration joint boards throughout Scotland include housing representation and whether the Government would consider making that a statutory requirement in the future.

I will outline housing issues in my constituency of Maryhill and Springburn, where it can be difficult to find an appropriate housing and care solution for many individuals and families. That is particularly the case for older home owners whose health is failing.

My constituency has a number of low-income home owners who are often—but not always—elderly people whose health is failing and who need suitable adaptations to their home or alternative accommodation. I will provide some examples. I am working with an elderly lady who is seeking to get a housing association to buy back her second-floor property. Without a ground-floor property, she will be isolated and housebound. We have to ensure that social work services—or, rather, health and social care boards—work collegiately with a housing association to make that happen. We need to ensure that the financial models that underpin that suit the care-at-home services that the person needs. That elderly individual cannot sell her property without having an appropriate place to go to, so there has to be seamless integrated support for her.

Another elderly home-owning constituent of mine is unable to return home at present. Their property would require significant adaptations, and the best outcome might be an extension to the property, which would present a huge challenge to budgets. Can adaptations criteria at a local authority level meet that need? Do we need new funding models to make that happen? There can be equity in properties. Do we have to think more carefully about how we achieve a joined-up system? There are opportunities if we think proactively and think out of the box.

I am giving a flavour of how the Local Government and Communities Committee might seek to work in partnership with the Health and Sport Committee on early intervention. As we know, if a person stays at home with the appropriate support, for longer, not only are they happier and healthier but they need a slimmer care package and the cost to the public purse in the long term is reduced. Everyone can be a winner in that situation. We just need to get the model right to make it happen.

I will say a bit more about the debate on preventative spend. Often, we get into a statistics war on the question of more money being spent in the community or the acute sector. I think that the Scottish Government has accounted for some of its spend unwisely. The money that will be spent on the acute elective surgical centres that will open across Scotland is accounted for in the column of acute services, which seems to show that we are going in the wrong direction, because we all want more money to be put into community services.

I cannot think of a more appropriate form of preventative spend than giving people the hip operations, knee operations and cataract operations that they need to enable them to stay in their own homes. If they do not get those operations timeously, slips, trips and falls become a huge issue. However, the presentation of the investment that the Scottish Government is making in those services ends up making the situation look worse than it is. That is positive preventative spend investment, but we do not account for it properly.

The inverse care law comes up quite a lot in the discussion—it was raised during discussions in the Health and Sport Committee in the previous session. It tends to involve an argument about moving away from universal services and instead targeting services on those who are living in poverty. I think that it would be unwise to move away from universal services. When I was a member of the Health and Sport Committee, I was convinced that we must be wedded to universal services but also have additional uptake drives in poorer areas, so that it is not just those in the areas that are better off in income terms who use the universal services.

Neil Findlay: Mr Doris will be familiar with the principle of proportionate universalism in which there is a universal service but the areas that need it more get more. Does he agree with that principle?

Bob Doris: That is the direction that the Government hopes to move in. We have to put in place the financial models to underpin that.

I will discuss the GP practices in the deep-end areas, many of which are in my constituency. To a degree, they are well resourced but, if someone goes to see a GP with multimorbidities—that is,

with five, six, seven or more things wrong with them—the 10 or 15-minute appointment does not allow them to get the support that they need. We can compare that with someone who goes into a GP surgery in a better-off area and has only one health condition or who is seeking support for a preventative health measure.

As I have a bit of time in hand, I would like to address one more issue. We can do health to people as much as we like, but we have to empower people to make positive choices in their lives. That links into the Scottish Government's community empowerment agenda and proper local regeneration initiatives.

In that regard, it is only right that I should name check Royston, which is a deprived community in my constituency. The local authority was doing no regeneration work there, so people in the community did their own. They developed their own regeneration plan and are now able to take land that was wasting away and redevelop it for the community, and they have secured money for a community centre. All of that was driven by the priorities of the community, not the council.

In Springburn, there is an eyesore called the Talisman pub. What does that have to do with preventative spend? That pub has been sitting there, withering away, for generations. If people in the community saw it demolished and saw something happening to that land, they might buy into community regeneration a bit more.

We have to get that right if we are to get everything else right as well. We need to think in terms of community empowerment—not just doing health to people but asking people what they want for their communities. That will make a huge difference.

The Deputy Presiding Officer (Linda Fabiani): I inform members that, as Mr Doris suggested, we have some time in hand.

15:18

Monica Lennon (Central Scotland) (Lab): I join colleagues in commending the Health and Sport Committee for its inquiry into the preventative health agenda. In my role as inequalities spokesperson for Scottish Labour, much of the work that I have been engaged in since being elected last year has focused on highlighting the causes of and solutions to complex health inequalities. Whenever we talk in this place about health inequality or how we can address Scotland's ill-health problems in the long term, the conversation seems to circle back to preventative spend and action.

Dealing with health problems after they have occurred is much more difficult and costly for us as a society than taking preventative action to stop health issues arising in the first place. We know that, but we also know that the prescription for preventative healthcare is not as simple as it sounds—or as simple as politicians would like it to be.

Preventing health inequality, which is often ingrained from the first days of life, requires cross-cutting action across Government, including action across the housing, education and environment portfolios. There is no one easy fix. It is therefore welcome that the Health and Sport Committee has taken the time to conduct its inquiry and to build on work in previous sessions on the Christie commission's work.

I welcome the committee's focus, in taking forward the inquiry's findings, on the cross-cutting nature of preventative action. I also welcome the British Medical Association's suggestion of a health-in-all-policies approach. Such an approach is certainly an intriguing idea and further investigation by the committee of how that could be achieved would be worth while.

In the time that I have, I will draw members' attention to two aspects of the preventative health agenda. I mentioned the importance of cross-cutting intervention. An issue that I have consistently raised over the past few months—how we improve the mental health of people in Scotland and how we achieve that by working across portfolios and in a meaningful way—requires exactly that.

Tackling Scotland's mental health problems needs urgent investment in the early years and adolescent support, because failure to intervene at that crucial developmental stage leads to problems being stored up for later in life. We know that half of all mental health problems start before the age of 15.

We know that there is a crisis in waiting times for child and adolescent mental health services. Last year, more than 300 children waited for more than a year to be seen and thousands more waited month after month for help. We know that, even after that wait, several hundred of those children were rejected for treatment with no further explanation or clear pathway to alternative support.

More children coming forward for help with mental health struggles might well be a welcome sign that the stigma surrounding mental health is reducing. However, it is also a sign that investment to ensure that those who require medical help receive it must be coupled with preventative action to provide support to those for whom CAMHS are not always the most appropriate destination.

Barnardo's Scotland recently backed Scottish Labour's plan for an independent review of rejected referrals. It is welcome that the Scottish Government has indicated a commitment to an audit of referrals in the mental health strategy but I—along with a number of mental health charities including the NSPCC in Scotland and SAMH—was disappointed by the lack of ambition and detail on the funding and the timescales for other preventative action in the strategy.

Most notably, there is no concrete commitment from the Government to back the plan for school-based counselling. Having a qualified counsellor in every school would be a welcome step to show that the Government is cognisant of the importance of prevention. It would be a clear, targeted action to improve the wellbeing of our children at the earliest stages and could be a crucial link in spotting and preventing mental health problems by providing support to young people quickly, at the right time and in their own environment.

I have consistently pressed the Government for further detail on how the dedicated Minister for Mental Health is working with the education secretary. We have heard reassuring and welcome words, but the lack of action in the 10-year mental health strategy is disappointing.

Preventative cross-cutting action is the bold vision that is required to transform Scotland's mental health services. Early prevention work is vital to reducing the harm of poor mental health, which, in turn, could have a transformative effect on reducing the pressure that mental health problems can place on other public services.

That brings me to the second aspect of the preventative health agenda to which I will draw members' attention: how we can reduce the impact of alcohol harm. The Scottish Government has pledged to bring forward another alcohol strategy later this year. I agree with Alcohol Focus Scotland's view that that presents a unique and excellent opportunity to set out the actions that are needed to reduce alcohol harm. I hope to see the Scottish Government commit to some bold, preventative action, including a commitment to tackling the marketing of alcohol to children and to introducing licensing regulations to reduce alcohol's availability.

The effects of alcohol harm are most acutely felt in the most deprived communities, as those who live in the poorest areas are up to five times more likely to suffer an alcohol-related death than those in the least deprived areas are. Given that the funding for alcohol and drug partnerships, which others have mentioned, has reduced by 22 per cent in the past financial year—a cut that has been maintained in the current budget—it would be a welcome move for the committee to investigate the impact of preventative spending on reducing alcohol harm more widely. Given the cost of alcohol harm across many portfolio areas, that cut is likely to have a significant impact.

Driving forward the preventative health agenda will be crucial to the development of health policy during the current session of Parliament. The committee's work on the topic so far has been promising, and I look forward to it investigating preventative spending further.

15:25

Alison Johnstone (Lothian) (Green): I am glad to contribute to the debate and to reflect on the evidence that the committee has heard so far as part of our inquiry on the preventative health agenda. It is a timely inquiry that questions our public health spending priorities and challenges assumptions about shifting the balance of care. I thank all those who submitted evidence to inform the inquiry, as well as everyone who provided briefings in advance of the debate. I also thank our clerks and researchers for their on-going support.

The committee's motion rightly stresses the cross-cutting nature of health inequalities. We need a range of portfolios, including housing, education and the environment, to have a decisive focus on health. We need to tackle serious, systemic threats to public health such as air pollution, which causes as many deaths as a lack of physical activity does. Research led by Professor David Newby at the University of Edinburgh and the British Heart Foundation just a couple of miles away from here at the Royal infirmary of Edinburgh has demonstrated that particulate matter from traffic has a serious impact on our cardiovascular health.

Urban air pollution presents a serious risk to young children and pregnant women, and it has been linked to premature birth, decreased lung function and even neurological disorders. The House of Commons will lead an unprecedented joint inquiry on air quality that will involve the Environmental Audit Committee, the Environment, Food and Rural Affairs Committee, the Health Committee and the Transport Committee, and I would like equivalent joined-up action to be taken here in Scotland. Friends of the Earth has shown that air pollution causes more than 2,500 early deaths in Scotland every year, but the matter is still not taken seriously enough. My colleague Mark Ruskell will soon introduce his bill to change the default speed limit, which will be a great step forward.

I emphasise the fundamental importance of income and the impact that poverty has on health and wellbeing. We will not make progress in tackling health inequalities until we take significant

steps to reduce inequality of income and wealth. NHS Health Scotland has laid out clear evidence that inequality damages our health, and it recommends the introduction of a minimum income for healthy living, more progressive taxation and the building of a more vibrant democracy, which are all Scottish Green values. We believe that, rather than simply involving the provision of some services at a slightly earlier stage of illness, preventative approaches to healthcare involve a fundamental rebalancing of our approach to public health.

The Royal College of Paediatrics and Child Health's "State of Child Health Report 2017" shows that we need a transformation in our approach to child health. There is a particularly urgent need to tackle child poverty because of the lifelong effect that growing up in poverty can have on health and wellbeing. The Social Security Committee, of which I am also a member, has heard how the healthier, wealthier children income maximisation programme that NHS Greater Glasgow and Clyde has developed has raised more than £13 million over the past seven years for families in poverty and has increased the uptake of healthy start vouchers. I am glad that the cabinet secretary has agreed to roll out that approach across Scotland. The Child Poverty Action Group has welcomed that, and it would welcome further details on how the extension will be implemented and funded.

The Scottish Government's proposed reforms to maternity services, which include the provision of individualised antenatal care for all women, present an ideal opportunity to embed income maximisation across all maternity services. A clear commitment to that must appear in any delivery plan that emerges from the Child Poverty (Scotland) Bill. This is also the right time for a right to income maximisation services to be put on a statutory footing.

Those actions are crucial because, sadly, child poverty levels throughout the UK are predicted to rise. The UK Government's decision to scrap child poverty targets was shameful, and limiting tax credits to a family's first two children is wrong. It beggars belief that women are expected to prove that they have been raped in order to receive tax credits for other children. I cannot begin to understand why anyone would ever think that it was acceptable to put such a form in front of anyone, and it is shameful that the Conservatives support that.

Such policies are hugely damaging to physical and mental health. We want to provide more support for financially vulnerable families, not less. That is why the Scottish Greens have called for a £5 child benefit top-up, which the Child Poverty Action Group also recommended.

We need to strengthen our focus on tackling health inequalities, and child poverty in particular. I have concerns that those areas are being lost in our debates about preventative spending and shifting the balance of care. The Scottish Government's health and social care delivery plan uses the phrase "health inequalities" only twice and does not use the words "poverty" or "income" at all.

Improving access to primary care and addressing unmet need should be key to health and social care integration, but there is a lack of clarity about the Government's plans for primary care. We know that the Scottish allocation formula has been reviewed, but the commissioned analysis has not been published; a further review of GP pay and expenses is under way, but details are not available for public scrutiny.

The Scottish Greens have stressed the need to ensure fairer funding for GPs and primary care specialists who work in areas of high deprivation. There is a case for adjusting the SAF to ensure that practices in deprived areas are properly resourced and for ring fencing for patient care and practice development some of the funds that are delivered through the formula. The need to strengthen primary care in areas of high deprivation has been recognised for a long time, but progress to achieve that has been slow. The Kerr report stated:

"Resources should be selectively targeted to deprived areas to ensure that patients in these areas have enhanced opportunities to be seen and have their problems dealt with at an early stage."

It is time for the Government to provide clear information about its plans to improve primary care in areas of multiple deprivation beyond the provision of link workers, although they are warmly welcomed, as are the welfare rights advisers who are working in some practices. It is crucial that our health services are equipped to meet the needs of an ageing population, but we must not lose our broader focus on families and child health.

15:32

Maree Todd (Highlands and Islands) (SNP): It is a pleasure to participate in this debate as a member of the Health and Sport Committee. I remind everyone that I am a pharmacist registered with the General Pharmaceutical Council.

As others have said, part of the challenge that we have in debating this issue is that there is no single definition of what the preventative health agenda is. There is general consensus that the preventative agenda is inextricably linked to the health inequalities agenda, but there remains a stubborn tension between the need to tackle the issues and problems that face health and social

care in the present, and the view that the focus of preventative spend should be on the root causes of health inequality—the upstream socioeconomic factors, of which the main one is the uneven distribution of wealth.

Some of the most potentially significant public health interventions that Government and health services can make might take decades to produce measurable financial outcomes. For example, the measures that successfully reduce the levels of overweight and obesity in children and young adults, about which we all care so passionately, might not lead to financial savings to health services until those children reach middle to older age, when weight-related health complications would otherwise be more likely to occur.

When improved health outcomes are identifiable, it can be very difficult to attribute particular outcomes to specific public health policies. For example, a variety of policies have been introduced to try to reduce tobacco consumption, but that multistranded approach can make it very difficult to attribute success to any particular policy intervention. That makes measuring the cost effectiveness and efficacy of individual approaches a challenge, and it is a real challenge for those of us whose job it is to scrutinise Government spend.

A number of the submissions to the committee's inquiry have highlighted the false dichotomy between reactive spend and preventative spend, and I want to explore that a little bit with regard to my profession. Lots of statistics are published that illustrate the need for a more preventative approach to pharmaceutical care and the scope for improvement. Over half of the medicines that are prescribed are not taken as the prescriber intended. More than one in four hospital admissions of older people are related to medication and are considered preventable.

According to Asthma UK, there were 1,143 deaths from asthma in the UK in 2010, but approximately 75 per cent of the hospital admissions and 90 per cent of the deaths that then occurred were preventable. Non-adherence to routine medicines has been estimated to cause approximately 48 per cent of asthma deaths. Would more investment in pharmaceutical care help? It certainly would, and I hope that it is clear that spending on the better treatment of illness can be considered to be preventative spend.

That illustrates that the preventative health agenda is not clear cut, and it is not an area in which there is universal agreement about the approach.

In Scotland, we have been really bold at times, and a recent example that I welcome is the approval of pre-exposure prophylaxis, or PrEP. Scotland has become the first part of the UK to approve a drug that reduces the chance of HIV infection. The daily pill known as PrEP, which has been approved for use in the Scottish NHS by the Scottish Medicines Consortium, reduces the risk of getting HIV from sex by more than 90 per cent; among people who inject drugs, it reduces the risk by more than 70 per cent. As Robert McKay, the national director at the Terrence Higgins Trust Scotland, said:

> "Not only will this make a life-changing difference to individuals by protecting them from a lifelong and stigmatised condition, but for every person who would have become HIV positive without PrEP, NHS Scotland will save £360,000 in lifetime treatment costs."

We have also been bold in the many different measures that the Scottish Government has taken to change our cultural attitudes to tobacco and alcohol. One question that was posed to us at committee was why there is a reluctance to use the most cost-effective forms of prevention that are most likely to reduce health inequalities. Measures that use fiscal and regulatory or legislative levers to encourage behaviour change, such as minimum unit pricing and tobacco taxation, are very cost effective, but politicians tend to favour less effective methods, perhaps because of the huge pressure from multinational companies. Less effective methods such as individual behaviour change, education and lifestyle change can increase inequality, and they should only ever be a small part of a comprehensive approach.

In Scotland, we have taken a comprehensive and bold approach to alcohol and smoking. I believe that we need to take the same comprehensive approach to obesity and to tackle the quality of the food that we eat. We live in an obesogenic environment. We need to make it easy for people to do the right thing, and in my opinion that should include using fiscal, regulatory and legislative levers to change culture.

I will finish by mentioning welfare reform, as others have done. An inquiry by the UN into the actions of the previous UK Government, which was a Conservative and Lib Dem coalition, found that its austerity policies amounted to systematic violations of the rights of people with disabilities. With the current Conservative Government, that continues. Disabled people losing Motability cars means that they cannot work, and the introduction of universal credit in the Highlands has caused severe hardship because of the delays in processing applications. Just in the past couple of weeks, we have seen the introduction of the two-child cap for families claiming tax credits. Why on earth a child with more than one brother or sister is less deserving of state support, I cannot comprehend. We must also consider the callousness of the rape clause.

I finish with a quote from the BMA submission:

"inequalities have remained persistent and cuts to welfare support in particular have undermined progress that might otherwise have been made in this area."

The Deputy Presiding Officer: We still have some time in hand.

15:39

Jeremy Balfour (Lothian) (Con): I thank the Health and Sport Committee for the work that it has put in with regard to preparing the report. I welcome today's debate, which enables us to air a number of issues.

As my colleague Donald Cameron said, early intervention is perhaps the most significant way in which we can help individuals and society. If we intervene to help young children and their families to live healthy lifestyles, they will be less likely to have health implications later on. Good habits that are picked up in early life can reduce the future cost of ill health to the NHS as well as the loss of economic output and the risk of individuals becoming involved in crime and prison, with all of the associated costs.

There can also be an impact on the quality of learning and the type of life that an individual has. As a local councillor in Edinburgh, I am aware that within 3 or 4 miles of my ward, life expectancy is five or 10 years less. That seems unacceptable to me in Scotland today. We need to work with all areas of society, but we need to focus money and resources where they can help the most vulnerable.

Nobel prize-winning economist James Heckman has argued that returns on investments that are made in early years greatly outweigh returns on investments that are made in any stage of education. He says that

"an optimal investment strategy is to invest less in the old and more in the young".

That is a challenge that we face today. When we talk about the young, we are not talking about those who are in nursery or in school; we are talking about those from zero to three years old. Helping families to set patterns at the earliest stage will give us the biggest improvement.

Maree Todd: How does the member's current theme of supporting the youngest of children fit with the policy of the Conservative Government in Westminster of not providing tax credits for more than two children in one family?

Jeremy Balfour: We are looking today at how we can help families generally, but also at how Government—at UK level, here in Scotland and, as I will cover in a moment, in local authorities—can direct that help to individuals. We, as a Government and a country, have made the decision that we should put that limit in place, and I think that it is a very sensible measure.

I would like to move on. This morning I had the privilege of visiting Dr Bell's family centre in Leith. Dr Bell's family centre has been going for many years, helping children who live in Leith and north Edinburgh. They can get encouragement, support and advice in a very relaxed environment. The centre is there to support and help vulnerable and disadvantaged people from different cultures in that area. The centre provides a drop-in centre for nurseries, and 48 per cent of those who go along to it have English as a second language.

Sadly, the City of Edinburgh Council's Scottish National Party administration has cut the budget for the centre, which is affecting the services that it can provide. Giving money to that type of centre would be much more advantageous than having a token baby box go to well-off families. We need to put the money where it helps most. That type of centre provides that help.

The Minister for Public Health and Sport (Aileen Campbell): Will the member take an intervention?

Stuart McMillan (Greenock and Inverclyde) (SNP): Will the member take an intervention?

Jeremy Balfour: Absolutely.

The Deputy Presiding Officer: Which intervention will you take, Mr Balfour?

Jeremy Balfour: I will take both.

The Deputy Presiding Officer: Well, we have plenty of time. We will go to Aileen Campbell first.

Aileen Campbell: Returning to the member's response to Maree Todd's intervention, which I do not think that he properly articulated, I wonder how he can square his criticism of the baby box, which has given all children the best start in life, with the policy of limiting tax credits for families with more than two children. Does he not see that those two comments are contradictory and that he should distance himself from his UK Government's policies?

Jeremy Balfour: I wonder whether the minister accepts that reducing the amount that is given to local authorities, particularly here in the capital city, is affecting the amount of money that they can give to third sector organisations that are providing the most benefit. Perhaps the minister will reflect that if her Government better supported local government, we would not have those issues.

I am happy to take the second intervention as well.

Stuart McMillan: The question that I was going to pose was posed by the minister, but Mr Balfour's response gives rise to further questions. If Mr Balfour is so concerned about the amount of money that is going to local authorities, what did he do to lobby his UK counterparts and the UK Government not to cut the budget coming to the Scottish Parliament?

Jeremy Balfour: Mr McMillan must be living in a slightly different world from me, because the money that we got from Westminster was more than we got last year. It is for the Scottish Government to decide where to give the money—that is a choice of the Scottish Government and the Scottish Parliament, and we have given less to local government this year than we gave in previous years. It is not a Westminster issue; it is a Scottish Government and Scottish Parliament decision.

My time is up, so I conclude by re-emphasising the point that early intervention will help in the longer term in all areas. We need to look at that very carefully.

15:46

Alex Cole-Hamilton (Edinburgh Western) (LD): I express my thanks to my fellow members of the Health and Sport Committee for their work in the inquiry. I also thank the clerks and researchers who so ably serve that committee in its work.

In his foreword to the 2011 report of the commission on the future delivery of public services, Dr Campbell Christie said:

> "Experience tells us that all institutions and structures resist change, especially radical change. However, the scale of the challenges ahead is such that a comprehensive public service reform process must now be initiated, involving all stakeholders."

Although that insight was offered in respect of the macro-institutions that make up our public sector, I am sure that, if Dr Christie had thought about it, he would have ascribed it to this institution as well. For a great many years, and since the beginnings of devolution, each of us has employed the language of prevention but there has not necessarily been the structural and financial investment or the culture shift that are required to see upstream funding set about reducing negative social outcomes. That aim continues to evade us.

Nowhere is the cost of that demand failure, as it has been described by Campbell Christie, more evident than in the continuum that represents our health service. It would be easy for me to spend the entirety of my time poking holes in, and pointing fingers at, the failures of command in the conduct of the Administration's efforts in the area. However, I believe that one can offer such criticism with any meaningful credibility only if credit is also offered where it is due.

As Maree Todd articulated, since we last met in the chamber the Scottish Government, through the Scottish Medicines Consortium, has made the prophylactic HIV medication PrEP available on the NHS. That is a tremendous victory for campaigners and a welcome recognition by the Government that the problem of HIV is still growing. The widespread availability of PrEP, which serves as a vaccine in many ways, will help to dramatically lower infection rates in at-risk communities and prevent future failure demands in the NHS in terms of the lifelong HIV medication that failure to prevent infection can lead to. Would that that foresight could be replicated across the board.

I have talked about our health service being a continuum. Like a river, it wants to exist in a state of flow, but upward pressures exist at every level in that continuum, which act to disrupt the state of flow. A shortage of general practitioners leads to conditions becoming more acute and diagnoses being delayed, and a lack of appropriate social care provision can lead to patients such as my constituent George Ballantyne, whose case I have raised in the chamber many times, languishing in hospital for 150 nights or more after being declared fit to go home for want of provision. In turn, bed blocking can see the cancellation of elective surgical operations such as those that are carried out by Dr Patrick Statham, a consultant neurosurgeon at the Western general hospital in Edinburgh, and severe delays in discharge from the accident and emergency ward into the wider hospital due to there not being an available bed—something that is manifest in statistics that we see every week in relation to the A and E waiting time targets.

We can mitigate those blockages through prevention at all stages of life and in all demographics and communities in our society. We understand the keystones of prevention, but we singularly fail to meet that understanding with preventative spending, particularly—as we have heard many times in the debate—on addressing health inequalities.

John Mason (Glasgow Shettleston) (SNP): Where is all the money coming from? Should we take money away from the hospitals and put it into preventative spending? Presumably, we cannot spend the money on both hospitals and preventative spending.

Alex Cole-Hamilton: I think that we can, absolutely, and I am about to come to the ways in which we can recalibrate the front loading and pump priming of our health service to meet demand within existing resources.

Despite a measurable increase in drug-related deaths and a causal spike in HIV infection in Glasgow, the SNP Government has reduced funding for alcohol and drug partnerships by as much as a quarter—a cut that totals nearly £1.3 million a year in our nation's capital. Despite the cabinet secretary's assurances, those cuts have not yet bitten so we have not yet seen the impact on outcomes.

In our elderly population—despite the excellent work resulting from the 2014 falls framework, which has done much to reduce falls among our older population in care settings—the Government has yet to act on the mandate that it received from Parliament earlier this year to bring forward a comprehensive falls strategy to tackle the problem. Falls have become one of the biggest causes of anxiety for older people—and with good reason, given the demonstrable relationship between protracted hospital stays and mortality.

As Monica Lennon said, it is in tackling the challenge of our nation's mental health, particularly among children and young people, that the Government has arguably been found wanting the most. Delays in waiting times have spanned years, and children in abject crisis are being turned away from tier 4 beds because of a lack of available staffing.

The First Minister, in her first speech to this Parliament following the election, was very gracious in citing my party as the catalyst for the appointment of Scotland's inaugural Minister for Mental Health. I do not doubt the integrity with which Maureen Watt seeks to discharge her brief, and the revelation that, despite a protracted delay, the nascent mental health strategy would span 10 years was greeted with great approval from the sector, but such approval has been short lived. With such targeted and stretching aims as what has been described as support for an increase in support for the mental health of young offenders, and an even further delay in refreshing the expired suicide strategy, we might start to doubt the reach of this Government's ambition in mental health. Many now doubt that reach; professional bodies have greeted the new strategy with dismay, characterising it as unambitious, underresourced and profoundly lacking in detail.

There can be no greater frontier in which we, as a legislative body, must push forward in the healthcare arena and the preventative agenda than mental health. Suicide is the principal cause of death in men under the age of 50, and more than 600,000 days are lost to the workplace each year as a result of mental health issues. Most crucially, there is the interruption in the flow and continuum of the health sector, given that one quarter of all patients who present to appointments in GP surgeries around Scotland do so with an underlying mental health condition.

The stewardship of the health of our nation must not be measured by the treatment or absence of symptoms, but by what we do as a Parliament to keep people well in mind and body; to stabilise chaotic lifestyles and reduce health inequalities; and to protect vulnerable communities. Only then can we possibly hope to meet the challenge before us.

15:53

Ivan McKee (Glasgow Provan) (SNP): I am glad to have the opportunity to speak on preventative spend and on the Health and Sport Committee's inquiry into that important subject. The debate allows members to have an input into the committee's work, and I hope that many will take the opportunity.

I intend to focus on three specific areas. The first is the scale of the task before us. We will not provide a modern fit-for-purpose health service for the 21st century by continuing to do things as we have always done them—the need for change is compelling. Secondly, I will look at the solutions that are available to us, drawing in particular on the work of the Christie commission, which has been mentioned several times already. The third area is the imperative to shift the political discourse from the language of inputs to the language of results and outcomes.

Health services across the UK and the developed world are facing unprecedented challenges. Indeed, advances in health provision have been victims of their own success. An ageing population and technological advances in new medicines and equipment mean that health inflation—the cost of just standing still—is running well in advance of general inflation. Estimates range from 4.5 per cent upwards.

Let me put those numbers into context. The Scottish Government has committed to a health service spend of £500 million over and above inflation for the lifetime of this session of Parliament—more than that committed by any other party. However, it represents an above-inflation increase of less than 1 per cent per year on the £13 billion annual health budget—around one third of the increase necessary to match health sector inflation. It is an easy sound bite to call for tax increases to fund that, but even easier to see that that is not a sustainable solution: the sums just do not add up. Matching health inflation of 4.5 per cent for just 10 years would require an annual spend increase of more than £3 billion above inflation by year 10—the equivalent of increasing basic rate income tax by up to 7 per cent.

That is not a particularly Scottish problem—all health services face that challenge. The English NHS has gone down the route of increasing privatisation, privatising more than 7 per cent of its services—10 times the level in Scotland—and is delivering poorer services, with a gap of more than 10 per cent in A and E waiting times compared with those in Scotland. The challenges are real, but the direction of the solution is also clear: it is not cuts to services, and it is not privatisation.

The Christie Commission report of 2011 identified four principles to underpin reform of public services. First is the integration of service provision, reducing silo working. The integration of health and social care is a good example of that. Secondly, there is empowering individuals and communities. The Scottish Government's Community Empowerment (Scotland) Act 2015 is a welcome move in that direction. Thirdly, there is the need for public services to become more efficient, through technology or the adoption of operational best practice. Christie called for delivering more with less. Fourthly, there is the need for prioritisation of spending that prevents negative outcomes. Christie went as far as stating that 40 per cent of public sector spend was due to fixing problems that could have been prevented by more focus on preventative spend. That is a significant number: some £5 billion across the health service alone. While it may be ambitious, it gives us a view of the size of the prize.

A country the size of Scotland is well placed to deliver on the Christie agenda. It is big enough to support a full range of specialist and high-technology services, yet small enough to ensure rapid development of best practice.

We must also recognise that technology is a double-edged sword. Better medicines and equipment cost, but they also enable efficient solutions in meeting the challenge—be that through the use of advanced communications, remote diagnosis, information technology or advances in operational management processes. Those must be embraced.

It is also important to recognise that not all preventative spend actions are effective. A robust process for data-driven evaluation of preventative spend proposals is necessary, taking into account up-front spend and projected time-phased cost savings, calculated on a net present value basis. I make no apologies for the use of accountancy language in this debate, because, to be effective, the preventative agenda needs to be constantly evaluated in terms of return on investment.

Here we encounter another problem: the data is not as good as it needs to be. In general, there is a surprising shortage of data-driven policy proposals. I take this opportunity to urge third sector organisations not just to produce policy wish lists but to focus on generating fully costed preventative proposals that deliver measurable results.

We should also recognise that while some preventative spend decisions cost money, others—often the most effective, if we consider smoking or drink-driving legislation—are free. Decisions on health promotion legislation also need to take into account savings accruing to the public purse flowing from improved health outcomes.

Finally, we need to change the political discourse and have a much-needed move away from a focus on inputs towards one on outcomes. It is often easy for politicians to announce extra spend on public services, but outcomes are what matter to service users. The preventative agenda has, at its core, the concept that we can do more with less—that the relationship between inputs and outcomes is not linear. Otherwise, this discourse is pointless. A continued political focus on inputs serves neither service users nor taxpayers. The transition will not be an easy one for us, as politicians, to make, but it is one that we must make.

In my remarks, I hope that I have outlined the scale of the challenge before us, and offered some pointers to the way forward. The preventative spend agenda offers much to be positive about, in improving outcomes and in managing cost challenges. We need to embrace this agenda with some urgency.

15:59

Alison Harris (Central Scotland) (Con): The problems caused by the abuse of alcohol, tobacco and drugs are major concerns for public health in Scotland, and ways to prevent or even reduce their impact will have substantial benefits for not only the individuals affected but society in general.

All three can lead to a variety of social problems, including family tensions, antisocial behaviour, absenteeism from work, and financial difficulties. Today, it is mainly their impact on health and wellbeing that I wish to speak about.

More than 60 medical conditions are linked to alcohol use alone. Alcohol is classed by the International Agency for Research on Cancer as a group 1 carcinogen—the same grouping as tobacco and asbestos. About 4 per cent of all cancers that are diagnosed in the UK are caused by alcohol; for cancers of the mouth and throat, alcohol is the second biggest risk factor after smoking.

Alcohol is often a factor in coronary heart disease and is a commonly seen factor in the development of anxiety, depression, and other

mental health issues. Not only can excess alcohol lead to damage to essential organs such as the pancreas, it has an adverse effect on fertility. Alcohol-related brain damage is another reason why overindulgence needs to be tackled head on.

It is estimated that at peak times 70 per cent of the admissions to hospital A and Es are alcohol related. Alcohol contributes to more than 1,000 suicides a year and almost half of violent crimes are committed by people who are believed to be under the influence of alcohol. More than 50 per cent of all domestic violence incidents in the UK are carried out by people who have been drinking.

Very often, dependence on drugs, alcohol and tobacco is highest among those who already have health issues due to poor diet and lifestyle and such dependence is a major contributor to health inequalities in Scotland. The 2015 Scottish health survey found that alcohol-related mortality is not evenly distributed throughout the population but is highest among those living in the most deprived areas and there is a clear correlation between levels of deprivation and the rate of alcohol-related admissions.

Worryingly, the misuse of alcohol and the start of potential associated health problems can begin at an early age. The trend for people to drink more at home rather than in pubs introduces children to alcohol—often in a responsible way but, sadly, not always.

Youth culture too often links alcohol with having a good time. Getting drunk is now far too often the desired effect of an evening out. It is clear that work needs to be done with that age group to counter the alcohol industry's promotion of alcohol to the youth market.

Stuart McMillan: I thank the member for taking an intervention. On the last point about working with young people, does Alison Harris agree that this is not a new issue but one that has been there for some time—for decades?

I think that we would all accept that it is a difficult nut to crack and Alison Harris should recognise that it is not a new issue. All parties, of whichever hue, should certainly attempt to work to try to get successful solutions in this particular area.

Alison Harris: I thank Stuart McMillan for his question. I do not think that it is a new issue—it is a longstanding issue. Unfortunately, it is an issue that is getting worse and causing more and more problems—sometimes, sadly, for those who are not so well off in society. It is very important, as Stuart McMillan says, for us all to work together to try to sort out the issue once and for all.

With regard to youth culture, perhaps a way of trying to help young people understand what is happening would be through a wider circulation of the excellent leaflet produced by Alcohol Focus Scotland and NHS Health Scotland, "Alcohol & healthy living", which warns of the dangers caused by drinking alcohol in excess of the sensible drinking guidelines.

The harmful effects of smoking are even better known than those of alcohol and thankfully over the years the number of smokers has steadily declined to about 20 per cent of the adult population. The ambition of a tobacco-free Scotland by 2034 is very much a work in progress; 34 per cent of adults in the most deprived areas of Scotland still smoke compared with 9 per cent of those in the least deprived areas.

At the time of their first antenatal appointment, 29.3 per cent of pregnant women in the most deprived areas are smokers, compared with 4.5 per cent in the least deprived areas. A child born in a more socially deprived area of Scotland is, thus, much more likely to be growing up around smokers. Figures show that children born into a family that smokes are far more likely to become smokers themselves and so repeat the cycle, which imposes on our poorest citizens the financial burden of smoking as well as the health issues. NHS Scotland advises that smokers from deprived areas get less encouragement and social support to quit smoking.

Maree Todd: Will the member take an intervention?

Alison Harris: I am sorry, I will keep going for a minute.

Smokers from deprived areas are less likely to be aware of the harm of smoking and of second-hand smoke and are more likely to be heavy smokers, thus having a stronger nicotine dependence.

In my remaining time, I would like to touch upon another aspect of the preventable damage that drugs can cause. My colleague Douglas Ross has highlighted that the number of people who are on drugs when they die at the wheel is now the same as the number of driving fatalities who test positive for alcohol, while the powers available to the police and courts for dealing with drug drivers are far less clear than for dealing with drink driving. Drugs, drink and tobacco can shatter lives, break up families and cause untold health problems, many of which lead to premature death. Sadly, the burden of misery caused by them falls heaviest on the poorest in our society.

The need to improve public health is one that we all agree must be addressed and I recognise the importance of the work being carried out by the Health and Sport Committee on the wider preventative health agenda. I thank Neil Findlay for his motion this afternoon.

The Deputy Presiding Officer (Christine Grahame): Thank you, Miss Harris. I apologise for the minute clock stopping, but it will be restarted now for the next speaker. I call Richard Lochhead.

16:06

Richard Lochhead (Moray) (SNP): Thank you, Presiding Officer—your comment is a relief.

I suspect that the spotlight that is shone upon this debate is not quite as bright as what might otherwise have been the case, had not an announcement been made elsewhere in the UK today.

I expect that the general election, if it goes ahead as we all expect, will feature many of the preventative measures that may require to be addressed to tackle the health inequalities and other social ills in this country, not least of which is that, according to the Institute of Fiscal Studies, a three-child family will lose an average of £2,500 per year, while families with four children or more will lose £7,000 per year and 4 million families across the UK will see entitlements fall as a result of UK welfare policies. I guess that the two issues in the news today—hopefully this debate but also the calling of a UK general election—are very much interlinked.

I welcome this inquiry by the Health and Sport Committee. As many members have highlighted in their speeches, at the very crux of this debate is a dilemma: how can we feed the insatiable appetite of the NHS for more resources, as more drugs are developed and as people live longer and so on, while at the same time trying to find the resources to address the preventative measures that we need in the first place to lessen the burden upon the NHS?

That dilemma is at the crux of this debate. I do not pretend to have the answers, because we know that, given the current financial climate, there are not a lot of spare resources out there, but it is something that politicians in this Parliament and elsewhere have to wrestle with—we cannot ignore it. I hope that the inquiry will find some solutions to that dilemma. This is a multifaceted issue: there is no silver bullet. It is a complex issue and many members have addressed many of those complexities in their speeches.

I hope that we can all agree that to address the issue of essential preventative measures, we need bold and ambitious interventions from Governments. It is obviously easier for ministers to stand up and deliver more resources to the NHS than to deliver controversial measures that can sometimes lead to difficult headlines about some of the preventative measures that perhaps have to be taken in society. As a member of the Parliament that debated the smoking ban, I recall how controversial that was at the time, and how divisive in many ways, yet here we are in 2017 looking back and talking about how it has been such a successful policy. As the health survey published last year showed, in 2003, 28 per cent of the population said that they currently smoked, while in 2015 it was 21 per cent. Smoking is still a big issue, responsible for 128,000 hospital admissions and 13,500 smoking-attributable deaths every year. As members have mentioned, lung cancer is expected to be the most common cancer from the year 2023 onwards.

I want to use the time available to touch on two issues that are close to my heart and that relate to preventative measures. One is food and the other is the need for more sports facilities in Scotland. A news release by Cancer Research UK in September 2016 highlighted that, as members have mentioned,

"Obesity is the UK's second-largest single preventable cause of cancer after smoking."

The charity said that

"junk food advertising and price promotions are among the issues which need to be tackled"

and called for

"junk food marketing to be restricted, along with price promotions and multi-buy offers on unhealthy food."

It continued:

"If left unchecked, obesity will lead to a rising tide in ill health, including cancers, and become a crippling burden on the NHS."

There are statistics in the press release that we cannot ignore, such as the fact that

"Scottish households spend more than any other UK nation on soft drinks, at £2.60 per week compared to the British average of £1.90".

The Parliament will have to take a lot of difficult and challenging decisions, with, I hope, more powers over some of those issues.

I welcome the fact that the Scottish Government has committed to introducing a good food nation bill. The Scottish food coalition has been leading the campaign on what should be included in the bill. It wants the bill to make a statement of food rights and responsibilities and to establish the principle of sustainable development, which ensures that the needs of the present are met without compromising the needs of future generations. The coalition also wants the bill to establish a statutory food commission, with a civil society participation mechanism to promote involvement in policy making and ensure transparency and collaboration across Government departments.

Food and tackling some of the issues with Scotland's food culture are at the heart of preventative measures. I am delighted that, in this parliamentary session, we will debate what should be in that food bill and then take it forward. According to the Scottish food coalition, legislation is needed to address the high levels of food insecurity and the reliance on food banks, low wages and insecure working conditions in many parts of the food industry; and the on-going challenge of diet-related illnesses, particularly diabetes, cancer and heart disease, and the impact of those illnesses on inequalities, including in relation to child attainment and quality of life. There are of course other issues about the food system and global environmental crises such as climate change and biodiversity loss.

There is plenty for us to get our teeth into—if members will forgive the pun—in considering what should be in the food bill, and all those issues are related to preventative measures. There will be tough debates and tough decisions to take, but I hope that, as a Parliament, we will be radical, bold and ambitious.

I also want to address the issue of sports facilities. The Scottish health survey, which I referred to earlier and which was published in 2015, said that

"Just under two-thirds (63%) of adults in 2015 met the guideline for Moderate or Vigorous Physical Activity",

which was

"a similar level to those seen since 2012".

So there has not been much progress. The survey also said that,

"In 2015, just under three-quarters (73%) of children met the guideline on physical activity",

which was

"a similar proportion to that seen in 2008 (71%)",

so there has not been much progress. It continued:

"Around two-thirds (68%) of children had participated in sport in the prior week, a similar level to that seen in 2014 ... but lower than in 2008".

At the moment in my constituency, the Moray Sports Foundation is trying to raise funds for a Moray sports centre. The foundation argues that, in Scotland, on average, there is one sports centre per 33,000 people, whereas in Moray there is none—there is not one designated centre to develop sports for a population of more than 95,500. A Moray Council survey that was carried out in 2014 found many worrying statistics on access to sports provision in the area.

In terms of preventative measures, as a Parliament and a Government we have to do a lot more to promote sports facilities. The Commonwealth games have been and gone, yet we have the statistics that I mentioned. I understand that, at the moment, sportscotland grants are limited to £200,000. If a company wants to come to Scotland and invest in creating 30 or 100 jobs, we offer millions of pounds, but when it comes to building sports facilities to serve 95,500 people, the grants that are available are £200,000. That is not just an issue about present Scottish Government policy; it applies to historical policy. We perhaps have to grasp that issue if we are serious about preventative measures and making it easier for people to live healthier lifestyles and to access physical activity.

I urge ministers and all members and parties in the Parliament to grasp some of those issues. We know that there is competition for limited resources, but we have to be radical, bold and innovative if we really want to take preventative measures seriously. I congratulate Neil Findlay on his opening speech. I hope that he and his committee will address some of those fundamental issues and then advise Parliament on how to move forward and give the people of Scotland a healthier and better quality of life.

The Deputy Presiding Officer: Before we move to the closing speeches, I note that Monica Lennon, who took part in the debate, does not have the courtesy to hear her colleagues summing up. She obviously has better things to do with her time. No doubt the front-bench members will advise her that that has been noted.

I call Anas Sarwar to close for the Labour Party. You have up to nine minutes, Mr Sarwar.

16:15

Anas Sarwar (Glasgow) (Lab): That is noted, Presiding Officer. [*Interruption*.] I will ignore what the Minister for Mental Health said in my ear. I hope that it was in jest.

I agree with Richard Lochhead that we need to be bold and radical when it comes to preventative policy and tackling inequality. I would like to believe that we would all have been excited by Scotland listening to a really important debate in the Parliament about prevention rather than talk of another election. Sadly, those of us who came into politics to talk about inequality have to accept that the debate is perhaps on the back burner while the talk is of politics elsewhere.

I thank Neil Findlay and all members of the Health and Sport Committee for advancing the inquiry. It will have support from members from all political parties. We look forward to hearing the inquiry's findings and thank the committee for having the debate to enable us all to contribute to the process.

As Neil Findlay said in his opening speech, the issue goes beyond the health and social care portfolio. It has relevance not only for health and social care policy but for equalities, housing, welfare, poverty, education and much more. Therefore, I hope that the debate is listened to and that the committee's report will be reflected on not only by the ministers with responsibility for health and social care but by ministers across the Scottish Government.

In Scotland, we have made good progress on preventative measures on behaviour and lifestyle. A good example is the smoking ban, which has had a transformative effect in Scotland and was replicated throughout the rest of the UK. However, I repeat the point that Emma Harper made: that does not mean that there are no continuing challenges, particularly in relation to lung health and the effects of smoking. We have made progress on alcohol, but there are still 12,800 cases of alcohol-related cancer in the UK each year. The sugar tax is being introduced, which will have some impact on fizzy drinks, but we have an opportunity to tackle the next big public health issue—obesity and diet—on which we need to campaign. Therefore, we look forward to seeing the Government's strategy.

We encourage the Government to make its obesity and diet strategy bold and radical. If it is bold and radical, it will have the full support of all the Scottish Labour members. As set out by Cancer Research UK, which has done much work on the issue, the strategy must consider a number of areas. One is physical activity, which is of particular interest to members. We must also consider price promotions, particularly of junk food; advertising, particularly advertising of junk food on children's television channels; portion sizes; and what more we can do to tackle the high levels of sugar not only in fizzy drinks but in confectionery and other products.

I note Alex Cole-Hamilton's points about cuts to alcohol and drug partnerships, which are a concern. I ask the Government to reflect again on that decision.

I mentioned inequality. I agree with Donald Cameron that we need to be honest, but I say to Conservative members such as him, Brian Whittle, Jeremy Balfour and Alison Harris that, as part of that honesty, we have to admit that UK Government decisions impact on inequality and have a negative impact on people's health. They must reflect on that.

Members of the SNP must also reflect on the impact of decisions that the Scottish Government makes on inequality and health. The reality is that health inequality in Scotland is on the rise and that income inequality has got bigger, not smaller, in Scotland and, indeed, the UK. We have tax powers and could choose to use them to create a more progressive taxation system, as was mentioned by Colin Smyth and Alison Johnstone and touched upon by Maree Todd. We could use the levers that the Parliament has to tackle income inequality, helping to drive resources towards the most deprived communities and reduce inequality.

We still have a postcode lottery in Scotland, where a postcode determines not only a child's life chances but their life expectancy. While that postcode lottery continues, it will be a stain on our politics and our society, and we must all redouble our efforts to challenge it. We must accept, sadly, that child poverty is also increasing in Scotland. This Parliament has the powers to tackle child poverty through education, housing, welfare, health and the criminal justice system, and we should get on with using those powers so that we can tackle child poverty in Scotland. I also want to touch on fuel poverty. Although we have come out of winter and are heading into the summer, there is no doubt that housing quality and the high levels of fuel poverty that still exist also impact on health outcomes, and we must challenge that situation.

I want to repeat a point made by my colleague Monica Lennon, who I wish was in the chamber now.

The Deputy Presiding Officer: She has just come in. No doubt she is penning an apology to me.

Anas Sarwar: Excellent. She has some apologising to do, Presiding Officer, but I am sure that she has heard your comments, and I will pass on to her what you said.

As Monica Lennon and Alex Cole-Hamilton mentioned, mental health is important when it comes to inequality and prevention. We have a once-in-a-generation opportunity. A generation ago, we did not talk about mental health in Parliaments—it was not even recognised as being equal to physical health. That attitude is now changing, but we still have work to do, so we should use the opportunity to make a generational shift by putting counsellors into schools to ensure that we support children who may go on to have mental health issues later in life. Children often have mental health issues at the most important points of their school careers, when they are going into exams, and that can have an impact on their access to college and university, and their access to the job market for the rest of their adult lives. It is therefore important that we act on mental health.

Finally, I will touch on two issues: budget structures and the workforce. We have the right intention in focusing on prevention, but we have to recognise that decisions that are made in Parliament and those that are made by health

boards and integration joint boards can have a negative impact on patient care, services and the pressures on staff. Ivan McKee touched on health board budgets in his speech, and the reality is that the £1 billion of cuts that health boards will have to make over the next four years will have a direct impact on services, staffing and patient care and will undermine the preventative agenda that we are all, I hope, signed up to.

As the Royal College of Nursing's briefing, which was sent to us all for the debate, points out, the pressure on integration joint boards means that they are using resources to cover other areas when there are issues around recruiting the community nurses who often lead preventative work. How health boards and IJBs operate and choose to use their budgets will have a direct impact on how our healthcare professionals deliver prevention on the ground.

Colin Smyth mentioned an issue specific to Glasgow in relation to welfare and benefits advice. In Glasgow, the Scottish Government has cut £600,000 from benefits support and advice. That will have a negative impact on income equality and can lead to health issues. I ask the Government to consider the impact of that cut on the city of Glasgow.

There is no doubt that GP practices and community care are the entry points for the majority of people into our NHS. We must consider how we can overcome the issue of one in four practices reporting a vacancy, how we can fill vacancies and respond to the shortage of GPs, how we can use the GP contract process to get more auxiliary support services into general practice, and how we can use the inverse care law, mentioned by Bob Doris, to give more support to struggling practices. There should be universal access to the service, but if we believe in tackling inequality we should also recognise that there are some areas and some practices that will require additional resources and capacity to challenge that inequality. Professor Graham Watt's work addresses the inverse care law head on.

I realise that I am short of time, Presiding Officer.

The Deputy Presiding Officer: No, you are not.

Anas Sarwar: If I have loads of time, I will keep going.

The Deputy Presiding Officer: Our generosity does not extend to allowing you to speak ad infinitum.

Anas Sarwar: I will address one final issue, which is about the workforce. The RCN and other professional bodies and trade unions for the NHS workforce have highlighted that we do not have enough staff for them to do their jobs properly. One in three NHS staff say that there are not enough of them to do their jobs properly, and nine out of 10 nurses say that their work pressures have increased. There are 2,500 nursing vacancies throughout the UK and a 300 per cent increase in long-term vacancies in the NHS. All of that affects the time that existing staff have to care for their patients. We have to get a grip of the workforce crisis because it has a direct impact on the delivery of the preventative health agenda.

I would hope that the intention of all of us in the chamber is to end inequality and promote preventative health. This Parliament has the power to end inequality and make a difference; indeed it has a duty to do so. It should be the mission of Parliament to tackle inequality head-on, whether that is wealth or income inequality, child poverty or health inequality. It is only through collective working and using the Parliament's powers that we will ensure that every child—no matter where they are born, their social status or their gender—can maximise their life chances.

The Deputy Presiding Officer: Mr Sarwar, I have no doubt that you could have used the extra time.

I call Miles Briggs to close for the Conservatives. I will be equally generous with you, Mr Briggs, although that is a challenge in light of Mr Sarwar's speech.

16:26

Miles Briggs (Lothian) (Con): I am pleased to close on behalf of the Scottish Conservatives. Like many others speakers, I thank the many organisations that provided briefings for the debate. That large number of briefings is a sign of the level of interest in the work of the Health and Sport Committee on the preventative health agenda.

There have been some very good speeches from across the chamber, and there has been consensus in a number of key areas and on key issues. As my colleagues have set out, the Scottish Conservatives support the principle of preventative spending and early interventions that can prevent negative health outcomes later in life. Such investment in tackling the causes of ill health has the potential to save a significant amount of public spending over the long term and can help to reduce health inequalities.

This country has the greatest inequalities in mortality in western Europe. No one in the chamber wants our country to continue to have such a bad reputation in health. Suicide is three times more likely among the poorest Scots. The gap in the cancer survival rate for those living in the most and least deprived parts in Scotland has

not really closed. Stroke mortality rates are at their highest in some of our deprived communities. It is not a record or a reputation that any of us in the chamber wants our country to have. We acknowledge the many challenges that face the Government as it seeks to shift health spending away from acute care and towards preventative investment.

Ivan McKee made some important points in his speech. Preventative spending should, in time, help to reduce the demand for key services, but there will clearly have to be a crossover period in which full spending is required on both preventative and acute services. That is a challenge for all politicians in the chamber.

I agree with RCN Scotland, which has said that we need to have a more informed public debate about the fact that spending on preventative health may mean redistribution, service redesign and investment in the benefits of primary prevention. That may take many years to come to fruition or to show that such decisions can make a huge difference.

I back up what my colleague Brian Whittle said about diet and physical activity. As co-convener of the Parliament's cross-party group on cancer, I am very much aware that more than 40 per cent of cancer diagnoses are attributed to lifestyle and environmental factors—a point made by Cancer Research UK in its excellent briefing ahead of today's debate. As Donald Cameron said, the cost of obesity in Scotland—the single biggest preventable cause of cancer after smoking—has been estimated to add up to more than £600 million a year, with wider economic costs of more than £4.5 billion a year.

A number of speakers have mentioned the need for cross-portfolio working. It is time that we, as a Parliament, reflected on that and on how we can improve the workings of Parliament and the development of policy on a cross-portfolio and cross-committee basis. As a relatively new MSP, I still do not see how we can influence the work of one another's committees well enough to be able to make that difference when it comes to policy development. As we look towards reform of the Parliament, I hope that we will see that taken forward.

A focus on promoting exercise and a healthy balanced diet that avoids excessive calorie consumption is vital. Perhaps the best example that I have seen of cross-portfolio work in that regard outwith the Parliament is the work of jogscotland. It has a major success story to tell, with the involvement of nearly 40,000 Scots in hundreds of local groups across our country. I share the concerns of many constituents who have contacted me about the Scottish Government's regrettable decision to stop funding that programme. I am pleased to say that SAMH and scottishathletics have stepped into the void to help to secure jogscotland's future, recognising the links between good mental and physical health. However, it seems wrong that a Government that is reviewing the effectiveness of its policies and says that it wants to boost physical activity in the population is looking to remove support for a scheme that has successfully encouraged a cohort of inactive people to become active.

Aileen Campbell: I do not know whether the member saw the announcement of the £2 million that we are giving our governing bodies, which will, of course, benefit Scottish athletics. Will he join us in our call for the UK Government to work out how to improve the way in which national lottery money, which it manages, is distributed, so that sport does not have to feel the pinch?

Miles Briggs: As is always the case with this Government, the devil is in the detail. I would be delighted if the minister would like to intervene again to confirm whether any of that money is for jogscotland.

Aileen Campbell: We have given money to sportscotland for the governing bodies, to ensure that they can continue with programmes that increase participation. That will, of course, include looking at jogscotland.

Miles Briggs: I think that jogscotland was missing from that response. Perhaps the minister will write to all of us to outline whether the money that she mentions will make up for the cuts that the Government made to jogscotland's funding.

Aileen Campbell *rose—*

Miles Briggs: I want to make some progress.

The work of jogscotland has also helped to reduce health inequalities by encouraging more women to participate in physical activity.

Colleagues, including Alex Cole-Hamilton and Alison Harris, have talked about their real concerns over the reductions in the funding of alcohol and drug partnerships. I agree that the Government needs to consider that area. For too long, alcohol and drug partnerships have been a Cinderella service. I have concerns about how the drug and alcohol partnerships in Edinburgh are developing and where they will be placed within the health service. In some cases, even they do not know where they will be in the future. They need to plan in order to provide better services. Certainly, that issue needs to be addressed as soon as possible.

I want to use the time that I have today to talk about preventative health in relation to mental health. I have previously emphasised the

importance of building resilience in our young people and the vital role of youth organisations.

Maree Todd: As the member knows, I worked in mental health for 20 years. In that time, the most significant impact that I saw on the health of the people I worked with resulted from the programme of welfare reform that was brought in by the Tory-Liberal Democrat coalition between 2010 and 2015. I saw people made significantly insecure in their situations, tipped into poverty and, frankly, made sick by their treatment by the Government. Will Miles Briggs address that issue when he talks about mental health?

Miles Briggs: In terms of the powers that we have coming to this Parliament, I have not heard anything from Maree Todd here or in the Health and Sport Committee about the plans that her Government are bringing forward. There appears to be no thought going on in this area at all.

As I said, I have previously emphasised the importance of building resilience in our young people and have stressed the vital role that youth organisations such as the scouts and the guides play in helping our young people to develop the life skills that can prepare them for difficulties later in life. Support for youth organisations is essential, and we want to ensure that every school pupil has access to those groups and that all parents are provided with a list of local groups in their area. Early intervention in providing swift access to support, counselling and psychological and talking therapies for people with minor mental health issues is essential if we are to prevent less serious conditions from developing into more severe ones.

I have consistently called for more action to reduce waiting times for psychological therapy treatments. That remains a big concern for the many constituents of mine who are trying to access services in NHS Lothian. In looking back on the Scottish National Party's 10 years in government, Maree Todd should perhaps consider why, in some cases, it takes two years for my Lothian constituents to be seen by a specialist and why it takes up to a year for children to be seen. That is this Government's record, and it should start to look at the matter in more detail.

Today's debate is welcome and has been largely constructive. The challenge is to take forward the consensus that exists on preventative health policy and to see that goodwill implemented in practice through policies that cut across Government departments at all levels. As the BMA rightly said ahead of the debate, public health interventions are more likely to have an impact when they are long term and substantive. I urge Scottish Government ministers to work closely with the Health and Sport Committee as we continue our inquiry into preventative health and to listen to our findings as the Government and the Parliament take forward policy developments in the area.

The Deputy Presiding Officer: I call Aileen Campbell to close for the Government. Minister—you have up to 11 minutes, if you wish.

16:36

The Minister for Public Health and Sport (Aileen Campbell): Oh. Gosh. Thank you very much, Presiding Officer.

The Deputy Presiding Officer: That did not sound as though you are very keen. I am sure that you are.

Aileen Campbell: No—I am delighted. Thank you very much for the additional time.

I, too, commend the Health and Sport Committee for its inquiry and I welcome the mature and considered range of contributions from members from across the political divide as we all seek to create a fairer and healthier country. That tone was very much set by the convener. I know that he and the committee will seek to scrutinise the Government—as they are right to do—and I sincerely look forward to the committee's report and to working with it as it prepares its recommendations and findings.

We all understand the challenges that Scotland faces—many members have articulated them today. We have an ageing population, the country continues to have an unhealthy relationship with alcohol, it is more common to be overweight than not and we need to increase our activity levels. Exacerbating and magnifying all those challenges are deep, unfair and persistent inequalities that are driven, in part, by the harsh consequences of austerity and welfare reform.

Where there is challenge we must seek opportunity, because we have enormous potential to transform Scotland's health and wellbeing. There have been improvements. Last October's Scottish schools adolescent lifestyle and substance use survey showed that smoking, drinking alcohol and drug use among young people are among the lowest levels that have been recorded. I hope that that gives some comfort to Alison Harris, who spoke about young people in her speech. However, we know that the pace of improvement is not quick enough, and in a challenging fiscal climate the ability simply to plough more resources into funding increasing demand is not an option—or, as Donald Cameron put it, we need "to challenge established orthodoxies", and to be frank and candid about how we marshal our public finances.

The challenge of what the late Campbell Christie wrote in his report is still relevant. We need not only to reform our services to cope with

the fiscal climate, but to reform services so that they improve the quality of public services to better meet the needs of the people and communities whom they seek to support.

We need to prioritise prevention and reduce duplication, and we must empower individuals and communities. We must trust our communities to find their own solutions and we must trust that their members will not be merely passive recipients. That is very much in line with the views that were articulated by the previous chief medical officer, Harry Burns, and it is very much in line with the current CMO's realistic medicine agenda.

We must also tackle the established orthodoxies—as Neil Findlay, Bob Doris, Alison Johnstone and Ivan McKee rightly outlined—by ensuring that preventative health is not seen as the preserve solely of the NHS. It is about housing, education, justice, environment, transport and a host of other disciplines, professions and portfolios. It requires us to work together: in a country of just 5 million people, there is no excuse not to do so.

Bob Doris gave clear examples of how working together at local level can make transformative changes and tangible differences. We also need to be bold and innovative. When we do all those things, progress and improvement are tangible.

Scotland has frequently led the way in respect of alcohol and tobacco. Parliament has passed legislation that allows minimum unit pricing for alcohol. The Scottish courts have found that to be lawful, so it is with some regret that we must now go to the Supreme Court on a measure that would save lives. If we had had minimum unit pricing, there could have been more than 200 fewer deaths and more than 4,500 fewer hospital admissions over the past three years. I will be progressing a refresh of our alcohol strategy, so I look forward to the outcome of the Supreme Court's consideration of the matter.

Similarly, our efforts on smoking have been bold, and remarkable progress has been made across several Administrations. That illustrates that when we take an ambitious Scottish approach we can bring about improvement.

Moreover, our cancer screening programmes are among the best in the world. They play an important role in prevention by detecting cancers at their earliest stages. As part of our £100 million cancer strategy, we are investing up to £5 million to reduce inequalities and to improve uptake—in particular, among people who are less likely to participate in screening. Members made the important point—the point was well made—about the connection between obesity and cancer, and I will have that very much in mind as I develop our obesity strategy.

We are also making progress and achieving significant success with our vaccination programmes, uptake of which is among the highest in Europe. About 3 million vaccinations are administered annually in Scotland, and they help to protect against a wide variety of diseases. Those hugely effective preventative programmes are second only to clean water in terms of their value in disease prevention. On a loosely related matter, I echo Maree Todd's comments on the welcome progress on PrEP, or pre-exposure prophylaxis.

Collaboration and innovation have been the hallmarks of the approach that my colleague Maureen Watt and I have taken to our mental health strategy. We must give to mental health the same priority and drive that we give to physical wellbeing, and we must intervene early to prevent problems from developing, while also ensuring that a person need ask only once to get the help that they need fast. To support our strategy over the next five years, we have committed £35 million for 800 additional mental health workers in key settings. In response to Monica Lennon's point, we have begun a review of personal and social education and will investigate what the evidence tells us works.

Many members have called on us to be innovative in tackling obesity, which—as Anas Sarwar said—is one of the most pressing public health challenges. I echo the comments that a host of members made on the topic, and I sincerely look forward to engaging with all members as we proceed with our consultation. We want to ensure that we can bring about the innovation that is needed to address the problem that Scotland faces with obesity, and to address the on-going health challenges that it presents for our NHS.

Another issue that has been discussed in the debate is measurement. Ivan McKee strongly articulated its importance: he was right about the need for robust data to guide policy, especially when we face challenges in the public finances. We need to ensure that we can invest with confidence in what works.

In September last year, we launched an independent review of health and social care targets and indicators, which is being chaired by Sir Harry Burns. Sir Harry will offer an initial report soon. His report will set out proposals that will ensure that our targets and indicators support our strategies for improvement of health and social care outcomes, and for the future of the NHS and social care services, and that they support the best use of public resources. The review has taken a whole-system approach to measuring health and social care. Prevention is part of the

agenda, and there is a focus on upstream determinants of wellbeing.

I want to touch on the speeches of Alison Johnstone and Maree Todd, who powerfully articulated the damaging impact of welfare reform. They illustrated starkly the cruelty of some of the measures and highlighted the limiting of tax credits to the first two children in a family, and the callousness of the rape clause. I mention that because I find it absolutely astounding that some members have, while remaining silent on the rape clause, had the audacity to criticise the baby box, the aim of which is to give all children the best start in life. That is hypocritical, and it is regrettable—in what has been a very consensual debate—that no attempt was made to reconcile those views.

Monica Lennon: Does the minister agree—

Shona Robison: It's nice to see you.

Monica Lennon: I know—I am back, although I have not been feeling very healthy during the debate.

Does the minister agree that some people are not choosing to remain silent on the rape clause, but actually support the cap on child tax credits and support a rape clause as a way of achieving that?

The Deputy Presiding Officer: I got a lovely note of apology from Monica Lennon, minister.

Aileen Campbell: I am pleased that Monica Lennon has managed to get back to the debate, because the point that she has raised is very important indeed. The silence of some members on the rape clause is not because they disagree with it. Too many members seem to agree, but do not have the courage of their convictions to come out and say so and be bold enough to defend what I think—members from across the chamber agree—is indefensible. The SNP disagrees with the rape clause, so we pay tribute to the work that Alison Thewliss, in particular, has done in highlighting the issue. That is why the Cabinet Secretary for Health and Sport has written to the UK Government to say that we will not distribute the Whitehall guidance on the issue, as it stands, to the Scottish NHS.

Alison Johnstone and Maree Todd were also right to talk about inequalities. Imagine what we could do as a Government if we did not have to spend £100 million a year on welfare reform mitigation. However, the SNP Government has taken action on tackling inequalities with our "Fairer Scotland Action Plan", which sets out the things that we need to do to make the changes that we need—decisive action to reduce poverty and child poverty, including massive investment in childcare in the early years, delivery of 50,000 affordable homes over the current session, and free school meals for children in primaries 1 to 3.

Overall, the health of Scotland is improving. We should celebrate the fact that people are living longer and healthier lives, but the benefits of those improvements are not being felt equally. What has been clear during the debate is the ambition to do better. Our ambition is for a fair, smart and inclusive Scotland in which everyone can feel at home, and where there is genuine equality of opportunity for everyone. We must seek to use all the levers that are at our disposal to improve community health, social security, community empowerment, housing and education. They are interlinked, so success is dependent on our working across traditional boundaries.

It is a complex area, but the prize of a healthier and fairer nation is worth working hard for. On that basis, I look forward to the conclusions of the Health and Sport Committee, and to working with it on the aims and ambitions that we all share.

The Deputy Presiding Officer: Thank you very much. I call Clare Haughey to close for the Health and Sport Committee. You have until 4.59 or thereabouts, Miss Haughey, so speak slowly.

16:47

Clare Haughey (Rutherglen) (SNP): I will do my best. Before I begin, I refer members to my entry in the register of members' interests.

It is my pleasure to close the debate on the Health and Sport Committee's behalf. It has been the first debate since the Easter recess, and it is refreshing to witness the benefit that the holidays have had on some members across the chamber, although the news that was announced earlier today might mean that some of us feel much more weary than we did at 9 o'clock this morning.

We have had a thoughtful, helpful and informative debate during which there has mostly been a welcome outbreak of consensus. Members have spoken on a wide range of subjects. Donald Cameron referred to the health inequalities between the rich and the poor in our society and to how we need to work across the chamber to challenge that. Brian Whittle spoke about the importance of physical activity—a cause that I know is close to his heart—and its place in improving and maintaining health.

Bob Doris spoke about the importance of housing that is fit for purpose in the preventative agenda. Emma Harper spoke about targeted interventions that have helped to improve health outcomes and reduce mortality and about the importance of team working in achieving those goals.

Alison Johnstone spoke about the impact that child poverty can have on health outcomes, the importance of income maximisation in tackling child poverty and the proven monetary benefits to families of such programmes. She also spoke of the shameful two-child policy and the appalling impact that it will have on children and on the income of some of our poorest and most vulnerable families.

Maree Todd spoke about reactive versus preventative spend, particularly in relation to pharmacy and the prescription of medications, and about the importance of education on the appropriate use of medications. She also spoke about the impact of welfare cuts on families and how that, in turn, can impact on health outcomes.

Jeremy Balfour urged more investment in the young, and particularly in nought to three-year-olds. Alex Cole-Hamilton spoke about the importance of treating both mind and body. Ivan McKee spoke about the need for change in health service delivery and the need for a focus on results and outcomes in the preventative agenda. Alison Harris spoke about drugs, alcohol and tobacco causing premature deaths, particularly in lower-income families. Richard Lochhead spoke of the importance of good-quality food and sporting facilities in the prevention of ill health.

Miles Briggs: I listened to the minister's closing remarks, in which she did not talk about sport at all in discussing how we address preventative health measures. Funding for sport development is likely to be cut by a fifth, which will mean £2 million less for schools and physical education and £1.5 million less for sport hubs. How does Clare Haughey think that that will impact on attempts to reduce the inequalities that we see in sport across our country?

Clare Haughey: I am not the minister and I cannot answer for her. I am speaking on the committee's behalf, as Miles Briggs knows.

When the committee asked for the debate to inform our work, we did so in the knowledge—as our convener, Neil Findlay, said in opening the debate—that the subject is cross cutting and does not lie with a single committee, minister or department. The need for a preventative approach has been acknowledged by members in all parts of the chamber during the debate.

Presiding Officer,

"One key aspect of the need for a preventative approach lies in the persistence of significant inequalities in our country—the stubborn fact that a substantial proportion of the people of Scotland do not share fairly in the wealth and success of the country. People experiencing high levels of multiple deprivation experience a number of negative outcomes that are inextricably interlinked. They frequently live in families and communities where poor outcomes are mutually reinforcing, reflecting the significant spatial dimension to inequalities."

Those are not my words but those of the Christie commission—the cabinet secretary mentioned the commission—in its seminal report. That led to the clear conclusion that

"it is imperative that public services adopt a much more preventative approach",

and hence the Health and Sport Committee's inquiry. We want to ascertain how much our health and sport services have moved into the preventative agenda in the past six years, what works and how it can be measured and—crucially—rolled out.

I remind members that this is a cross-cutting issue that involves every committee. In the Health and Sport Committee, we scrutinise every activity and piece of expenditure for the impact that it has on health inequalities. We agreed at our first meeting to do that, and the approach stands up front in our strategic plan.

As members know, I was and still am a mental health nurse and, naturally, I retain a keen interest in that area. Mental health has been raised in numerous submissions to the committee, as it was today by Monica Lennon, Alex Cole-Hamilton and others. Many have observed that it is frequently associated with health-harming behaviours and long-term conditions, and they suggest that if we tackle mental health issues early—in or before adolescence, when they often first emerge—it is possible to prevent health-harming behaviours as well as to provide people with a degree of resilience in coping with other long-term health conditions. I am therefore pleased that the new mental health strategy provides a renewed focus on mental health. The committee will watch closely the delivery of the strategy in practice, and not only for what it promises in preventative terms.

We need to remember that many of the issues that cause poor mental health are to do with other social factors such as income, housing and the environments that people live in, and only through a range of approaches across portfolios can such factors be addressed. A number of support programmes are being tried across the country. In the committee's work to date, we have heard good reports of the link worker programme and of initial successes in the deep-end practices. We are keen for the Government's roll-out of link workers to be completed as soon as possible.

Last month, we heard from Midlothian integration joint board about a similar type of support scheme—a wellbeing service that has been rolled out to eight GP practices. It sounds simple. It involves skilled workers working with individuals who are referred by their GP because they have underlying issues. It is about focusing

on the outcomes that the individual wants and helping them to make connections and use a range of supports to enable them to take control of their life. We are told that initial evaluation results look positive.

We have also heard about an organisation in Midlothian with the fantastic name Pink Ladies 1st, which is, in effect, a self-help group in which people use their experience to support one another.

In a similar supporting vein are the family nurse partnerships, which, as I have mentioned in the chamber, are part of a preventative programme for vulnerable first-time mothers until their child reaches the age of two. The partnerships are another good example of spend that is intended to be preventative that has been piloted and evaluated and is being rolled out across the country with the aim of improving pregnancy and early years outcomes.

We have heard today calls for regulation. Submissions to the committee that made the same point highlighted potential levies on soft drinks and the regulation of formula milk adverts, to name but two suggestions. We also had comments on the responsibility of public bodies across the board to think system-wide and with a community focus on what they should stop doing, which is an approach that would be in tune with realistic medicine principles.

The committee is grateful for the opportunity to involve all in those issues, and we are grateful for the contributions that have been made today. After today, we will consider how best we can proceed with the inquiry and identify what we consider to be preventative spend and preventative expenditure, as well as how they can be planned, funded and measured. We will grapple with counterfactuals, failure demand and false dichotomies, and we will report our findings and suggestions to Parliament by the end of 2017.

Bob Doris: The member mentioned that the committee is open to suggestions for things that it might look at. Sport is a theme that has come up quite often this afternoon. Could sports investment come from proceeds of crime or cashback for communities funds? Are there pots of cash out there that might not be under the Health and Sport Committee's scrutiny? Will the committee consider how that money is directed at areas of deprivation and low physical activity? There has to be a more targeted approach to sporting opportunities in such areas. I can think of organisations in my area—I am sure that there are some in the area of the committee's deputy convener—that would definitely benefit from that.

Clare Haughey: Mr Doris raises an interesting point. In my constituency, I am well aware of cashback initiatives and the positive impact that they have had, particularly on community sporting clubs. I certainly think that the committee would welcome the opportunity to look at that idea, now that the member has raised it in the chamber. Part of the reason why we had the debate was to encourage discussion and the sharing of ideas across the chamber from members of different committees who might not be able to have direct input into the Health and Sport Committee. I thank Mr Doris for that intervention.

I again thank all contributors today. I thank all the witnesses who have assisted us with oral evidence and those who have provided written submissions. I thank our researchers for their support. Most of all, I thank all those who work in our health and social care services to look after the citizens of Scotland. We owe them a huge debt, and the least that we can do is ensure that the policies that we have identified and agreed on are delivered quickly and fairly. I commend the motion to the chamber.

Business Motion

16:58

The Presiding Officer (Ken Macintosh): The next item of business is consideration of business motion S5M-05181, in the name of Joe FitzPatrick, on behalf of the Parliamentary Bureau, which sets out a revised business programme.

Motion moved,

That the Parliament agrees to the following revisions to the programme of business for Thursday 20 April 2017—

after	
12.00 pm	First Minister's Questions
insert	
followed by	Members' Business
after	
2.30 pm	Scottish Government Debate: Defence Basing Reforms and the Impact on Scotland
insert	
followed by	Standards, Procedures and Public Appointments Committee Motion: Super-Majorities - Standing Order Rule Changes—[*Joe FitzPatrick.*]

Motion agreed to.

The Presiding Officer: There is a single question to put at decision time today, but we will wait for a few seconds before we come to it.

Decision Time

17:00

The Presiding Officer (Ken Macintosh): There is one question to be put as a result of today's business. The question is, that motion S5M-04948, in the name of Neil Findlay, on behalf of the Health and Sport Committee, on its inquiry into the preventative health agenda, be agreed to.

Motion agreed to,

That the Parliament recognises the importance of the work of the Health and Sport Committee in its inquiry into the preventative health agenda; welcomes its examination of policies and actions, which prioritise and build in actions to reduce demand on health in the longer term following on the work of the Christie Commission on the Future Delivery of Public Services, and the Finance Committee in 2010; notes that the cross-cutting nature of health inequalities also encompasses housing, education, justice, transport, the environment and other portfolios, and welcomes attempts to meet the growing demand for public services by preventing health problems before they occur by early interventions and by tackling causes as well as their effects.

Addaction

The Deputy Presiding Officer (Linda Fabiani): The next item of business is a members' business debate on motion S5M-03632, in the name of Christine Grahame, on Addaction. The debate will be concluded without any question being put.

Motion debated,

That the Parliament commends the work undertaken by the drug, alcohol and mental health charity, Addaction; notes that Addaction has 23 regional sites in Scotland, including Galashiels, and is the largest organisation of its kind; further notes its ethos that the wellbeing, health and happiness of people, families and communities is paramount and its assertion that people with substance misuse problems should be supported through health and social care agencies and diverted away from the criminal justice system; recognises the dedication and work that the staff and volunteers of Addaction undertake every day to support sustainable recovery in people with addiction issues, and looks forward to hearing more about their work at their exhibition in the Parliament from 21 to 23 February 2017.

The Deputy Presiding Officer: I call Christine Grahame to open the debate—[*Interruption*.] Ms Grahame, I would have thought that you would know to put your card in the slot.

17:02

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): I will not blush.

I thank all the members who signed my motion, which has allowed us to have the debate. I also thank in advance the members who will speak in the debate, and I welcome representatives from Addaction to the public gallery.

What is Addaction? To be frank, until last year, I had not heard of this United Kingdom charity—I did not have a clue. That was entirely my fault. I wonder how many of my colleagues were also, and still are, in the dark about the organisation and the work that it does. Addaction is a leading UK drug, alcohol and mental health charity that deals with 75,000 people across 100 places in the UK, including 23 sites in Scotland from Argyll and Bute to the Borders. Its aim is to support people in their recovery from addiction, in the recognition that drug and alcohol addictions are health and wellbeing issues and not an issue for the criminal justice system. We all know that far too many people land in our prisons because of addictions and mental health issues. Although the prison staff and health staff do their best, the question is whether those men and women should be there in the first place.

How did I find out about Addaction? Like many of the most important things in life, it happened by chance. I had put out a call for nominations for a local hero to be my guest at the opening of this session of Parliament. There were worthy nominees, but one stood out. I received a letter from a woman who had recovered her life from alcohol addiction through contacting Rod Anderson, who had been her support and had been through that recovery himself.

This is what the letter said:

"He not only saved my life he transformed it beyond recognition. He gave my children a future. I am not the only one there are dozens of us. He performs miracles on a daily basis and saves the lives of many. For the first time in the history of the borders we now have a recovery community.

After overcoming his own battle with alcohol using the support of Addaction Rod decided to dedicate himself to saving lives. Recognising the difference Rod was making Addaction chose to employ him as a substance misuse worker. My words aren't doing justice to this selfless unassuming man so I will share my personal story.

A year ago I was an emotionally bankrupt, psychologically disturbed woman. Under the threat of being sectioned under the mental health act or facing an ASBO due to the number of times emergency services had attended my address I agreed to being admitted to a psychiatric unit. Now I am a dedicated mother, attending college and contributing to society in a positive manner.

His success in supporting others to overcome addiction created a need for him to create a recovery community. He spent his days off travelling all over Scotland searching for practical advice that would enable him to create what was now needed. His vision started as a recovery cafe which after mere months has become so much more. Rod created Serendipity. A charity which provides what our community needs. He has created a Serendipity ... board. We members now give the lifeline that Rod freely gave us to other addicts.

Addiction will never provide cute, fuzzy photo ops. Addaction will never be a sexy, popular charity to donate to. Addiction is real, gritty, shameful—an illness which we pretend doesn't exist in our scenic, rural pretty border towns.

Rod gives inspirational quotes which reach the heart of addicts. He freely gives a kind word, gentle hug or kick up the backside to us all.

He will forever be my hero. I owe Rod a debt which can never be repaid."

I was privileged to have Rod Anderson accept my invitation to be my local hero, although I know that he will be embarrassed by the fuss. I also know that there are other Rod Andersons working for Addaction, supporting vulnerable people and helping them to recover and turn their lives into something positive.

I have since visited Addaction in Galashiels—having praised Rod Anderson, I nevertheless know that the charity's work is a team effort, as they say. There is a dedicated and professional team of workers, complemented by volunteers, recovery champions and students, who work hard

to reduce harm and promote recovery among people who are affected by substance misuse.

Here are some statistics from Addaction Borders. Under the heading "Front end crisis intervention alcohol and drugs", for "Injecting Equipment Provision" there were

"in the year nearly 70 new people with around 60 using the service each month".

For "Naloxone saving lives", there were

"in the year more than 100 kits supplied and more than 50 used in an emergency".

Under the heading "Planned care", there were referrals of

"in the year more than 450 people, about three quarters"

with alcohol abuse issues and

"one quarter"

with drug issues, with the

"vast majority seen within 3 weeks".

The service has an active case load and there are around

"120 on the books at any time across the whole of the Borders".

On discharges, there were

"Nearly 50% planned, with many reduced or stopped their drugs or alcohol".

There are three busy mutual aid groups in Galashiels, Peebles and Hawick. Recovery activities cover employability, so people move to jobs, education or training; a volunteer programme that is certificated through Borders College; a women's group that is run jointly with criminal justice services; and a music group that meets fortnightly in Galashiels.

Despite the forthcoming hiatus of a general election that we have heard about today, we should remember that, in the everyday world, charities such as Addaction simply get on with the job of helping and supporting people whose lives are falling apart. Those people have far bigger problems on their mind than Brexit, and their lives are turned around thanks to Addaction and its staff and volunteers.

17:08

Rachael Hamilton (South Scotland) (Con): I welcome the debate, and I am pleased to join Christine Grahame in recognising the good work that is carried out by Addaction, in particular at the Galashiels site. Drug and alcohol addiction remains a serious issue in our communities. Addiction is a terrifying disease that, when it takes hold, has the ability to destroy the person and the lives of their family and friends. Addaction, through its work, fights addiction. It seeks to help people with addiction issues, and it helps their families, friends and communities. It provides help for anyone who needs its services when they are faced with addiction.

Addaction started in Scotland in 2004 and is now the largest provider of drug and alcohol support services in the country. It has expertise in issues ranging from early years work, community recovery and rehabilitation, work with older people and harm reduction to education and employment. The work done by Addaction is vital for the lives of those who fight addiction and for their loved ones.

Addaction is making an impact: it has 98 sites across the UK—23 of which are in Scotland, including the site in Galashiels—supporting tens of thousands of people, including 1,000 families.

As Christine Grahame mentioned, one of those helped is project worker Rod Anderson, who is from the Borders. Wanting to give back to Addaction, he set up the Serendipity recovery cafe with Addaction's support. Mr Anderson became a recovery champion for Addaction Scotland in 2014, and then became a full-time project worker. He is an example of the positive impact that Addaction has on people's lives and, of course, his story is not the only success.

However, let us be realistic: drug and alcohol misuse is not going away any time soon. In Scotland, alcohol alone claims 22 lives a week and costs £3.5 billion each year. That highlights the crucial need for charities such as Addaction and the mammoth task that they face in fighting the disease.

A report from the Scottish Parliament information centre states that, in Scotland, problem drug use is disproportionately high compared with that in England and other European countries. The latest available data shows that more than 700 drug-related deaths were registered in Scotland in 2015 and 73 per cent of drug-related deaths in 2015 involved individuals aged 35 or over—and that is despite drug use falling overall.

However, Scottish Conservative research has shown that, in half of Scotland's 14 health board areas, support for alcohol and drug partnerships has fallen this year, which contradicts a promise from the Scottish Government that treatment would be maintained at existing levels. Although the Scottish Borders has seen an increase in funding for those partnerships, funds have been cut by more than £200,000 in Dumfries and Galloway and by almost £700,000 in Lanarkshire. Furthermore, official statistics show that more than 1,100 inmates in our country's prisons were caught either taking drugs or administering them to others in 2016—a seven-year high. Substance misuse in our prisons is undermining any attempts that are being made to rehabilitate criminals and

ensure that prison is a secure place for people to work in. This is at a bit of a tangent, but all of us agree that the rehabilitation of offenders is critical for society, although it remains near impossible to achieve while drug taking remains so prevalent.

Tackling alcohol and drug misuse remains a highly important issue in Scotland, and we need a focused attempt to tackle it—working with local programmes rather than taking a blanket approach of substituting illegal drugs with methadone, without any meaningful progress in treatment.

Drugs and alcohol damage and even destroy our communities. Fantastic work is being done in an effort to eradicate their devastating impact, and I am fully supportive of such efforts—efforts made by Addaction, with the involvement of people such Rod Anderson. I wish both Addaction and Mr Anderson further success in their work.

17:13

Colin Smyth (South Scotland) (Lab): I refer members to my entry in the register of members' interests, which states that I am a local councillor in Dumfries and Galloway.

I, too, thank Christine Grahame for lodging the motion and allowing the chamber the opportunity to celebrate the contribution of Addaction in our communities across Scotland. She highlighted the excellent work of the charity in the scenic, rural and pretty villages of the Scottish Borders—I think that those were the words that she used—and quite rightly so. In the short time that I have, I want to focus my comments on work more to the west of the South Scotland region, in Dumfries and Galloway in particular, although many of the challenges across the Borders and Dumfries and Galloway, which are both largely rural areas, are very similar.

I recently visited Addaction's Dumfries office—one of its 23 regional sites across Scotland—where I had the privilege of meeting the regional service manager, Hugh Robertson. It is clear that Hugh is passionate about the work of Addaction and leads a dedicated team that supports people across Dumfries and Galloway, working in close partnership with the national health service, Alcohol and Drugs Support South West Scotland and the local social work department. Few of the team were in the office behind the charity's discreet front door when I visited. Instead, they were out in communities, providing personalised support and help to the hundreds of people battling with drugs and alcohol addiction in the region. Addaction provides that support in a number of ways, from individual face-to-face assessments to group sessions using mutual aid partnership meetings. It does that in an entirely non-judgmental and personalised manner, putting the goals of the service user first, and the results are impressive.

In the year from April 2016, Addaction has had 550 people in Dumfries and Galloway leave its service, with 449 of those service users attending at least one appointment. Two hundred and ninety-two service users—64 per cent—achieved a planned and positive outcome, far exceeding the service's target of 40 per cent. It was a surprise to me that most of those benefiting from the service are self-referrals, often turning to Addaction for support at a time of crisis, whether that is after a drink-driving charge or, sometimes, after the breakdown of a marriage, making the challenge all the more difficult for the team at Addaction. However, Addaction is there for them in their time of need—in Hugh Robertson's words, it helps them to find the person that in many cases their addictions stole from them.

On my visit, I was incredibly struck to learn that older people make up a growing number of those who face addictions. The proportion of problem drug users who are male and aged between 35 to 64 in Scotland has increased from 43 per cent in 2009-10 to 51 per cent in 2012-13, and 73 per cent of drug-related deaths in 2015 were of individuals aged 35 or over. That group of older drug users is set to grow in size. That makes the recent decision by the Government to reduce direct funding for drug and alcohol treatment and support services all the more disappointing.

In 2016-17, the allocation to NHS boards for alcohol and drug partnerships was £53.8 million—down from £69.2 million in 2015-16. In Dumfries and Galloway, that led to a cut in direct funding from £1.98 million to £1.53 million. Although health boards were asked to make up that difference, Dumfries and Galloway was able to find only £234,000 of the £452,000 shortfall. The cut led to a 20 per cent reduction in funding for Addaction in Dumfries and Galloway and as a result the team in the region was reduced from 18 people to 12.

However, Addaction continues to do a fantastic job right across Dumfries and Galloway, so I once again thank Christine Grahame for bringing the issue to the chamber and I wish Addaction well as it celebrates its 50th year. In particular, I thank Addaction for all the work that it does in Dumfries and Galloway and across the south of Scotland.

17:17

Stuart McMillan (Greenock and Inverclyde) (SNP): I, too, welcome the debate and I congratulate Christine Grahame on securing it. I refer members to my entry in the register of members' interests as a member of the management board of Moving On (Inverclyde). I

intend to touch on some aspects of Moving On in my speech.

Christine Grahame's motion is certainly helpful and it has been a reminder of the Addaction exhibition in Parliament in February. I spoke to the Addaction representative at the exhibition and I was greatly impressed by what they had to say and how they are working to help many people in the areas that they cover.

Addaction does not operate in Inverclyde, but we have a range of other organisations working with those with addictions. Whether it is Addaction or other organisations, including Moving On, it is not an easy job. It is a job that is tough to undertake, as many people with addictions live chaotic lifestyles. That affects everything from the person's health to their housing situation, their family life, and their social activities. The challenges are vast, but the rewards are immense when someone manages to turn their life around and leaves the life of addiction. That shows that working with people and treating them as individuals and human beings can work.

As the motion states, Addaction

"is the largest organisation of its kind".

That is where the comparison with Moving On ends, as it is a small, grass-roots organisation that employs six people. It is a well-established local organisation and, in the past five years, 750 people have sought support. The staff at Moving On recognise that it is impossible to help someone with one great leap; small steps are required to move people forward.

From a personal perspective, smaller organisations such as Moving On do not get the national recognition that they deserve. They do not have the larger number of staff that would enable them to promote their activities. I do not say that as a point of criticism of any organisation; I am merely stating that as a fact.

I welcome the promotion of organisations that are undertaking such work because it is crucial to highlight the positive activity that is under way across Scotland. We need to hear about the positive activity that takes place to turn people's lives around. It is all too easy to highlight the many negative situations regarding addiction. Positive work takes place, and Addaction plays its part, as do other organisations across Scotland.

The total number of drug deaths in 2015 was 706, including 16 in Inverclyde, where drug deaths have unfortunately doubled in the past 10 years. There were 33 alcohol-related deaths in 2015 in Inverclyde, which had the second-highest number of deaths per 1,000 people from drugs and alcohol in 2015 in Scotland, behind Dundee. That gives members of the Parliament a picture of the challenge that we all face.

I thank Christine Grahame for lodging the motion and securing the debate, which I welcome. I also pass on my gratitude to Addaction, Moving On and many other organisations that work daily with people with addictions. The challenge to turn somebody's life around is huge, and the workers who deliver that daily deserve a huge amount of credit and praise. They deliver life-changing work that makes a positive difference to help our fellow citizens.

17:21

Ross Thomson (North East Scotland) (Con): I thank Christine Grahame for bringing this debate to the chamber.

We live in a time when drug overdoses kill more than twice as many people in the UK per year than road traffic accidents, and when the mortality rate from drug poisoning is at its highest since records began. That puts a significant burden on the NHS to treat the consequences of drugs, and on our police to enforce the law in the face of a complex and ever-expanding network of distribution and consumption. In fact, I read only last Friday in *The Courier* that Superintendent Derek McEwan, from Police Scotland's Fife division, said that it was "only a matter of time" before dangerous new legal highs become more widespread in Tayside and in the north-east, which I represent. In these dark and challenging times, the vital work of Addaction has been a beacon of hope and optimism.

Addaction has evolved over the last 50 years to develop a wide expertise in community alcohol and drug addiction support and rehabilitation, blood-borne virus treatment, bespoke sexual health advice, and education, employment and welfare issues. Throughout those years, Addaction has held true to its core approach: treating people with dignity and respect, putting individual needs at the heart of its work, and not wavering in the belief that addiction should never be allowed to cripple or end a life—recovery is possible, and indeed probable, with the right framework of care and support.

I have been most struck by Addaction's work with young people across the UK. Andrew was just 14 when he started taking cocaine and ecstasy as a means to combat his Asperger's syndrome. What began as a means to feel more sociable and outgoing became a devastating addiction that caused Andrew to suffer paranoid delusions, extreme agitation and palpitations. Young people like Andrew often feel isolated and unable to talk to anyone about their problems; they do not wish to anger their parents or teachers, nor do they want to feel embarrassed or ashamed among their

friends and peers. That is where young Addaction stepped in to provide support and treatment for Andrew, not just for his addiction, but with practical advice and guidance on managing his Asperger's syndrome. He now works in an information technology retailer; his confidence has grown vastly and he lives a happy, stable and drug-free life.

I also want to take a moment to draw attention to the incredible work of young Addaction Dundee, a successful partnership between Addaction Dundee and The Corner, which targets young people aged between 11 and 18.

The tragic stories of young people dying as a result of drugs resonate with us all in the chamber. We hear of new drugs emerging almost every week, and of so-called legal highs having devastating consequences. In response to that, I launched Aberdeen against legal highs and lodged motions in Aberdeen City Council to raise public awareness of the dangers of legal highs.

I remain committed to combating the epidemic of legal highs and to making our streets safe and drug free, and I commend the fantastic work of Addaction in contributing to that cause. The work of Addaction, in Scotland and across the United Kingdom, in providing specialist advice and early intervention programmes in schools and youth clubs has saved countless lives over the years.

After reading Andrew's story and hearing the many powerful contributions in the chamber today, it has become clear to me that Addaction is more than just an addiction charity. It provides support for those who have none, hope for those who think that all is lost and a future for those who cannot see a way forward.

17:25

The Minister for Public Health and Sport (Aileen Campbell): Like other members, I am grateful to Christine Grahame for bringing the debate to the chamber, and I am pleased to close the debate on behalf of the Government. Like many members, I was able to take time to visit the Addaction exhibition and hear at first hand about its work. As Ms Grahame did, I welcome the visitors from Addaction to the Parliament.

I am pleased that the motion has attracted cross-party support. There is a commitment in the chamber to ensure that some of our most vulnerable people access the care and support that they need, and that that is delivered in the context of a recovery-oriented system of care. Christine Grahame's contribution was incredibly powerful and showed the transformative impact that a person-centred approach can bring. She spoke about Rod Anderson, who works in the Borders and who sounds like an incredibly special person. He has created the first recovery community in the area. We heard that those whom he has helped articulated that as him giving their children a future or saving their life. That shows how lives can be and have been turned around if people are given the right help, if their addiction is seen as a health problem and if the stigma can be removed.

Christine Grahame was correct to point out that addiction does not just happen in the gritty urban areas and that it happens in our remote and rural communities, too. We therefore need to take a national approach and recognise that we cannot simply brush the issue under the carpet.

Our drugs strategy, "The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem", is a framework that has at its heart an aspiration to support those facing drug-use problems and their families and to see that through a health lens. Although the strategy remains as robust and relevant as it was when it was launched with cross-party support, the challenges and context of tackling substance misuse have nevertheless changed.

As members have pointed out, we have an increasing and ageing cohort of older drug users, who require particular support to help to keep them safe. In addition, the challenges that are posed by new psychoactive substances have been well documented in the chamber as we undertake a cross-party approach to tackling them.

We continue to work with the drug and alcohol sector to look afresh at how we might make further progress on addiction issues. The partnership for action on drugs in Scotland, which I chair, is currently providing its thoughts on the extent to which we need to refresh our thinking while retaining the ambitions that are set out in "The Road to Recovery". I am delighted that Andrew Horne from Addaction Scotland is part of those discussions, and I am incredibly grateful to him and others for their energy, commitment and candour, which is informed by years of experience in delivering high-quality drug, alcohol and mental health services to those who need them.

Christine Grahame: I am delighted that the minister has mentioned the Scottish leadership of Addaction. I know that her diary is very busy, but I invite her to visit Addaction in Galashiels and see the hands-on experience and teamwork there. We have mentioned Rod Anderson a lot, but it is a team, and the minister might find a visit useful.

Aileen Campbell: Absolutely. When Addaction was at the Parliament, it was good to get a chance to speak to Andrew Horne and to hear at first hand about some of the really transformative work that Addaction is doing across the country in the many

settings in which it has a footprint. I am interested in visiting Addaction in Galashiels, particularly as it has been so instrumental in creating the first recovery community in the Borders. That will be helpful in ensuring that people recognise that, as Christine Grahame said in her speech, addiction issues do not just happen in urban centres and that they happen across the country. We need to ensure that that is heard clearly by people across the country.

Of course, addiction relates not only to drugs misuse; it includes issues with alcohol. Through our alcohol framework for action, we have taken bold action to tackle and reduce the damage that alcohol causes. That framework includes a package of more than 40 measures to reduce alcohol-related harm. In recent years, we have made progress. Alcohol-related harm has reduced but it is still at unacceptably high levels. With 22 alcohol-related deaths and 670 alcohol-related hospital admissions a week, we need to do more. We are refreshing our framework and will build on the progress that we have made so far.

Given the link between affordability, consumption and harm, addressing price is an important element of any long-term strategy to tackle alcohol misuse. Therefore, we remain absolutely committed to implementing minimum unit pricing, which will tackle the cheap, high-strength alcohol that does much damage in our communities.

Addaction has a strong reputation for delivering high-quality services and for embedding lived experience and user involvement in its governance and service delivery. Echoing Rod Anderson and the team in Galashiels, Andrew Horne has been supporting some work to ensure that people with lived experience can be heard as we develop policy approaches at a national level.

We must never be complacent. We must always strive to improve the quality of services and seek to bring consistency across Scotland. Addaction is a national organisation, but I am aware of the range of local statutory and third sector services that operate across the country and provide much-needed support to people who have a substance misuse addiction.

The development of national standards of care—set out in our quality principles—a clear set of outcomes for alcohol and drug partnerships and a shared statement on workforce development remains critical as part of the framework within which excellence in local delivery can flourish. However, there remains a place for innovation, and I was delighted that my officials recently wrote to Addaction to confirm that it has been successful in securing funding from the Scottish Government for a project that will, where appropriate, pilot and test the opportunities that digital technology presents for reaching out and engaging with clients.

Christine Grahame's motion specifically invites us to tackle problem substance use as a health and social care issue, rather than a criminal justice one. Although there is a place for the criminal justice system, the aspiration to divert people away from criminal sanction at the earliest opportunity is to be welcomed and should continue. We should build upon that in however we develop our drugs policy, strategy and approach. That must be managed well, and I am aware of many innovative and successful schemes in Scotland and elsewhere to ensure that people whose offending behaviour is exacerbated by addiction are supported in a person-centred treatment pathway.

That principle should be true irrespective of whether someone is in prison. I recently had the opportunity to offer views on that matter to the Health and Sport Committee when it considered prisoner healthcare. I look forward to seeing the committee's conclusions.

The Government made a decision in November 2012 to transfer responsibility for healthcare from the Scottish Prison Service to the NHS for the reasons set out in the motion—to ensure that people who spend time in prison can expect the same level of care and attention as those who receive help in the community. The responsibility for drugs policy moved in April 2016 from the justice portfolio to my health portfolio. That demonstrates the Government's commitment to look at substance misuse through a different lens and to address it in the wider context of the public health challenges that we face.

I further congratulate Addaction and thank it and organisations like it for all that they do. I renew my commitment to tackle the problem in a fresh way, drawing on the expertise and perspectives available, including those of people with lived experience. Christine Grahame is right that, as we debate Brexit and prepare for another election, groups such as Addaction are saving lives, giving children a future and providing much-needed support. We need to continue to look at addiction through a health lens so that we continue to make the progress that we and our country need to ensure that public health services in Scotland can ensure that everybody, regardless of the health issues that they face, gets their fair chance to flourish.

Meeting closed at 17:34.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

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