HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 27 October 1999
(*Morning*)

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CONTENTS

Wednesday 27 October 1999

HEALTH AND COMMUNITY CARE COMMITTEE
10th Meeting

CONVENER:

*Mrs Margaret Smith (Edinburgh West) (LD)

COMMITTEE MEMBERS:

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)
*Dorothy-Grace Elder (Glasgow) (SNP)
*Mr Duncan Hamilton (Highlands and Islands) (SNP)
Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Ms Irene Oldfather (Cunninghame South) (Lab)
*Mary Scanlon (Highlands and Islands) (Con)
Dr Richard Simpson (Ochil) (Lab)
*Kay Ullrich (West of Scotland) (SNP)
*Ben Wallace (North-East Scotland) (Con)

*attended

WITNESSES:

Susan Deacon (Minister of Health and Community Care)
Chris Spry (Greater Glasgow Health Board)
Dr Andrew Walker (Greater Glasgow Health Board)
Dr Kevin Woods (Scottish Executive Health Department)

COMMITTEE CLERK:

Jennifer Smart

ASSISTANT CLERK:

Irene Fleming

COMMITTEE ADVISER:

Dr John Forbes

Scottish Parliament

Health and Community Care Committee

Wednesday 27 October 1999

(*Morning*)

[THE CONVENER *opened the meeting at 09:49*]

The Convener (Mrs Margaret Smith): The committee will go immediately into private session, as it did yesterday, to discuss how to proceed with today's business and who will ask certain questions. I hope that should take no more than 10 minutes. We will then hear from Greater Glasgow Health Board. Is that agreed?

Members *indicated agreement.*

09:50

Meeting suspended.

10:13

On resuming—

Arbuthnott Report

The Convener: Good morning, gentlemen, and welcome to the Health and Community Care Committee. Could you kick off by following up your written submission on the review with a short oral presentation? The committee will then ask questions. It would be helpful if you could introduce yourselves and tell the committee what your roles are.

Chris Spry (Greater Glasgow Health Board): I am Chris Spry, the chief executive of Greater Glasgow Health Board. Andrew Walker is our health economist and statistician on these issues. He is far more adept at deep, technical questions on this than I am. Members have received our submission, which was work in progress because we were working to a different cycle. It was written before we had had an opportunity to have a detailed session with the Arbuthnott team. We have now had that session.

First, we warmly welcome the review. It seems to have been done thoroughly and impartially, and it has as good a level of transparency as one could hope to get in such matters. We raised six points in our submission to the Health and Community Care Committee. I will mention those points briefly.

The first point concerns the attention that the Arbuthnott work inevitably gives to health care, at a time when the health boards' responsibilities are, increasingly, broadening beyond those confines. Much of our current work is on tackling inequalities in health and working with other agencies to promote social inclusion. It involves community development projects and capacity building, which includes local health projects, food co-operatives, work with others on community schools, family support groups and our contribution to social inclusion partnerships. All those are examples of contributions that we make to that sort of agenda. Very few of them are measured in NHS information systems, but we spend about £1 million a year on them and that figure is rising. We accept that that is very small beer in the context of an allocation formula that deals with billions of pounds in the country as a whole, but nevertheless we think that the omission of this area from the formula sends an unfortunate signal.

The Convener: That is also a trend, is it not?

Chris Spry: Yes and we would expect the trend to draw in an increasing amount of expenditure.

The second point, which forms our main reservation about Arbuthnott's work, concerns the community services aspect of the formula. If Greater Glasgow Health Board's allocation followed the Arbuthnott framework, our spending per head on community health services would be 3.3 per cent less than the national average. If we replicated that into the way we spend money in Glasgow, that would mean a reduction of about 22 per cent in services such as physiotherapy, district nursing and health visiting at a time when we would expect to spend more on those services, in order to address health inequalities, the community development agenda, community care and various social inclusion objectives.

It is also important to bear in mind the fact that those services have a particularly close interface with local authority community care and social work spending, which is pretty volatile and unpredictable. We have some concerns about that, but I will not go into details about the nature of those concerns. Andrew Walker can respond to questions on that. Our view is that some further work should be done on this or, alternatively, that a weighted average of the morbidity and life circumstances adjustment might be used for acute services, mental illness, learning disabilities and obstetrics, all of which have service connections with community health services.

Our third point concerns the adjustment made for rurality. As you would expect, we in Glasgow were interested in that. We accept fully the principle that there is an issue about higher costs being associated with rurality. However, we were mindful of the fact that, even after allowing for differences in the age and sex of the populations, the influence of extreme deprivation on Glasgow's

allocation is more or less offset by the rural adjustment for the islands, the Highlands and Dumfries and Galloway. We intuitively felt that to be strange.

However, there are two caveats. The first is that some of our discomfort with that strange observation may be offset by the further work that is to be done on unmet need, and I will say more about that in a minute. The second concerns the data that were available. When we met the Arbuthnott team, they took us through their thinking. Although they acknowledged some of the methodological points that we made—and Andrew will deal with those in detail if you are interested—they reminded us that they had used the best data that they had. We thought that that was a fair response.

The fourth point is about unmet need. That has been flagged up in the report as an area in which further work needs to be done. As you would expect, we are very interested in that further work and would like to see it drawn to a conclusion as soon as possible. The concept of unmet need is not an easy one to grasp and it is certainly difficult to measure. The Arbuthnott report draws attention to some data about the disparate access to such treatments as hip replacement and statins.

One would expect that Glasgow's deprivation would be reflected to some extent in the existing higher levels of utilisation of services; it is already reflected in the morbidity and life circumstances adjustment. The disparities and the patchy nature of local access seem to be the key priorities for further examination of the issue. We suspect that we should consider the fact that unmet need is more likely in the areas in which there is chronic ill health or pre-acute drift towards ill health in which people who should be seeking support or help are not doing so. We think that that is where the problem lies, but we must find a statistically reliable proxy to measure it.

Those are the main points. The other issue that we were concerned about involves the way in which the formula should continue to be reviewed. A balance should be struck between constantly returning to it and refining it and the health boards' needs for some sort of certainty. Of course, nothing in this world is ever certain, but it makes life easier if one can have confidence about a forward projection of the resources that one is likely to have. The formula needs to be kept under review, but not in such a way that it swings around in short periods of time, making planning more difficult than it already is.

The Convener: Thank you for that submission. Dorothy, do you want to kick off with the questions?

Dorothy-Grace Elder (Glasgow) (SNP): Yesterday, the representative of the Scottish Association of Health Councils said that she believed that Sir John Arbuthnott's original remit was far too narrow in that it just spreads around an existing pot of money without suggesting where fresh money might be found. Do you agree with that view?

Chris Spry: Arbuthnott was given a remit and, as far as we can see, he has followed it. If the Parliament or the Executive felt that there should be a wider review about the quantum of money that goes into health or about the way in which different agencies can come together to get best value out of the resources that they have, we would agree that there is a lot to do about that, but that is not what Arbuthnott was asked to do.

Dorothy-Grace Elder: It seems extraordinary that the report does not attempt to go beyond its remit. It is one of the few reports that I have seen that does not do that.

The Convener: Sir John Arbuthnott told us that in chapter 15 he was dipping his toe in that direction. That is obviously going on behind the scenes.

Dorothy-Grace Elder: I did not understand it to be a dip, but a large part of the report was not transparent to some of us.

Chris Spry: It is undoubtedly the case that an awful lot of our work involves working with other agencies on a wider agenda than just health care services. That is a real issue for us, but it is a different issue from working out a national formula for allocating NHS resources around the country.

The Convener: The formula relies on a wide range of morbidity and life circumstance indicators that vary from one area to another. Why, in Greater Glasgow Health Board, does the inclusion of those indicators seem to have so little effect? Is it because your deprivation indicators have been cancelled out by the remoteness indicator?

Chris Spry: In broad terms, that is correct.

Dr Andrew Walker (Greater Glasgow Health Board): I echo that. Glasgow has the most extreme indicators of deprivation in the country. Around 80 per cent of the most deprived postcode areas in the country are in greater Glasgow. We are being weighted against because of the excess cost adjustment that reflects the remoteness of rural areas and the age and sex adjustment that reflects older populations. Our population is slightly younger and we have a much more geographically concentrated service than the UK average, which has a substantial offsetting effect.

The Convener: Yesterday, we heard from representatives from Shetland Health Board, which has a different set of problems. They told us about their problems in terms of transport of

patients and so on. Do you think that one formula would suit all health boards?

Chris Spry: There has to be one formula to deal with the challenge of how to distribute the money that the Executive allocates to the national health service. That formula has to be sufficiently statistically robust to handle that, which is why Arbuthnott talked about building up the formula. If we had lots of different formulae, arguments about the fairness of the allocation of resources would never end.

Do not underestimate the potency of that issue. People will spend a lot of energy arguing over small variations in a formula and will be distracted from the more important need to focus on how well resources are being used.

Ms Irene Oldfather (Cunninghame South) (Lab): By its nature, the report is detailed and technical. It is important that there is a high degree of confidence in the statistical outcomes, which affect people's lives directly.

I asked Sir John Arbuthnott yesterday about the prospect of independent peer review of the analysis. Would Greater Glasgow Health Board have the capacity and the expertise to check the methods and results underpinning the proposed allocation formula?

Dr Walker: I am an economist by training and could comment on those aspects. I can do enough statistics to cope with this report, but I would feel uncomfortable commenting on detailed statistical methods.

I feel comfortable with the thinking and the principles behind the report and I believe that it would be possible for us to help with the peer review but I hope that it would not be solely our responsibility.

Mary Scanlon (Highlands and Islands) (Con): Yesterday, Professor Graham Watt, from Glasgow University, mentioned that the report underestimated the level of health deprivation and did not address co-morbidity adequately. He said that that might be why Greater Glasgow Health Board did not get the allocation that it expected. Has analysis been conducted on how targeted allocations in greater Glasgow might fluctuate as a result of assumptions about the value of key variables such as population?

Dr Walker: As Graham Watt said, there is potential for lots of interaction in this model. As members of the committee have already said, this is a very technical exercise and involves a lot of number crunching. Given the time that was available, I think that the report is as good as it could be. A more extensive exercise might consider interactions. Age and sex are taken account of first and the effects of deprivation are examined, but I do not have the statistical knowledge to know whether we are allowing for an interaction between age and deprivation.

Mary Scanlon: Do you think that it would be possible to have a model that takes co-morbidity into account?

Dr Walker: That is very important, as it might be one of the main causes of some of the unmet need that exists. If someone has a condition such as angina, but has a co-morbidity of severe respiratory disease, they might not be fit to undergo an operation. That might explain some of the statistics that are cited in chapter 15. My slight concern is over the quality of our data. The problem that we return to all the time is that we know quite well what goes on in hospitals—who goes in and out of the hospitals—but we are less sure about the health of the population who are out there. It seems strange to say that, after 51 years of the national health service. However, we are still a little way off an ideal population data set.

Mary Scanlon: Do not GPs have data that would be helpful in that respect?

Dr Walker: They have some data, certainly; however, it varies throughout the country. One GP, who is interested in diabetes and who is computer literate, might have an excellent diabetes register for his or her list. Another GP in another area might not have the same interest or computer skills and might use a different system. If those two types of GP were in different areas, we would not get a fair reflection of the situation throughout the country. Nevertheless, there is potential for the collection of such data to be built on, as people become increasingly computer literate.

10:30

Mary Scanlon: So, to address that problem, do you feel that we require the GPs to keep a much more comprehensive list of patients' problems than they do at the moment?

Dr Walker: GPs provide the closest contact that the health service has with the population on a daily, monthly and yearly basis. If you were to talk to someone from general practice, they would point to how time-consuming that exercise would be. Anything that they did in that direction would start to deflect them away from patient care. Although, as a number cruncher, I would welcome better data on the population, I think that we must be wary about the costs of gathering those data and must ensure that something useful enough would be done with them. The data would have to add enough value to justify the extra effort that would be involved in collecting them.

Mary Scanlon: Yes, I understand.

Dr Walker: You asked about sensitivity analysis, and whether allocations were robust. That should be directed to the Arbuthnott review team, as it holds all the spreadsheets. We have asked for elements of the formula to be varied a little, particularly concerning the sparsity adjustments for community services. However, I imagine that they have been inundated with such requests, as they have not had time to reply to that request.

The Convener: Ben, do you have any general questions on the same subject?

Ben Wallace (North-East Scotland) (Con): Yes. I want to return to the point that you made about people spending too much time examining the statistics and missing the bigger picture of the better use of money. Do you recognise that the Arbuthnott report fails to take into account the efficiency, better use of money and better practices in different health boards? A particular practice may make one's pound go further in certain aspects of care in Greater Glasgow Health Board, whereas those aspects may not be implemented in Grampian Health Board. Do you accept that the Arbuthnott report does not take that efficiency coefficient into account?

Chris Spry: An allocation formula from the Scottish Executive to the NHS in Scotland should reflect the needs of the population. In that sense, it should not reflect relative efficiencies. That is not to say that differential efficiencies between health boards are not important; they are extremely important. However, we must look for other devices to tackle that issue. An allocation formula concerns the fair distribution of the cash that is available to the NHS, based on the characteristics of the population rather than the efficiency of the institutions that provide the care. The efficiency issue is extremely important, but there must be other means of addressing it: through audit, performance management by the NHS executive, and so on.

Ben Wallace: An allocation formula could actually take that into account in its make-up. The technical report defines the factors that make up the overall formula, and that could have been included in it.

Dr Walker: I look to John Forbes to guide me on this. My understanding is that they use national average costs to value the resource use at a local level, so that should be taken out of the equation, as it were. It should not matter how efficient one hospital is relative to another on a local basis, because—and correct me if I am wrong, John—I think that they used a national average costing base to value the resources that we used.

The Convener: Apparently our experts cannot speak, but I am allowed to speak for them. Is that not nice? It is absolutely ridiculous, but hold on a minute while I consult the oracle. No, this is silly. John will answer the question.

Dr John Forbes (Committee Adviser): You are absolutely right when you say that they use national average costs, but the key question about efficiency seems to relate to any differential between the national average and what is actually happening in a particular health board, where a whole set of incentives can be seen emerging in terms of the wedge that could be driven between the national average—where you should be, according to the allocation—and where you actually are. You could be above or below that national expectation, which is, I guess, why Chris made the point about how important it is to look at the differentials.

Dr Walker: That starts to kick in when we look at the rurality adjustment for hospitals. The economies of scale argument says that central belt populations tend to be served by large hospitals that should be reaping economies of scale and should be more efficient.

Dr Forbes: That was the next point that I wanted to make. The efficiency issue, in terms of that particular adjustment, is already embedded in Arbuthnott.

Ben Wallace: What, if any, are the gaps in the data available for each modelled care programme?

Dr Walker: I could probably spend the rest of the hour saying where the gaps are. To start with, we know nothing about the quality of care. All these data assume is that a bed-day is a bed-day is a bed-day, and that there is no significant difference by outcome. Speaking generally, we think that the data for acute hospitals are fairly robust, and the hospital data sets are fairly robust. The system used for general practitioners—the so-called continuous morbidity records data set, which I am sure you will have covered yesterday—is not a comprehensive data set: it uses spotter practices around the country. We certainly feel that that could be improved in terms of its coverage of the most deprived populations. The GP prescribing data set is also a fairly good one. The community data set, which we will come to in a few minutes, is a very weak one at present, with data from a small selection of trusts that are not necessarily representative of the country.

Ms Oldfather: I have a question about the community data, which we discussed yesterday with a number of groups. I am aware that they cover two professions, making up approximately 30 to 32 per cent of the budget. Do you have any thoughts on how the data could be improved and on what alternative measures we should be considering? What information do we need to think about collecting now for the future?

Dr Walker: The fact that what you said about community data is the case must be partly a product of the historical development of information services in those professions. The general medical services system—the CMR data set for general practice—is coming along. There does not seem to be any inherent reason why the community service should not be collecting good routine data. If you are taking evidence from anyone in the information and statistics division, such as Richard Copland, they will tell you that the systems are in place and that the data sets are starting to be built up. The issue is still about the quality and the coverage. We hear anecdotal evidence of people who fill in stacks of forms and then, a month later, find them stuck in a filing cabinet somewhere, having never gone off to be processed. It is partly a cultural thing as well.

You asked what better data we could be collecting. I have a table in front of me that shows the percentage spent on each part of the community in front of me. A large element of it is described simply as "other services", and that covers 56 per cent of community spending. We have to start to understand what makes up those other services, and the way in which they are being allocated across the socio-economic groups in the population. It is very frustrating that 56 per cent of £200 million of taxpayers' money can be described only as "other services".

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I have two questions. I do not know whether I may ask them both, but I had better in case I am not invited to speak again.

The Convener: Go ahead. I am going to be thrown out anyway, so you may as well.

Malcolm Chisholm: The first question picks up on the point that you made before, which is of general importance to the whole issue of the remoteness indicator. In your submission to the committee, you said that

"the proof of economies of scale for hospitals is open to a number of detailed criticisms".

Could you give a brief indication of what those criticisms are? Does that subvert the basis of the remoteness indicator?

My second question is about health promotion. The section of your submission on health promotion was interesting and opened up a number of general questions about the methodology of the review. How do you think the allocations for health promotion should be dealt with? On the one hand, there could be an allocation within the health service budget, but you suggest that much of that runs into other budgets. Would you have preferred the distribution to have been done in combination with another budget?

Dr Walker: On rurality, as Chris Spry emphasised, we accept absolutely the principle that a population that is geographically scattered should receive more money in a fair-share allocation than a geographically concentrated urban population. We want to do more work on the community and general medical services adjustments, but our real concern is on hospitals. It is in that connection that I said that we had a couple of detailed criticisms.

One of the things that I considered, in terms of proof of economies of scale across hospitals, was the data set that was used—were things such as case mix adjusted for, for example? The data set was quite truncated, in that small hospitals were left out on the ground that their costs, over time, were not reliable enough to be able to base policy on them. The larger teaching hospitals were also left out, because their costs are so difficult to adjust for. I wonder how representative that truncated data set was of the range of hospitals in Glasgow. That is the sort of thing I meant when I talked about detailed criticisms. I have thought of a few more since, but I will not burden the committee with further details now.

Our concern, when we see a smaller rural board that does not have a high level of deprivation getting roughly the same allocation per head as Greater Glasgow Health Board, which has an intensive concentration of deprivation, is whether the rurality adjustment has gone too far. However, I would have to get right into the nitty-gritty of the adjustments that were carried out if I were to go beyond saying that. This might be a good place to pause before we try to tackle the question on health promotion, or shall I keep going?

The Convener: Is your question on health promotion, Dorothy-Grace?

Dorothy-Grace Elder: I want to mention something about health promotion, but I also wanted to come in on rurality—which is a dreadful word. We mean rural areas. Let us try to use English occasionally.

The major schemes in Glasgow are quite remote. I am sure that you would agree that a major scheme is as distant from some essential services as some outer villages in rural areas. We need to get rid of the problem about distance—it is a mindset. People in those areas often have little cash to use a bus to go very far. Yet, Greater Glasgow Health Board has closed three out of four day psychiatric units near the east end, where demand for mental health services is higher.

The Convener: Dorothy-Grace, will you please get to your point?

Dorothy-Grace Elder: Are you worried about more closures in the key areas of deprivation in Glasgow if the scheme is implemented as it is?

Chris Spry: No. Closures would not arise as a consequence of implementing the Arbuthnott recommendations. Where there is a change in the location of services, especially in the field of mental health—where millions of pounds are put in over a period—it is usually to do with trying to get better concentrations of teams, of skills in mental illness and so on. There is always a big debate about the extent to which one should try to line up mental health services with GP practices and health centres; it is a complicated area. However, the short answer to your question—whether there would be a retraction of access to service in schemes in Glasgow as a consequence of implementing Arbuthnott—is no.

The Convener: Can we go back to the health promotion issue?

10:45

Dr Walker: Certainly. There are at least two aspects, and possibly a spectrum in between. One aspect is what we would all recognise as traditional health promotion, when people go round giving advice on smoking, exercise, lifestyle and so on—the sort of things that are directly linked to illness. There is also the bigger agenda that Chris talked about—you might call it public health promotion—which is more about the fundamental determinants of health: education, housing and so on. It is a question of horses for courses. The problem for the Arbuthnott approach is that the same types of data set are not available at postcode level, with current spending on services, compared with data on acute services, psychiatric services and so on.

As part of future work on the Arbuthnott review, we would have to start thinking of ways to tap into the available data. The Scottish health survey is a good source of data on the lifestyle of the Scottish population and how it is distributed by age and social class. That could be used as the basis for a health promotion formula.

When we say that we may be spending only 0.4 per cent of the national budget on health promotion, according to the management executive performance management template, that is where the judgments come in. Should it be that figure? The statisticians would say that it is—and always will be—0.4 per cent. Economists are different beasts. To say that it should be more than that is a potential policy lever for the management executive. Nothing is written in tablets of stone. It could be said that a particular weighting is put on the acute sector, according to how much is spent on it. There is nothing to say that that has to be the case.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): You have indicated that greater Glasgow is diverse in population spread and deprivation. The Greater Glasgow Health Board is allocated a sum—can you indicate how your method of disbursal of those funds measures the socio-economic deprivation levels in Glasgow and how that would alter, should Arbuthnott be implemented as it stands?

Chris Spry: It is a complex area. I would probably take all morning trying to answer your question. The biggest driver of resource distribution within a health board is history—where existing services have been sitting for decades. For a health board, there are two angles on how to change focus to meet need: how to use any development money that is coming in, year on year; and the parts of the pattern of existing services that could be changed better to meet objectives for tackling inequalities in health and so on.

We focus on those two broad areas and have developed a financial framework that sets out how we would like to spend money over the next five years. It focuses quite heavily on the new money coming in; that is, using the old Scottish health authorities revenue equalisation formula, without the Arbuthnott effect. We would have expected an annual uplift on the existing resource assumptions of £23 million to £24 million a year. If one takes inflation as equating to the GDP deflator, inflation would take up about £14 million to £15 million of that. That leaves about £9 million a year to use for service development. At the end of a five-year period, one would expect to have a £45 million change in service provision on the back of development.

How might we use £45 million over five years? We would probably use about a quarter of it—about £11 million—to develop mental health services. We would use about £3 million to strengthen services for children and families and for community development. About £2.2 million to £2.3 million would be used to strengthen services for addictions and about £1.5 million would be used to strengthen primary care. I could go on and give figures for dialysis growth and so on, but the upshot is that there are a number of things that we would want to do to tackle inequalities in health, and we have a pretty clear idea of what those things are.

The constant difficulty that we face is what I would describe as the pressure cooker of acute services. The drivers of increased costs in acute services are relentless—new techniques, new drugs, new materials and so on. Year after year, our difficulty is how to protect our ability to put more money into such things as mental health, community development and services for children, in the face of the relentless pressure that drives the costs of acute services upwards. That

becomes a matter of judgment.

Margaret Jamieson: Obviously, Greater Glasgow Health Board has a large daily influx of people to the west of Scotland from the east. How does the health board allocate funds to deal with such issues? That influx will not always be to the acute sector, but might be in the form of a need to call out a general practitioner, for example. I found nothing in the Arbuthnott report about dealing with the transient population. That is an issue, especially in cities, but the west of Scotland and Ayrshire also have a large influx, particularly during July and August.

Chris Spry: That is dealt with in several different ways. If patients are admitted to hospital as in-patients or as out-patients, there are arrangements whereby the trusts in Glasgow must negotiate with neighbouring health boards, say what the cost of treating people from those health boards' areas has been and ask them for the money. Year after year, they end up saying that they have treated more of the other health boards' patients than they did the previous year and that they must be given more money by those other health boards. That problem is solved between the individual trusts and neighbouring health boards.

There are two main exceptions. The first is patients attending accident and emergency departments. Greater Glasgow Health Board pays for those patients, regardless of where they have come from. The second main exception is in treatment of sexually transmitted diseases, because it is important that there are no barriers to people accessing those services where they want to access them.

A slightly different issue relates to what Margaret Jamieson said about transient populations—whether we have a sufficient grasp of the numbers, distribution and needs of homeless people and people who move frequently from one living place to another.

Kay Ullrich (West of Scotland) (SNP): What measures are used by Greater Glasgow Health Board to measure socio-economic deprivation?

Dr Walker: When we do those exercises, we always apply the national formula to Glasgow, and we have applied the old SHARE formula to sectors of the city. I know that Arbuthnott advises against applying the formula below health board level, but we feel that we are large enough to do that. Even if we divide Glasgow into north and south along the line of the Clyde, there are still sectors that are bigger than some health boards' areas.

Once the consultation is over and we know for certain what will be in the Arbuthnott formula as it is applied to health boards, we will co-operate with colleagues in the management executive to get the data, to see how that money would be split north and south of the river.

The Convener: What measure of deprivation is used?

Dr Walker: We would use the same measures that the Arbuthnott formula does.

Dr Forbes: The question is not exclusively in connection with the Arbuthnott formula. What measures of deprivation do you commonly use in studies of health or health care utilisation—such as the Carstairs index?

Chris Spry: We use the Carstairs index.

Dr Forbes: You use the Carstairs index as opposed to single indicators. Are you content with its use in the studies that you have conducted?

Chris Spry: It is an index with which people are now familiar. Broadly, those who need to understand it, do. It provides a means of comparison from one place to another, and we find it useful.

For years, Glasgow would have argued that its scale of deprivation was such that the formula for allocation should be different, and it would have argued the issues of inequalities of health and so on. Intellectually, those arguments have been won and the issue now comes back to us. How do we tackle inequalities in health in Glasgow? It is no good our saying that a significant proportion of the population is in deprivation categories 6 and 7—we must target. One of the things that we have done is to cluster the postcodes in Glasgow into four more or less equal cohorts. From that we have found significant differences in Glasgow, with things such as breastfeeding, premature mortality and so on. We are using the clustering of postcodes in Glasgow as a way of focusing on differences in the region.

The Convener: It is one thing to have a formula that says, "Let's move things round so that we can hit inequalities, deprivation"—whatever. It is then in the hands of the health boards to ensure that they use the resources and target the things that we want.

Unfortunately, we are running out of time, but I have one last question. Generally, you have commented on gaps in the formula and areas of the report that concern you. Broadly, your concerns are the scope of health promotion and health—as opposed to health care; the lack of data for community services and the results of that; unmet need, which Arbuthnott identified as requiring further work, and on which it looks as if we will begin at least one other consultation; and the need for on-going review, taking into account the fact that you do not want to rock the boat too much, because people need to know what is planned over a period of years.

I put all that to you in order to pump-prime my question. If you were the person who had the ear of the minister, do you feel that the formula is at the stage where you would be telling her to go ahead and implement it and then tinker around with it and keep reviewing it? Or would you say that this is the point at which to refuse to implement the formula because it requires more work and improvement? Which of those courses of action would you recommend?

Chris Spry: The one adjustment that we think could and should be made before implementation concerns community services. We have suggested a way of doing that which is not rocket science. With that caveat, plus the injunction to get on with the unmet need part, we would recommend implementation.

Arbuthnott talks about a gain of £14 million for Glasgow, which is about 1.9 per cent of our allocation. We need to understand that, if Arbuthnott were implemented, that money would not come in a single instalment—it would be spread over time. We recognise that and accept it. The important thing is the ability to build that into one's financial planning.

11:00

The Convener: On the difficulties with unmet need, the community services data methodology presents substantial problems. You say:

"The community services element of the formula has significant problems and should not be implemented as it stands."

That is a fairly strong statement. It is not a question of tinkering around with it for a couple of weeks and then bringing it in anyway.

Dr Walker: That would be possible with the adjustment that Chris suggested—the community deprivation adjustment would become a weighted average of the other data that are already included. We would take the acute sector deprivation adjustment and the psychiatric deprivation adjustment, consider to what, out of those different services, community services are most akin, and make the community deprivation adjustment a weighted average of the good work that is already included.

We might say that community mental health teams are part of the community service, so let us use the psychiatric weight for them and try to build up a composite. The only gap would be the 56 per cent of the formula for other services, to which I referred. It would be a pragmatic alternative to what has been put before us, which takes money out of community services in Glasgow.

Chris Spry: It is not intellectually unreasonable.

The Convener: No. So, despite the fact that the other services element would not have been tackled at that stage, if the other matters that you mentioned were taken into account, you would feel that you could move forward, with the caveat that the current unmet needs work had also been tackled.

Chris Spry: The key issue relates to the judgment that needs to be made about the pace of change. It is always difficult to put oneself in the place of someone else, but if I were the minister I would think about implementing Arbuthnott now and state that there would be modest changes for the next two years, but that, in year 3, further work on unmet need and community services would be done. We would regard that as a perfectly reasonable way of addressing the problem.

The Convener: Unfortunately, we have run out of time.

Thank you for your time and your submission. We will now take a short break.

11:02

Meeting suspended.

11:10

On resuming—

The Convener: I call the committee to order. We have the *Official Report* of yesterday's meeting, which will be useful—it is everybody' s weekend reading.

I welcome the minister again to the Health and Community Care Committee. We all know who you are, Susan, but it will be worthwhile for you to introduce the people with you and tell us what their role is.

The minister will remember that her office requested that we consider the Arbuthnott review early on and put in a submission as part of the consultation process. Sir John Arbuthnott also asked this committee formally in the letter he sent with the copies of the review, to consider it. We are, therefore, examining this very important review of resource allocation for the national health service in Scotland.

Please introduce the people with you, and give us a short submission, after which we will ask questions.

The Minister for Health and Community Care (Susan Deacon): I am very pleased that the committee has responded so positively to our request to look at the Arbuthnott review fully and carefully. We consider the review to be an important development. In a moment, I will say more from the Executive's point of view about the background to the review and some of its key

elements.

I have with me Dr Kevin Woods, who is the director of strategy and performance management for the management executive in the Scottish Executive health department. He was also chair of the expert group for the review committee. He will be happy to answer points of detail about the review exercise. We are joined by Mike Palmer and Alasdair Munro from the health department, who have also been involved in the review.

At the outset—I hope that this is in keeping with the committee's needs and expectations—I want to place the Arbuthnott report in the context of the Executive's wider health policy.

I am conscious of the fact that committee members rightly spent all of yesterday and a chunk of this morning on the detail of the report. From my point of view, it is important that the report is seen in the broader context of Executive policy. I will concentrate on that in my opening remarks, although it will be for members of the committee to decide what to question me on.

The origins of the report date back to "Designed to Care", which was published in December 1997. As members will know, "Designed to Care" was a milestone document that set out a new future and a new way forward for the NHS in Scotland. The white paper's commitment to a review of the existing funding arrangements for the NHS in Scotland was just one element—albeit an important element—of the changes.

11:15

A lot has happened since the review was initiated; not least the creation of the Scottish Parliament, the appointment of the Scottish Executive and the change in health ministers. When the report was presented to the Executive, we inherited it as work that had been commenced under the previous Administration.

I was pleased to be able to receive the report because it is in line with the Executive's general emphasis on health policy. It represents another important step forward in completing the implementation of "Designed to Care". I often say, in relation to "Designed to Care", other strategy documents and white papers, that we have inherited a great number of positive policy documents upon which to base much of our thinking as a new Scottish Executive. However, we are now moving into the implementation phase of many of those policies and this is an important part of the implementation of the "Designed to Care" jigsaw.

It is important to see the Arbuthnott review in the context not only of our wider policies on health but of our policies on social inclusion and of our commitment to recognise and address the needs of rural communities, about which I will say more.

I appreciate, convener, that you will have considered this point in some detail, but it is worth reiterating why a review was suggested. The existing SHARE formula, which is still used for the allocation of health service resources, is more than 20 years old. We believe that the formula served a useful purpose but that it is in great need of replacement. It was essentially population based and did not take account of wider need, particularly the needs associated with deprivation and the delivery of health care in rural and remote settings.

As members know, having considered the review in some detail, it is very detailed and technical. The Executive wishes to endorse some of its key features and principles. The review proposes a way of examining the allocation of health service resources across Scotland that is fairer than the current arrangements, that identifies and addresses need more effectively than the current arrangements and that, in particular, addresses the needs of deprived communities and rural areas. The way in which it does that is based on evidence and is open and transparent. Those elements, individually and combined, make the report a genuinely innovative and groundbreaking exercise.

The other key point that I want to emphasise concerns the area in which the Arbuthnott review links in with the Executive's core commitments—health inequalities. As you know, that issue has already been debated in the chamber, but I want to reiterate the Executive's position. Not only do we recognise the existence of inequalities in health; we want to do something about them. We do not want just to identify need; we want to meet need. Part of that is about examining how we allocate the considerable sum of money that we distribute throughout the NHS in Scotland.

I stress that tackling health inequalities is part of a broader agenda for the Executive. The commitments set out in "Making it work together: A programme for government" and the principles in the public health white paper endorsed by the Parliament last month, are part of a wider picture of how we will address health inequalities. The activities of my colleagues in other departments are also part of that picture and part of the wider social inclusion agenda of the Scottish Executive.

Having described the broader policy framework, I want to mention a few key points about the Executive's approach to the review. First, I want to thank the review group, and Sir John Arbuthnott in particular, for the work that has been done. I am sure that committee members agree that a very comprehensive piece of work has been conducted.

That a review group involving people inside and outside the NHS and people with a wide range of expertise and experience has developed this process over 18 months is an important achievement in itself. The fact that the process is now being taken forward through a consultation period in an open and transparent way is also important. That is no accident. The Executive deliberately aims to replace a funding formula that has been in place for 20 years. We want to make changes that will serve us well now and in the future and we will ensure that we do that with the involvement and engagement of people throughout the NHS in Scotland and of the Parliament itself.

It is worth pointing out that, when the SHARE formula was introduced some 20 years ago, there was not, as far as I am aware, a great deal of consultation or involvement. The process was imposed at that time. The fact that we are consulting widely on this matter is indicative of our desire to ensure that we engage in a wider discussion on the future of NHS health policy and funding policy.

We all like to talk about distinctive Scottish solutions for distinctive Scottish problems. I believe that this is one example among many of how we are translating that rhetoric into reality. We are very much ahead of the game compared with other parts of the UK in this policy area—and probably in others too. It is distinctively Scottish and the methodology and approach that have been adopted in the overall exercise will affect the way in which we develop the NHS in Scotland.

It is understandable that, in discussions about funding, the implication of funding decisions for individual health board areas arises. I want to make a couple of points very clear. First, I will reiterate for the avoidance of doubt a point that I am sure the committee is aware of. The new formula is about the allocation of the overall NHS cake. It is not about the size of the cake, although I shall say something about that in a moment. Neither is it about how individual health boards choose to slice up their slices of the cake. It is about how we distribute the pot of overall NHS spending. As you know, the proposed new formula covers about 80 per cent—or more than £4 billion—of NHS resources.

Any change in the funding formula will have consequences for the proportions of the overall NHS cake that individual health boards receive. However, because we are making changes to the funding formula during a period of growth in the health service in Scotland, I have been able to give health boards the commitment—which I shall repeat here—that every individual health board will receive a real-terms growth in expenditure for the lifetime of this Parliament. We can do that by levelling up. We have made no secret of the fact that there will be different rates of growth in different health board areas, but there will be real growth in every health board area. I have given that very important assurance to health boards and reiterate it to the committee today.

I am aware that the committee wants to maximise time and ask me questions, so, although I would like to say more, I will restrict myself for now. However, I will say that, although we are pleased that there is a full and open consultation process and will carefully consider the inputs from that process—including this committee's contribution—we believe that the report and its methodology represent a significant step forward and are very much in keeping with the Executive's broader approach. On that note, convener, I will take any questions that the committee might have.

The Convener: You can sense that the committee is champing at the bit to ask the questions that it has homed in on over the last day and a half.

Some of the key principles of the review are equity—"Fair Shares for All" is the subtitle of the report—objectivity and, critically, transparency. I do not think that I am doing my parliamentary colleagues any disservice—they are a fine bunch of men and women—but the committee has struggled to call this report transparent. It is technical and detailed and contains an awful lot of subtexts. Later, you will be asked about the review's remit and place in the wider health care picture and about the changing trends in Scottish health. For the moment, can you tell us whether you are content that the report is transparent?

Susan Deacon: Your question raises a number of points. The short answer is yes, although I will define that more fully. A balance has to be struck, or perhaps we need to decide what we want from such a review. There is a difference between transparency and simplicity. It would be possible to have a simpler approach to this issue—for example, the SHARE formula. However, that is a much less equitable approach and does not address need effectively. If we want to make progress on measuring need more effectively and in turn allocating resources to meet need more effectively, we have to enter some fairly complex terrain.

Having entered that complex terrain, the Executive must ensure that the exercise is conducted effectively, objectively and independently, which is what we have done throughout the review process. As for transparency, we need to ensure that people—whoever or wherever they are—who wish to contribute to the process can do so.

It is significant that the report was published in

three forms. The technical report is for those who wish to analyse the statistical methodology. I know that the committee and the people who have spoken to you have been doing that. The full report is for those who want to explore the principles that underpin the review, and there is a well-written and accessible short guide.

The Convener: We like the short guide.

Susan Deacon: Likewise. We could not have provided more information. The right amount of complexity and—dare I say—sophistication was used to come up with an equitable evidence-based formula. We produced the information in a format that the public was able to engage with. I am pleased that the consultation programme was extensive and participative—it is evidence of the fact that people felt able to engage with a technical subject because we packaged the information in a way that allowed them to do so.

11:30

Ms Oldfather: You touched on this matter in your presentation, but I wish to ask you specifically whether you feel that Arbuthnott, as it stands, actually and adequately promotes the Government's health priorities. Do you think that there is coherence between the historic utilisation of services to generate the allocation and the innovative approaches that you mentioned in relation to service provision, which are outlined in documents such as "Designed to Care"? I can give you one example. "Designed to Care" promotes seamless care. Do you think that Arbuthnott does enough to promote it?

Susan Deacon: Is Arbuthnott sufficient to address our priorities? No. Is it an integral part of a much bigger picture? Yes.

In terms of some of the detailed methodology that is recommended in Arbuthnott, I do not want to say that everything in the report is perfect. That would negate the purpose of the consultation exercise, and I do not want to prejudge it. We will look carefully at the input that we receive although, as I have said, the broad thrust taken by the report is valid. It cannot do everything, and we should not look to it to do so.

The wider issue of seamless and integrated care was a primary objective of "Designed to Care". It is a subject that I have paid a great deal of attention to since I was appointed a few months ago, and it is being addressed. We are making changes to the design of services all the time and working out how we can best provide services to meet individual and community needs. As you know, that means shifting services from a hospital setting to a community setting. That means changes with regard to which agencies deliver services, which in turn means changes to working practices, which means changes to funding arrangements. That is a developing area.

"Designed to Care" was a necessary first step: I say that without looking in the direction of any particular party. A prerequisite to making changes—in my view, in the view of the Executive and in the view of the previous Administration—had to be the removal of the internal market in the NHS. That has happened: we have put in place a structure that is based on collaboration, not competition. That structural change was finished only in the past few months. It is now my job to ensure that we make effective use of the NHS partnership working arrangements that have been put in place and to extend them into effective partnerships with other agencies.

A lot of change and progress has occurred with regard to co-operation. A great deal of it has happened through effective joint working at a local level in many parts of the country. We have a long way to go, but it is right that we take one step at a time. It is important that we progress on a phased basis so that we move forward without undue disruption in the NHS and other service areas. Arbuthnott is one important element of moving along in the right direction, but we do not do that in isolation: we do it by addressing other areas as well.

Ms Oldfather: Do you think there is enough flexibility for that innovation within Arbuthnott's recommendations? A lot of the information concerns the historic utilisation of services, whereas what we want is change in many of those services.

The Convener: Before the minister answers that, I ask Margaret Jamieson to ask a question as well. The minister could answer both questions together.

Margaret Jamieson: There is a cross-over.

Although we are all happy with your comments about seamless care, minister, the biggest difficulty is funding it. Arbuthnott helps by ensuring that the funds are held by health boards, but difficulties arise when that transfer of money and resources happens only partially. What facilities are there, either within Arbuthnott's recommendations or in the options that your department will consider, to ensure that social work departments and the voluntary sector are given their fair share, which, in turn, will lead to the seamless care for which we are all desperately waiting?

Susan Deacon: I am glad that the voluntary sector was mentioned in that broader context. All too often, we speak of the NHS and social services but forget that the third important element of care is the services that the voluntary sector can provide.

In any discussion about funding, several different prongs emerge. The first concerns the level of funding; the second concerns the methods by which funding is allocated and spent—which is the area that Margaret Jamieson has touched on; and the third concerns how those resources are used, whichever agency is using them. There have been increases—significant increases in many cases—in NHS, social work and voluntary sector spending. However, simply increasing expenditure is not enough.

The Arbuthnott report is crucial in ensuring a robust and fair way of allocating money to the NHS. Whatever other changes take place, now or in the future, in the relationships between different agencies or in funding structures, the Scottish Executive will still be required to allocate a considerable sum of money to the NHS in Scotland. The fact that we have a formula that allows us to do that more fairly, and on the basis of need, is important.

As for how the resources are used—there are also structural concerns—I repeat two points, in scratched record mode, in most meetings with external organisations throughout the country. In many areas, far more can be done within existing structures and financial arrangements to ensure that seamless care is provided. I believe that absolutely and fundamentally. I repeat the point I made earlier: when I see examples of innovation and success, that illustrates to me that that can be achieved where people are willing to make it happen.

The other thing that I say to individuals and groups throughout the country is that it is important to identify where there are barriers in the system that stand in the way of the provision of seamless and integrated services, which can be removed only through our actions at a national level. That discussion—that investigation or evaluation—is a live and continuing process.

So much structural change has been made in recent months that it would be quite wrong for us to jump head first into more changes. A lot of the changes, for example putting the primary care trusts and the local health care co-operatives in place—I know I am talking in an NHS context again—are important developments. The new arrangements for joint investment funds are in place at a very early stage of development. We have to see how a lot of those arrangements work out, and do more—we are doing more—to examine what is happening and what is working on the ground, including the work on the monitoring and evaluation of the community care action plan.

Pooling a lot of that information will help us address, first, what can work at a local level and how we can disseminate that good practice across the country and, secondly, what we need to do at a national level to make the arrangements work better.

The Convener: I am very aware of the time, and I know that we have many questions to get through. Dorothy, I think that your question about the remit of the committee ties in with what we have discussed before.

Dorothy-Grace Elder: A couple of witnesses have questioned the remit of the Arbuthnott committee and the fact that the Arbuthnott report seems to have stuck to it rigidly—some people are not so rigid when they are compiling a report. The BMA's submission states:

> "A major drawback of the Review is that it does not address the chronic overall underfunding of the National Health Service in Scotland. We realise that this was not its remit, but consider it as a missing material factor."

All that Arbuthnott deals with—this is the point where I cannot get excited about Arbuthnott—is the moving around of £70 million; it is not about spending more. You indicated clearly, minister, that the Arbuthnott report is not the full picture. Are you prepared to spend more on health, given the need?

Susan Deacon: Yes.

Dorothy-Grace Elder: Right. Could I further ask how much more you consider needs to be spent on health in Scotland, above and beyond whatever shifting around you may do under Arbuthnott?

Susan Deacon: I hope that I can be forgiven, convener, for repeating one or two points that I made earlier, although I will try to add other information.

I wish to make this crystal clear again—it has been debated in the Parliament—that we have now entered a period of record investment in the NHS in Scotland. This year, for the first time, more than £5 billion is being spent on the NHS in Scotland. Over the next three years, we are seeing a 20 per cent increase in cash terms within the NHS in Scotland, which averages out as a real-terms increase of around 3.7 per cent per year across the NHS. That is real additional investment; it is real money.

We are now spending almost £1,000 per man, woman and child in Scotland on the NHS. We are also spending in the region of 20 per cent more per head of population than is spent in England. That is real additional money. Is it enough? No. There will never be enough money, no matter which Government is in power and no matter how much it spends.

Nye Bevan, the architect of the NHS, said when the health service was founded that it would never meet need, that demand would always exceed capacity, that people would always be demanding

more and new innovations from the service and that it was right and proper for it to seek always to improve and develop.

When we talk about NHS spending, it is important that we put it in that context. I feel that sometimes there is an inference that a magic wand can be waved and that we can pull a number out of the air, saying, "Here's the money, here's the allocation—all the problems are fixed." That is simply not so. As I said earlier— [*Interruption.*] I know that there other questions, convener.

The Convener: I am aware of the time factor.

Susan Deacon: May I reiterate the point that I made earlier? We must also consider how we spend the money. Already, £100 million has been saved through the reorganisation of the NHS—by the abolition of the internal market—and put into patient care. Action has been taken to examine how we provide joined-up, seamless services, reduce some of the inefficiencies in the system and give better patient care. By all means, let us talk about resources, but let us put them in context.

The Convener: I want to pull back the discussion to the specifics of the Arbuthnott review. I will allow members a bit of leeway, because I know that Kay wants to ask a supplementary on the issue that we have been discussing, but can we keep that as tight as possible? We have many other issues—rurality, unmet need, health inequalities and so on—to get through. We have about 15 minutes to do that. Kay, will you put your supplementary quickly, so that we can go to Malcolm?

Kay Ullrich: We are talking about redistributing about 2 per cent of the national health service budget in Scotland. I agree that it is good that we are looking to address the health inequalities. However, this report would reallocate a very small portion of the health service budget. Does the minister think that such a small shift will halt or start to reverse current trends? As she knows, the gap between the rich and poor is widening. Do you really think, minister, that this reallocation will make a significant difference in tackling poverty and ill health?

11:45

Susan Deacon: I am bound to say that my answer to that question is very similar to my answers to previous questions. I think that this report represents a significant step towards addressing and meeting need. The fact that this Government is willing to say that health inequalities exist and have to be identified and addressed is significant in itself. This exercise has allowed an independent group to come up with a way of doing that. We are putting our money where our mouth is.

Of course, I do not think that the reallocation will solve all the problems. Nothing that is done in health alone could achieve that. As I said at the outset, the needs that exist in our country, particularly in our deprived communities, cannot be addressed by NHS spending alone. They have to be tackled by the prevention, as well as the treatment, of ill health, and across the range of this Executive's policies—in housing, in training, in education and elsewhere. I can say only that this report is an important part of our strategy. There is no way that it or any exercise like it could be a solution in itself.

Kay Ullrich: But do you think that the Arbuthnott report will halt the current trend towards a widening of the gap between rich and poor in terms of poverty and ill health? Will it do anything to address that problem?

Susan Deacon: "Halt" and "do anything" are two different things. I think that the report will help to address the problem that you have identified. I have already said that it will not, in itself, halt the trend.

The Convener: I want to move on to the points that are raised in chapter 15 of the review document on unmet need and inequalities. We want to know what is happening on that behind the scenes at the Executive, in terms of extra consultation. Malcolm has some questions.

Malcolm Chisholm: Everybody is pleased that Arbuthnott has taken account of so many indicators of deprivation, but there are two outstanding issues. The first is unmet need. From what Sir John Arbuthnott said yesterday, it is obvious that he intends to make an allowance for that as well.

Related to that is our concern—which we have expressed at various points in the inquiry—that additional money that is set aside to deal with unmet need should be targeted correctly. That is not something that the Arbuthnott report could address. How do you intend to deal with Arbuthnott's further recommendations? Are you confident that you have the mechanisms to ensure that health boards target the new inequality money in the right way? It may be too early to say this, but would you consider other mechanisms for spending inequality money, if we can call it that? Is there a case for not redistributing everything to health boards, but holding back money for central allocation to specific work in the deprived areas? Is that one of the options that you might consider, or is it too early to say?

Susan Deacon: You have made some specific points, but I will say that, in general, you and other members have illustrated precisely the sorts of

areas in which we welcome input from others, not least from the committee.

We must recognise that this is just one piece of the jigsaw. I stress that we are open to contributions, although we are looking for solutions that are consistent with our overall policy objectives, which I have outlined.

In some respects, the committee has an advantage over me on possible adjustments for inequalities. As you know, work on inequalities has been done since the production of the report; there was a recognition that this was a complex, novel and innovative area, on which the review group wanted to do more work. I have not yet formally received the results of that work. As I said in my submission to the committee, we intend, because of the novel nature of the work, to put the group's specific proposals on inequalities adjustments out for a further month's consultation at the end of the review exercise.

The convener referred to the thinking behind the scenes. As we welcome input, some of our thinking on this area is very much in front of the scenes.

The Convener: It was not a loaded comment.

Susan Deacon: On ensuring that resources are spent to meet need, I recognise—as I said at the very beginning—that the scope of the review is solely to consider how the overall cake is divided up, as opposed to how health boards spend money locally or, as members have mentioned, how other agencies in turn allocate resources.

I will not spend time going into those wider areas again. I believe that it is right and proper that the starting point of central Government is to consider how to allocate a substantial sum—almost a third of this Parliament's budget—according to need. Thereafter, we need to think about how needs are met on the ground. That is not to say that mechanisms are not in place to address our priorities. As part of the accountability process, health boards are required to say what they are doing to address health inequalities locally, and so on. However, I am sure that we could introduce better arrangements locally.

When we launched this document we said—and we said it to health boards during the consultation process—that we were open to ideas about how to extend this approach and methodology into our localities. The right starting point is to think about the national allocation process.

The Convener: I have a couple of questions on health boards—on their accountability and the openness of their decision making, for example—which relate to what you have just said. Yesterday, the witness representing the health councils made some good points. Are health boards necessarily the best building blocks for the resource allocation process? Is the health board level the level of critical mass? I do not expect you to answer questions on that as I am keen to move the committee on to other issues, particularly to rural and remoteness factors in the report.

Ben Wallace: Yesterday, Sir John Arbuthnott said that the allocation should be reviewed annually. Do you have ideas about introducing an advisory committee for resources, as there is in England and Wales? What should the time scale for review be once the final formula is accepted?

Susan Deacon: Those are important questions. In the report, Sir John suggested the idea of a standing committee that could monitor the formula. We are open to the idea that the formula and its effects should be effectively monitored. Moreover, there is a need to adjust it to take account of developments in precisely the sort of areas that we have discussed today. I would welcome the thoughts of the committee on what the standing committee should look like and how it could carry out that work.

We must ensure that we do not put in place a rigid arrangement that cannot be adapted to suit future needs. We must strike a balance between flexibility and stability, within the service generally and within health board areas, to ensure that there is not continual uncertainty about resource allocation. As long as we get that balance right, the idea of a regular review is eminently sensible.

Ben Wallace: You said that SHARE did not address need. I recognise the inequalities in health across Scotland. Yesterday and today, a number of experts have warned us not to get too bogged down in the details of the statistical differences. When you finally consider the results of the allocation—annually or every other year—will you feel that it is appropriate to override some of those allocations? The 2 per cent redistribution under this formula will not go towards addressing the obvious needs in places such as Dundee or Glasgow. Will you be prepared to use your power to override that allocation? Will you bind yourself to the result of that allocation equation?

Susan Deacon: For the proportion of the health service spend that this formula covers, I would not be inclined to override the application of that formula. The point of adopting a formula-based approach is to have a transparent system so that all those affected can see the basis on which decisions have been made. It would undermine that principle if we were to apply the formula and then say, "We do not like the outcome there, so we will just make an adjustment." The consultation exercise gives us the opportunity to identify whether things are fundamentally wrong with the proposals so that we can ensure that the formula is robust.

Alongside the 80 per cent of NHS spend that is covered by the formula, there will always be other areas of spend that could be introduced for specific purposes—capital spend, for example, falls outwith the area that is covered by the formula. Therefore, there is still scope for other elements of spend. However, for the area that is covered by the formula, I want to put in place an arrangement whereby we can apply that formula openly, uniformly and transparently. That is a proper and fair way in which to go forward.

Mary Scanlon: I have lots of questions, but as there is only a minute and a half left, I will just make one comment about a concern consistently expressed in the submissions of speakers in the past couple of days. Can we examine co-morbidity again, as it seems to seriously underestimate the degrees of deprivation?

Many contributors expressed concern about new moneys to health boards. This morning Greater Glasgow Health Board said that, given the demands on the acute trusts with the need for new technologies and new drugs, any new resources could be gobbled up by the acute trusts and will not address inequality, poverty and deprivation.

12:00

I will focus my remarks on rural areas. As a member for the Highlands and Islands, I am delighted that there is an increase in its allocation, but I am aware that many Highland patients receive specialist treatments in Lothian. However, there has been a decrease—if that is how we can talk about it—in Lothian's allocation. The Lothian submission mentioned its concern about the specialist treatments. It may be that the Highlands allocation is increased, but that that does not benefit the region because specialist services are no longer available in Lothian.

Finally, how would you respond to the British Medical Association's comment that the implementation of your plans would mean a decrease of 20 to 30 GPs in the Highlands and around 33 per cent in Shetland?

I am sorry that this is such a long question, but Shetland's contribution yesterday made the case that there are fixed costs involved in catering for the small islands which means that they cannot achieve economies of scale. They feel that they have been unfairly treated by this process.

The Convener: I will make your question even longer by asking Duncan Hamilton to come in with something in the same vein.

Mr Duncan Hamilton (Highlands and Islands) (SNP): I want to look at some of the losers in this game. The point about island communities was made strongly yesterday. I would be interested to know whether you think that they have been fairly treated by the application of a fairly rigid formula. The submission by Shetland Health Board—if you have not read it, I recommend that you do—outlines clearly some of the problems of this formula. In particular, I would like to know whether you think that there is a critical mass in population size which leads to disproportionate swings.

My second question is about mainland health boards with island communities. They seem to have fallen through the net of the formula. I am thinking in particular of places such as Argyll and Clyde. They have 26 inhabited islands, but there is no additional allocation to match that need. I would like your comment on that.

I would also like to back up what Mary said about general medical services. In many ways our points are the same, so you should be all right to cover them. I would be interested to know whether you think that the reduction in GPs is an acceptable state of affairs. You seem to suggest that everyone is winning, when clearly they are not.

Susan Deacon: I will do my best to be as succinct as I can. We could sit here until this time next week and still be having healthy debate.

The Convener: We feel that we have.

Susan Deacon: I will take Duncan Hamilton's points first. If he, or any other member of the committee, has substantive reservations about any element of the report, its recommendations or the formula, then now is the time to record them. That is why we are having a four-month consultation process. That is why we have something like 8,500 copies of this document in circulation across the country. We are open to hear points being made, be they by individual health boards, MSPs, the parliamentary committee or other bodies who want to make substantive proposals on how the formula might be adjusted to be more effective.

Mr Hamilton: What is your view?

Susan Deacon: I do not think that it is for me to have a view. It would be quite erroneous for me to prejudge the outcome of a consultation exercise by passing comment on individual elements of the formula. It is my job to say what our broad principles are. It is my job to put in place arrangements to make recommendations as to how those principles can be taken forward and needs identified and met. It is then my job to ensure that there is a full and effective discussion and debate around what, as we have agreed, is a complex terrain. We will then look very carefully at all the submissions when we receive them. To be frank, anything else would make a nonsense of consultation and MSPs would, rightly, be critical of me if I were to start passing comment on individual

elements of methodology that might ultimately change as a result of the consultation process.

I know that I have six other points to get through, but I want to say something about rural areas. I have just returned from a series of visits in the Highlands and Islands and I was very pleased to see at close quarters a number of issues relating to the delivery of health services in a rural setting, which served to reinforce my view that we are absolutely right to try to get better at allocating resources in a way that recognises the cost of delivering health care in a rural setting. My visits also served to illustrate to me again how innovative people have been in different parts of the country, for example, in embracing technology and ensuring that services are provided effectively.

Arbuthnott and the resources in question are just one part of that jigsaw. There are also issues of service design and harnessing technology and so on. I was very pleased when I was in Orkney to be able to announce that Orkney Health Board has now moved—with in excess of £200,000 of funding from the Scottish Executive—to the final stage of a project that will look at the design of health care from general practitioner to out-patient right through to hospital, in an island setting. We have a lot of initiatives.

Our commitment to addressing the needs of rural communities is absolute. If there are proposals on how we can refine these recommendations or make them better, we would be pleased to see them. That is obviously for the committee to put in its report, if it so wishes.

I have to pick up on the suggestion that was made about the reduction in the numbers of GPs. I have heard that suggested elsewhere. I stress that that is not what this exercise is about—absolutely the opposite. It will be for individual health boards to address, within the framework that is in place, how local needs are addressed in local communities. There is nothing in the report that is about cutting the numbers of GPs. There are different methods of calculating need in different settings, but this is not about cutting services in any individual area. I realise that this is complex terrain, but it is important that, within that complexity, the facts are represented appropriately.

Mary Scanlon: Do you think that you could—

Susan Deacon: I think there were another three points that Mary Scanlon raised. I do not know whether you want me to say more, convener?

Mary Scanlon: Specialist services in Lothian, if you do not mind. That is a crucial issue that was raised by Lothian Health.

Susan Deacon: We have to be very careful here. I do not have the exact figures to hand, but it is true to say that there are transfers of patients across different parts of Scotland and across different parts of the United Kingdom, which is where we get benefits from working on a co-operative basis across the UK. However, when that happens, mechanisms are in place so that a transfer of resources takes place to match that. If the suggestion has been made in the committee that those mechanisms are insufficient, or if other problems have been brought to your attention, I would be pleased to hear about them. You have obviously heard a lot of useful information from a wide range of people over the past couple of days, and we are happy to look at that. I will read the committee minutes with great interest.

Mary Scanlon: Do you think that the British Medical Association has got this wrong?

The Convener: I think that we can discuss that later. One of the things that I am going to say to the committee later is that we should be hearing from the BMA on this issue, so we can ask it some questions.

I will use the chair's prerogative, if I possibly can, by getting in the last few words in terms of questions. I have two questions, which will have to be the final ones.

We appreciate that there is a lot of data available, and some of the data are less robust than other data and methodology, but one of the things that has come through to us time and time again in submissions is that, critically, there does not seem to be the same amount of data available if you are considering primary care and community services rather than the acute services. That is obviously based on the historical background. We will be looking to the Executive to consider how we can build up the data that we require both to make this a more robust methodology and, at the same time, to improve primary care and community services.

My second point is about where we are and how we can continue the consultation process and the implementation of our aims. Picking up on comments made by other people, the representatives from Greater Glasgow Health Board told us that, because of its remit, the report does not go into the promotion and prevention aspects of public health that form a growing part of the work load. A number of submissions have raised problems with community services, and that is partly because of the issue of data. There is also a question of unmet need and inequalities, which Sir John himself says requires more work.

That is a pump-primed question, but the key question for me is whether we should put Arbuthnott into force and then make improvements as we go along, or whether, given some of the

concerns that I have listed, we should try to do the improvements before we put Arbuthnott's formula into force. What are the trade-offs between improving the Arbuthnott formula before implementation and implementing the formula before it is improved?

My other question is about the quality of data. After that, we shall bring this discussion to a close and go on to discuss shellfish.

Susan Deacon: I had almost forgotten about the shellfish.

I brought Dr Kevin Woods with me but, as is my wont, I have not given him a chance to say anything. It might be helpful to ask him about the question about the quality of data.

Dr Kevin Woods (Scottish Executive Health Department): We accept that the quality of the data in the areas that you indicated is not as good as it is on the hospital side. Nevertheless, the two data sources that have been used in the report represent significant developments and innovations here in Scotland. We see the development of the data sets as a priority and we hope that, over the next two or three years, there will be improvements in the quality of the data, which should inform the development of the formula.

The Convener: Such things as continuous morbidity recording are a small part of the big picture and are not necessarily representative of it.

Dr Woods: We believe that the data that have been used in the report for those groups are representative.

The Convener: Do you?

Dr Woods: Indeed we do, and the technical report explains how we came to that conclusion. We understand that people are concerned that we are dealing with data that are drawn from a small number of trusts and practices. We are alive to that concern and we will be happy to consider any points that people want to make.

The Convener: Graham Watt made some comments to us yesterday about levels of deprivation and the data that are available.

Susan Deacon: I return now to the other questions that were raised. If I have correctly understood the question about the wider health improvement and public health dimension, the short answer is that it cannot be an either/or. We cannot focus on just one area and make funding changes further down the line. Conversely, we cannot make funding changes and then—

The Convener: What I was trying to get at, Susan, was the fact that the element of health promotion was not in the building blocks of the Arbuthnott formula in the way that some other services were.

Susan Deacon: I will let Dr Woods explain a wee bit about that element of the formula. Your question touches on issues that are in some respects similar to the questions on the connections with social services and community care. We recognise that health promotion activities are not linked only to health board spend. Significant resources are channelled through the Health Education Board for Scotland, but work also goes on in schools and in community-based health projects. There are other funding routes and part of the Executive's task is to maximise the impact of all those messages and all that activity. That is a general point, but we can come to the technical aspects in a moment.

I want to make one other point on the British Medical Association, in case this is my last chance to speak. It is worth noting that, as part of the Executive's consultation process, a meeting is scheduled between officials and the Scottish general practitioners committee of the BMA next week precisely to explore in detail the points that it may want to raise.

Dr Woods will answer the question on health promotion.

Dr Woods: I think that I am correct in saying that the formal health promotion spend is subsumed within the acute block. However, we should not lose sight of the fact that much of the activity in GMS and community services is concerned with health improvement and health promotion. It is true that we want the NHS in Scotland to pay much greater attention in general to the whole issue of public health and health improvement. That is why the guidance issued to the health service by ministers encourages the development of health improvement programmes that set out clearly how improvements will be achieved. We want a greater relative share of resources to be used to support health improvement initiatives. That means working with other statutory and voluntary organisations.

12:15

The Convener: I want to pull you back to the final bit of the question. The reason that I mentioned health promotion and the links to other services, the queries about the community services data and the point about unmet need and inequalities—which Sir John Arbuthnott, himself, raised—was to highlight the areas where people have expressed concerns to us and will, in the fullness of time, if they have not already, express them to you. There are areas of the formula that are not as robust as others or where there are problems. What is the trade-off? How do you decide whether to go ahead with something, which

you know still needs a lot of work, or do the work before it is implemented?

Susan Deacon: I reiterate that we would welcome the committee drawing together the comments that it has received as part of the submission so that we can consider them. On inequalities, I suspect that Sir John would have said, as I have, and as he has said to me, that the inequalities element of the formula is one of the newest areas of development. That brings us back to the whole issue of addressing unmet need, which is a subject on which we are open to discussion.

I firmly believe that there is no such thing as perfection in any aspect of life, which applies equally to this report. I also firmly believe that it is always possible to improve things. Sometimes one cannot identify where improvements need to be made until something has been implemented, tried and one has seen how it works. We are doing as much as we possibly can through this consultation exercise, through discussions such as this one and through the review group to ensure that the resulting formula is as robust as possible. I do not believe that it will be perfect and I am sure that there will scope for future improvement, but it would be wrong for us to continue the process of analysis and review indefinitely, when we could put definite improvements in place. If the situation gets better further down the line, that is good and well.

The Convener: I am sorry that we have run out of time, as I am aware that all members of the committee have several more questions. There are a few technical questions that we might address to Dr Woods in writing if that was acceptable to him. Our priority today was to question the minister.

Dr Woods: I will be happy to receive any questions that the committee has.

The Convener: We will give them to you today.

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (No 3) (Scotland) Order 1999 (SSI 1999/110)

The Convener: The other reason for the minister's presence today is to revisit the problem of amnesic shellfish poisoning. I will ask the minister to move the motion before us. We have debated similar instruments, so I do not intend to have a debate on this one.

Susan Deacon: We are all learning by the day about our new procedures, but I understand that there is a requirement that I am present to move the motion formally, therefore I will simply do that. I move,

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (No 3) (Scotland) Order 1999 (SSI 1999/110) recommend that the Order be approved.

Motion agreed to.

Ben Wallace: On a point of order, convener. This SSI came before us with plenty time for us to consider it, which was refreshing. However, I would like the minister to take back to the department that, in the past, some SSIs have been put before us that have been in effect; with others, we have had such short notice that we have not had time to consider them.

The Convener: You have made your point, Ben, and we all agree that there has been a problem with that.

Susan Deacon: I suggest that that is a matter for the clerk to pursue.

The Convener: We are considering the matter at the conveners committee and through various other avenues.

I thank the minister and her colleagues for attending the meeting.

Arbuthnott Report

The Convener: I have a couple of other points to discuss with the committee. I suggest that we now suspend the public session and go into private session. We will discuss some housekeeping points about finalisation of witnesses and how we will produce the report. [*Interruption.*]

One of the matters that I want to discuss is the possible reduction in GP practice level that is mentioned in the BMA submission.

Immediately after this meeting, I have a meeting with representatives from Unison who want to speak to us about pay. Members are invited to attend that meeting.

Do members have any further questions?

Ben Wallace: Lothian Health made quite a thing about how it could lose out, cross-boundaries. Could we ask for an expanded written submission on that?

The Convener: I would prefer to have an expanded written submission from Lothian Health rather than that we go down the route of listening to all winners or losers. The two boards that we heard from, Shetland and Glasgow, have their views on their own allocations, but they also added something to our thoughts on the impact of remoteness and on deprivation and the urban

picture. Part of the reason that I decided to go for Shetland and Glasgow was because they could bring a wider impact to our discussions. We will return to this point when we decide on further submissions.

Duncan, did you have a question?

Mr Hamilton: I would like some clarification and discussion on the structure of the committee and the way in which it works. I found what we have just been through utterly infuriating, for a number of reasons. First, the length of the minister's attendance was not adequate. We all had a range of questions that we could not get through. That is particularly bad as the minister made a lengthy statement at the beginning and a party political broadcast halfway through. Frankly, that was disjointed and helped no one. One of the things that defines this committee is the fact that we tend to proceed on the basis of what is good for health, not what is good for one party.

Secondly, I am concerned about members' ability not just to ask a question but to follow it through. The whole point of having a minister here is so that we can pursue our point and ensure that the minister is accountable. For example, Mary made a point about the British Medical Association, but was not allowed to ask the minister whether she agreed with the BMA; that is a nonsense. She should be able to press her point all the way, then return to it to try to highlight contradictions. That is the role of a committee.

Thirdly, I am concerned about the way that this meeting has been managed. I understood that Mary and I—and others who asked questions before us—had to condense our questioning to ensure that we could fit it all in. We had been told that the minister had to leave at 5 past 12, but after that time we had 10 or 15 minutes of your questioning, convener. I am delighted for you to ask questions, but let us be fair. The position of convener does not entitle you to an additional 10 minutes.

The Convener: Before the point at which I asked those questions, I had kicked the minister off with the question on transparency. Apart from that, I asked no other questions during the session. By the time we reached the end of the questioning process, everyone had had a chance to ask some questions.

Duncan's first point is absolutely right. We did not have enough time with the minister. The minister gave very lengthy answers to our initial questions and I agree that, at one point, her response tended towards being a party political broadcast. Possibly I should have jumped in and stopped her, but it was difficult to do so at that stage in the proceedings. I was mindful of the fact that we had a range of issues to get through and I wanted to ensure that we had covered all the issues that we spoke about earlier this morning. Unfortunately, Duncan, you were not able to be with us when we had that discussion. I also wanted to ensure that everyone got a chance to ask a question. I know that that is not a perfect situation, but it meant that by the end of the session, all the points that people had discussed in advance had been covered.

Mr Hamilton *indicated disagreement.*

The Convener: You may shake your head, Duncan, but if we had gone down the route of pursuing people on particular issues beyond a certain point, we would not have been able to ask questions on other issues that we had previously agreed that we wanted to address.

Mr Hamilton: Margaret, with respect, I think that you are confused. We can raise an issue with one opening question—that goes on record as a question—but today the answers were, frankly, evasive or entirely vague. The point of the exercise is that one can pursue the matter until a proper answer is given or one can at least highlight the fact that there is not going to be an answer, but that did not happen today.

I suggest that, if we are to undertake this exercise at all, we should do it in proper depth. Either the minister gives us adequate time to pursue these subjects in depth or we restrict ourselves further and tackle a couple of subjects well. As far as I am concerned, this meeting was a complete mishmash—a complete joke.

12:30

The Convener: The key issue was the time available—I was aware that we were tight for time. I understand where you are coming from, Duncan, and I agree about pursuing issues to a logical conclusion. However, I felt that, if we had done that, we would have spent the time on only three issues rather than on the number of issues that we had decided in advance that we wanted to cover.

In our submission, we will be able to say what we think about these issues. We did not have enough time with the minister—we were just getting to the stage where everyone would have been happy to pick up on the points that had been made and to pursue them. I was trying to ensure that we covered the range of issues that we had decided that we wanted to cover; I also wanted to ensure that everyone had the opportunity to say something. Initially, I said to members of the committee that, as well as asking the questions that they had signed up to ask, they would also be able to input some of their own ideas—for example, Mary added to the question that we agreed earlier. The issue is both the time available and the length of time that the minister took to

respond, particularly to the earlier questions.

Mary Scanlon: The way in which the meeting was run meant that I started at about a minute and a half to 12 o'clock and was told that the minister finished at 12. Yesterday, I raised many points of concern that people had taken the time to tell us about. Like other members of the committee, I read through the papers, which contained genuine points of concern—they were not party political points.

I was quite insulted when the minister came in. I agree with Duncan Hamilton: as a committee, we all leave our political hats behind. We work extremely well as a committee and do not need the minister to insult our good working relationships. I am pleased to make that remark on the record.

I felt that the minister scornfully dismissed much of what was said. I am frustrated to end up with a list of points of which hardly any were adequately addressed—I leave this meeting with more questions than answers. I feel not only that she has done a disservice to this committee but that the committee has done a disservice to those who gave us these submissions and who raised their concerns at yesterday's meeting.

The Convener: I do not think that you can say that we have done a disservice to the people who raised issues with us, Mary, as the committee's report will make use of their submissions. It is up to us to ensure that that report is robust and reflects those submissions. I go along with you 110 per cent on the way in which this committee conducts itself as a group of individuals. I welcome the fact that we try to put party politics behind us—indeed, I gave Dorothy a hard time about that yesterday.

We have a job trying to access information about this issue in order to be able to put together a report. The way forward is for us to organise another meeting with the minister and the officials from the Executive. We should ask for another meeting in light of what we heard today and the fact that members had so many questions left. As I intimated earlier, that would be better than trying to pursue the matter through written questions.

Kay Ullrich: Will you convey to the minister the committee's displeasure at the way in which she handled her answers to our questions, which was terribly disrespectful to the committee? She made a party political broadcast; she did not answer questions. I would like you to convey the committee's view that she indulged in evasive, political stuff.

Malcolm Chisholm: I do not want to be too party political, but it is becoming unavoidable. There are two questions. The first concerns how the minister conducted herself; the second concerns how we conducted ourselves. We should deal with those separately. The next meeting that the minister will attend, on 17 November, will be different. That meeting is what we should address, as she will be in a different position. We must bear in mind the fact that she is in the middle of consultation.

The minister was asked about Shetland, but she is not bound to defend the allocation of money to Shetland. Members must give her the benefit of the doubt. She is conducting a consultation programme. If we make a good case for Shetland, or for anything else, we are likely to win the day. She was not here to defend everything in the Arbuthnott report and we should have borne that in mind—and perhaps some of us should have been more aware of it at the beginning. She is consulting on a report that has been prepared by someone else, so I do not agree with Duncan Hamilton that she had at this point to express an opinion on Shetland.

The Convener: I think that all members would agree with that. I certainly agree with it.

Malcolm Chisholm: I do not share members' condemnation of the minister on that point. However, I agree with Duncan Hamilton on the way in which we conduct ourselves. The next key meeting will be the one that the minister attends, which will provide us with the opportunity to pursue issues, although we will want to question other people as well. Perhaps we should adopt a habit—without being too mechanistic about it—of allowing all members to ask three supplementary questions, or some such principle, as long as we discipline ourselves.

The Convener: The next time the minister comes, we should be able question her for three hours, which would give members long enough to pursue issues as far as they want. Usually, I try to allow members to pursue a line of questioning until they nod in my direction to signal that they have finished and that they are happy. On this occasion, I was not able to do so. Today, I was aware that there were many aspects that we were still not addressing, and I was probably too nice to the minister. I let her go on a bit too much at the beginning and then made comments about the time that we had left and the need to get through things. There is a difference between having an hour of someone's time and having three hours of their time.

Dorothy-Grace Elder: It is a habit with the minister. She has got into a habit.

Kay Ullrich: You will have to address that, convener, as you ask questions at the beginning. Mary Scanlon had to rush through a whole series of disconnected questions with a gun at her head, so to speak, as there was only a minute and a half

to go. You allowed that to happen and proceeded to take 10 or 15 minutes yourself at the end.

The Convener: I took a few minutes, and the minister obviously had answers. I thought that the answers that she gave at the end were quite evasive.

Kay Ullrich: All her answers were evasive.

Dorothy-Grace Elder: She was dodging us all the way through.

The Convener: When she answered my questions, she brought in the officials, which she had not done before. She could have answered my questions quickly and simply, but she chose not to do so. She chose to get bogged down with one aspect of my second question—which was not what I was asking about—and chose to bring in the officials, which she had not done before. That extended the questioning more than I had anticipated. I thought that when I asked the questions she would say to the first, "Yes, we will look at extra data resources"—it was a simple question—and that she would have to spend a minute or two answering the second question, which did not warrant the 10 minutes that she took.

Dorothy-Grace Elder: That is the minister's habit. I had some sympathy for you when you asked your question, convener, as you had to repeat it. That is what took up a lot of your 10 minutes. She was still not giving an answer. That was the pattern throughout, as it was on the last occasion when she addressed us.

For some reason or other—I do not know why—I quite like the minister. She has some warmth and I would never accuse her of being dishonest; she is only starting out. However, she has got into the habit of talking an ever-rolling stream of waffle. If we can help to cure her of that habit, in the early days, I am sure that she will develop into a very good minister. She is hooked on the belief that she can get away with an endless, insulting stream of waffle, but that is part of the dishonesty of politics, which the public does not want to know about. In the worlds from which members—some of us, at least—have come, the answers that people want are "Yes", "No", "Maybe", or "I will look into it".

We do not want the waffle to continue. You need to pull up the minister on that and ask her for short answers, otherwise we will get nowhere. We will nag at you, convener—perhaps unfairly, because you, too, are a waffle victim. You have to come down on her about that.

The Convener: I accept some of the blame for what happened, because I should have come down on the minister harder and earlier. I did not really want to be unpleasant at the beginning of the meeting.

Dorothy-Grace Elder: I know, and the minister is likeable. It is just that what she is doing is not likeable.

Kay Ullrich: The minister is playing with that—it is her style.

Mary Scanlon: It is in the minister's interest to harness the good will of the committee. I feel that she was insulting and I believe that she owes us an apology. There is good will in the committee. We are considering joined-up government, partnerships and social inclusion; those practices should all begin in the committees of the Parliament. That was not a good way in which to conduct business.

The Convener: I would not go as far as that. It is Susan's style. I have been in situations outside the context of politics in which she has had a similar style. I think that we should ask for a further meeting with her.

Ben Wallace: I think that we are looking for a little more discipline from you, convener, towards the people whom we question. I agree with Malcolm that we need to have more discipline in the way in which we prioritise our questions.

Kay Ullrich: We want discipline.

The Convener: I am not going to be defensive about this point. Today, we were meant to start at 9.45 am, but we were only just quorate then. We were about to question the minister—someone else was coming in before that. We all have reasons why we do not attend committee meetings bang on time—I am not always on time—but at the beginning of today's meeting we were discussing how we would approach the questioning of the minister as a committee. The majority of the committee was not here to discuss that.

It is very difficult, in the middle of something else—we were tackling Greater Glasgow Health Board, whose representatives I had to give due respect—to spend my time going back and forward to the members of the committee who were not able, for whatever reason, to be here on time. I attempted to parcel out questions to people who had arrived late, because that was the only way in which to do it; once you have established that some members are going to ask certain questions, the meeting will work only if you give other members different questions. That was a major problem for me this morning. I did not expect to arrive at 9.45 am and find that the meeting was in danger of not being quorate when we were going to meet the minister.

I accept 110 per cent the point that I could have been far more robust with the minister and I will learn from it. We learn about so many things as we go along. Several weeks ago, I told members

that I would make mistakes; I made one this morning. I cannot accept that members of the committee who do not turn up at the beginning of a meeting—when we are discussing our tactics for taking evidence—will, later in the day, say that we did not take the right approach to questions to the minister.

12:45

Ben Wallace: My point is that you could be more robust with us, the members of the committee, as well as with the minister. In other words, you should tell members that they should put in a submission containing questions that they would like to ask the minister; if those members are not present, those questions can then be asked by people who turned up on time but did not put in a submission. As convener, you can tell us that.

The Convener: Yes, but as the convener, first and foremost I am an individual. It is not my style to be robust just for the sake of it. I would rather ensure that, as and when everybody is here for a meeting, they have their chance to say something; I also want to ensure that we cover the breadth of issues that we identified in advance. Many of those issues were identified as a result of the submissions and comments of members. We were not able to pick up on some of the detailed points, but we had only one hour.

Ms Oldfather: At previous meetings, convener, you kept an ordered list of members who wished to speak. That encouraged our discussion to flow, although one disadvantage was that it did not allow for supplementary questions. Perhaps we could return to that practice.

The Convener: That may be helpful and I will consider your suggestion. We must still decide whether to request a further meeting with the minister next week. What are members' views on that?

Dorothy-Grace Elder: There is no point. She will only waffle on for another three hours.

Malcolm Chisholm: There would be no point in asking the minister to come back next week. I explained my position; we will see the minister again on 17 November.

The Convener: Do we all agree?

Kay Ullrich: I think so. Having the minister here next week would be a futile exercise.

The Convener: It seems that we are all agreed on that.

The key point is that we need access to information. Do members agree that we should submit further written questions to Dr Kevin Woods?

Members *indicated agreement.*

The Convener: Good. I will e-mail members this afternoon to request details of their further questions. We will have to be quick to meet the Arbuthnott consultation deadline.

Jennifer Smart (Committee Clerk): I have had a verbal assurance from the Executive that the deadline has been extended until 22 November. That would allow us to discuss our submission on 3 November.

Malcolm Chisholm: Is the BMA coming to give evidence at that meeting?

The Convener: The BMA will certainly be invited. Do members want us to invite any other organisations?

Dorothy-Grace Elder: What about the unions?

The Convener: They were invited but have not responded.

Dorothy-Grace Elder: I am very surprised about that.

The Convener: We will leave it at that.

Meeting closed at 12:48.

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