HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 26 April 2000
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE
10th Meeting 2000, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
*Mr Duncan Hamilton (Highlands and Islands) (SNP)
*Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*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

THE FOLLOWING MEMBER ALSO ATTENDED:

Trish Godman (West Renfrewshire) (Lab)

WITNESSES

Dr James Dunbar (Borders Primary Care NHS Trust)
Dr Lesley Wilkie (Directors of Public Health)

CLERK TEAM LEADER

Jennifer Smart

ASSISTANT CLERK

Irene Fleming

LOCATION

Committee Room 1

Scottish Parliament

Health and Community Care Committee

Wednesday 26 April 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:34*]

Budget Process

The Convener (Mrs Margaret Smith): Good morning. Welcome to today's meeting of the Health and Community Care Committee.

The first item on the agenda is the budget 2001-02. As committee members will remember, there is a new process for scrutiny of the budget, whereby not only the parliamentary committees but the general public can be involved in examining the Executive's budget and linking it into its aims, objectives, upcoming legislation and policies. Members of the public will be aware that, in the past week or so, the First Minister and the Executive have opened the debate up to the wider community across Scotland and have asked for comments on the budget process, which is different from and much more open than the way in which the budget process was carried out in the Westminster context.

Some of that is to be welcomed. However, we are about to take evidence about the budget process for the first time. We will learn a lot this year. By next year, we will have a lot more experience. The year after that, the process will be even easier. It is an on-going, evolutionary process.

One of the things that may come out of our discussion this morning is the fact that we need more information or that we need to get information in a different way. Members should feel free to make such comments, because I think that they will be quite instructive and will give us a chance at stage 1 to submit requests for further information, so that the information is available to allow us to deliberate at stage 2.

We have an opportunity at stage 1 to examine the Executive's spending plans as outlined in the document "Investing in You". We are also required to report to the Finance Committee on our views on the Executive's plans for spending on health and community care. We have therefore decided to take some general evidence on the process from representatives of different sections of the health and community care field.

I am delighted to welcome Dr James Dunbar, medical director of the Borders Primary Care NHS Trust as our first guinea pig. I must call you that, Dr Dunbar. There is no other word for you, as this is a new process. I am sure that you will be able to give us the benefit of your experience and that that will stand us in good stead not only for this year but in the future.

I take this opportunity also to welcome to the Health and Community Care Committee Trish Godman, who I believe is here as reporter for the Local Government Committee, primarily because of the link between community care and local government.

Dr Dunbar, you will have had the chance to examine the Executive's document. Would you like to make an initial statement, or are you happy to go straight to questions?

Dr James Dunbar (Borders Primary Care NHS Trust): Thank you, convener. Good morning, everybody. I would like to take the opportunity to use 10 minutes, as suggested, to introduce the priorities as I see them. If the key to unnecessary health care costs lies in the decisions taken by doctors, I assume that the committee has invited me here to describe how the budget might be improved. However, before I go into how we can improve the way that we spend the money, I want to say a little about my background.

I have been the medical director in the Borders since the primary care trust was set up just over 15 months ago. Before that, I was a general practitioner in Dundee for about 25 years. During the 1990s, I used the opportunities of fundholding to innovate, initially to demonstrate what can be done by shifting resources into primary care. I became fascinated with it as an experiment and teamed up with Professor Malek's department of health economics at the University of St Andrews to study the impact on the system overall.

I come to you, therefore, as an ex-general practitioner with some knowledge of local health care co-operatives and primary care trusts. I notice that you have invited the chairmen of other organisations. I know that there is a Scottish Association of Trust Medical Directors. I will try to reflect the views of my acute trust colleagues as well as my primary care trust colleagues. That is a pretty tough order. In my defence, if I sometimes seem biased towards primary care, those of you who were at a recent meeting of the Royal College of Surgeons of Edinburgh will have heard Professor David Rowley from Dundee, a professor of orthopaedics, say much the same things. Those who were there will remember that I was sitting beside his medical director, and both of us were in complete agreement. I hope that I am presenting a rounded view of the system.

Global trends in health care are recognisable if you talk to people in North America, in other places in Europe and as far away as New Zealand. They can be summed up as: a shift towards prevention and a recognition that not only are patients customers of health care, but co-producers of health; an emphasis on health outcomes; the impact of new technology; and movement towards primary care settings, because frequently they are cheaper, of defined quality and more convenient for patients. Offset against that is the concentration of specialism in large regional centres. There is a trend towards role substitution, which means that a consultant should not do something that a GP can do, a GP should not do it if a nurse can do it, and neither should do it if a health care generic worker can do it.

There is an emphasis on trying to know more about the link between cost and quality. The health service is particularly weak in that area. It perplexes me almost every day when I try to make rational decisions in the absence of that kind of information. A further trend is trying to link the incentives and rewards in the system to the organisational goals. In terms of how that works for hospitals, it means that there is a move to stabilise the growth of district general hospitals and concentrate more on regional centres. That is already happening: I am simply reinforcing that these trends will continue. Trying to prevent admissions is another trend, as is reducing lengths of stay, easing discharge, emphasising day case work as much as we can, and looking at what are called utilisation rates, that is, the variance between doctors and units in the way that they use resources that cannot be explained on clinical grounds.

The three main issues running through primary care are: role substitution, particularly emphasising the increasing role of practice nurses and others; utilisation rates, that is, the different rates at which GPs refer or prescribe; and the issue that I will spend most of my effort on, chronic disease management. It is in that area that I cannot see a bullet point from the Executive, yet it seems to me, and to many acute and primary care medical directors, that that is the area we need to concentrate on. Indeed, the plans of Lothian Health and Tayside Health Board are predicated on those shifts in the system.

I will provide a few pen portraits about what has happened with general practice and primary care over the past few years. The figures that I will quote are UK figures from Professor Sir Brian Jarman, as in the Jarman index, to give you a feel for the matter. We currently spend about 76 per cent of our money on the hospital sector, 6 per cent on general medical services and 13 per cent on the drugs that GPs prescribe. Less than 3 per cent of the work seen by GPs goes into the secondary care sector, so that 3 per cent is consuming at least 76 per cent of the resource.

It is well known that the number of doctors per head of population is low, but GP consultations are going up per GP and in total. Just over 80 per cent of people see a GP in a year, and just over 50 per cent see a nurse. GPs are averaging 10,000 consultations a year, of which, as I said, a small proportion go beyond general practice, and they have increasing responsibilities. Indeed, it has proved very simple to shift work to primary care but exceedingly difficulty to shift the resources to match it.

We live in an age when most of us no longer face a threat from infectious diseases. I will be followed by a speaker on public health, so I will not stray too far into that. We will die from non-communicable diseases—heart disease, stroke and the four main cancers—the common causes of which are related to diet, exercise and smoking. We have been slower than other countries, in particular Finland, in recognising that just as you can prevent infectious diseases, you can prevent non-communicable diseases.

09:45

I will give you the figures for what the Finns have achieved over the past 25 years as a benchmark against which to think about spending in the acute sector. Taking men below the age of 65, the Finns have reduced the death rate by 45 per cent. They have reduced all cardiovascular causes of death, such as stroke and heart attack, by 68 per cent. The heart attack rate is down by 73 per cent, cancer is down by 45 per cent—which is worth remembering when we are being asked to pay for expensive drugs that frequently only prolong life by weeks or months—and lung cancer is down by 71 per cent. Those are striking figures, which were achieved by community action primary prevention, so one bit of the budget that delights me is that the tobacco tax is going towards public health. That is correct.

There is an area between primary prevention at the community action level and the acute sector, and that is chronic disease management, which is a role largely for primary care but which overlaps with prevention and involves people from acute trusts. Why are we looking at that? Professor Holman at Stanford University summed it up neatly, and he is a professor of medicine, which makes it nice for me to refer to him. He said that acute practices have proved inefficient and ineffective in dealing with chronic diseases. Such practices leave patients unresolved, result in unnecessary admissions and use expensive and indecisive technologies. We have a vicious circle, as described by Professor Hunter at the University of Durham. As the pressure on beds increases we

try to reduce the length of stay. We do not emphasise rehabilitation enough, which results in the increased use of nursing and residential homes. Prevention is seen as a low priority, or was until recently, and that results in increasing emergency admission rates. I will talk about how you reduce that heat on the acute sector.

What is disease management? It is a system of care across all sectors—from prevention through primary care to secondary care—but it is largely based in primary care. It covers the well-known conditions for which we can write guidelines based on evidence that says who should do what, where and when. The system has a continuous quality improvement cycle in it. It is part of the move away from cottage industry general practice to integrated population-based care, or anticipated care as it may be described. Disease management recognises that it is not great doctors that make health care, but great teams.

It is reckoned that the top ten chronic diseases, which I will mention in a minute, account for 30 per cent of health care costs, so we are not talking small beer. Disease management has been shown to reduce morbidity and costs and to increase patient satisfaction. That has been shown not just in this country and in my experience, but in the experience of many people who have experimented with it at practice level over the past decade and in the experience of policy academics. I should have mentioned that I am honorary reader of health care policy and management at St Andrews University.

You only have to win three arguments when deciding where services should go: they are cost, quality and patient convenience. Disease management hits all three. For example, in the case of asthma, over a decade we have seen that the practices that are doing disease management well are treating twice the number of patients for half the cost—twice the number because they are better at identifying the condition, and half the cost because they are teaching patients to manage their condition and to avoid admissions.

What conditions do we mean when we talk about disease management? Cardiovascular diseases such as stroke, diabetes, angina, heart failure, post-heart attack and high blood pressure are the main killers. The two main respiratory conditions that lead to admission are asthma and chronic obstructive pulmonary disease, which used to be known as chronic bronchitis or chronic chests. In the elderly we are talking about preventing falls and keeping them sprightly, mentally active and at home, and avoiding fracture of the neck and femur. In mental health, we mean the severe and enduring conditions of depression and schizophrenia, and there are conditions in the fields of dermatology, rheumatic diseases and osteoarthrosis. In that instance, early intervention by physiotherapy often reduces operative rates—it reduces the number of hips that we need to replace.

In a practice, the key ingredients are that staff operate from a guideline; they have worked out the skill mix of the team; they have trained as a team, not just in their individual professions, IT is used extensively; and if one asked, one might be shown the quality assurance. There has been a huge emphasis on patient education and self-management: teaching patients how to access services better, to understand their own disease and to place less demand on the system. There is large emphasis on non-drug treatment, such as the risk factors of diet, exercise and smoking. There is also an emphasis on ensuring that the drugs are used properly. Consultants continue to have a role as advisers, trainers and quality assurers. Nurses are the largest gaining group in terms of an enhanced role. However, the practice is an extended team that includes pharmacists, physiotherapists and others. It frequently leads to GP specialism within the system.

Disease management is about taking the heat off the acute sector. It wins the arguments in terms of cost, quality and patient convenience. If we want to implement the system across Scotland, we will have to rethink how we set up such services. I estimate that it will cost between £50 million and £75 million to staff during the set-up period of about three years. We also have a backlog in health centre building that must be taken into account. There would need to be a small additional investment in IT, which is quite good at the moment. There will also be drug costs that are not currently funded.

The Convener: We need to ask whether the three main priorities of the Executive are served by the figures. As you outlined, cancer, heart disease, and mental health problems are conditions that fall to GPs in primary care practices to a large extent. From what you have read in "Investing in You", do you think that the Executive's figures support the aims and objectives? The report says that

> "The development and support of community based services is key to ensuring people have to attend for hospital treatment only when they need it."

The fundamental shift from acute services to primary care is mentioned several times. Do you think that the shift in resources is radical enough?

Dr Dunbar: There is a long way to go. We need to bridge the gap from our current position to where we want to go. We are addressing the same conditions—heart disease, cancer and mental health—but going upstream, as we say in the business. Downstream is acute admission to hospital; upstream is disease management and

prevention. The objectives can be all things to all men; if everything is a priority, nothing is. For example, the document mentions one-stop clinics, which can be good or bad, depending on the clinic.

Chronic disease management has such a unified weight behind it that it should be singled out as the most important thing to do at a time when we know that development money is coming along.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): Thank you for your presentation, Dr Dunbar. Your comments have been very useful. You said that it is easy to shift work to primary care—we all think that that is a good thing—but that it is difficult to shift resources. We are starting from the Executive's figures and it is not entirely clear what is being spent on primary care and what is not. Could you help us with that? One of the difficulties is that the figures include two enormous blocks that are not broken up: the hospital and community health service block and the family health expenditure block.

The document says that

"Of the total in 1998-99, £1,915 million was spent on acute trusts, £1,009 million by the community trusts"

We have moved on to primary care trusts. Could you tell us how that works at a local level? How much money goes to your primary care trust and what negotiations take place with the health board about whether the money will go to the acute trust or the primary care trust?

Dr Dunbar: I looked at the figures and they do not really mean much to me. That is why I mentioned Professor Sir Brian Jarman, who made the point about the sharper contrast between the 6 per cent that goes to family health services—not just GPs, but dentists, pharmacists and opticians—and the amount that goes to the hospital sector.

The Borders gets about £100 million, £52 million of which goes to the primary care trust; within that budget, almost £14 million is spent on drugs. The other £48 million goes to the acute trust. The money is divided up—partly—through the health improvement plan, where everyone has agreed what it will be spent on. However, I would have to say that there is nothing like getting in the press and shouting for one's group—that is how we get the money.

Last winter, during the flu crisis, GPs were running around doing a lot of extra work—keeping at home people that they would have preferred to be in hospital—and they got beaten about the ears for asking to be paid for carrying out flu immunisations. Other people in the system who were paid for doing that even managed to strike a blow for intensive care units. In England, the money was spent on the rise in generic drug costs; in Scotland, that money was spent on the common services agency and intensive care beds.

If I, as a medical director, do not understand how that decision was made, what are the GPs to think of it? It is very difficult to understand how such things are decided. As a GP, one would make a link between the group that made a strike in the press—even as the GPs were running around dealing with the flu crisis—that caught the attention and where the money went. Such a tactic—I think we call it shroud waving—works.

Malcolm Chisholm: One of the things about which there was a lot of controversy was the drugs budget. How is the unified budget working?

Dr Dunbar: The local health care co-operatives thought that there was room to improve the quality of prescribing and reduce the cost in the drug budget. That money could then be shifted into other primary care services in the way that money was shifted at practice level during fundholding. The LHCCs had worked out a similar sum to the Accounts Commission.

Unfortunately, there was an extraordinary rise in the generic drug costs, which wiped out that money. I gather that the Government is planning to restore the generic prices to those of January 1999. That may regain a chunk of the incentive in primary care to move money from one area to another. In itself, that is probably not enough to fund the system. We do not know whether it will work out.

The Convener: The Accounts Commission report suggested that there was scope to save a substantial amount of money from the drugs budget. When we hear evidence from the Executive, I will want to know whether the figures take into account any of the potential savings from the drugs budget. As you have said, that is a complex issue, because it involves a range of different factors. There may be an increase in generic costs, but if trusts are able to take on board some of the suggestions from the Accounts Commission, the costs could be reduced in other ways. In the end, the level may stay the same.

A general point arising from the documents that we have had so far is that we do not have the story behind the figures. For example, when we are told that there is an objective such as one-stop clinics, do the documents tell us anything about pump-prime funding or suggestions for drugs or whatever?

10:00

Dr Dunbar: I want to return to the Accounts Commission figure. When the LHCCs set off on

their journey a year ago, the incentive of improving the quality of prescribing and reducing the cost was the nurses, physiotherapists and so on who could be added to their teams. That incentive disappeared. Even if it were technically possible to introduce that saving, unless the incentive is there, they will not do it—it is as simple as that. The LHCCs and the GPs have said that repeatedly over recent months.

Mary Scanlon (Highlands and Islands) (Con): Your presentation was excellent and opened up many areas for discussion.

Members of the committee received a letter this week from an LHCC outlining problems with GP morale. You talk about health care being more convenient for the patient, more effective, and of a higher quality but at a lower cost; what should be happening to achieve that? Is a transfer of funds required?

I understood that the joint investment fund was intended to allow GPs to offer chronic disease management for asthma or diabetes. I understood that the JIF was to be a cost-effective and beneficial link between the acute and primary sectors. Why has the JIF not been used effectively?

The figures from Finland are staggering. I knew that the Finns had been successful, but had not realised quite how successful. Can you give us some suggestions for changing priorities in the budget so that we can try to target and meet those objectives in Scotland? For as long as I can remember, we have identified that we have a public health problem. We all know the reasons for that problem, but Conservative and Labour Governments do not seem to have tackled it as directly as the Finns have done.

There are still 2,400 blocked beds. You touched on that in relation to acute services. Given that we are conducting an in-depth inquiry into care in the community, can you give us the benefit of your experience and give us some pointers as to how the national health service and social work can work better in future? Whose fault is it? Where is the money going? Does local government not get enough money for care in the community? Is it not spending it in the right manner? Are the resource transfers not there?

The Convener: Once Mary Scanlon starts, she gets her money's worth.

Dr Dunbar: I will address JIF first, because that is the nub of the matter. I was a member of the national support group for JIF, which was chaired by the general manager of Dumfries and Galloway Health Board. We went round Scotland and could not find a single JIF.

It depends what one thinks a JIF is. The GPs were led to believe—I remember Sam Galbraith saying this and I think that Richard Simpson was there at the time—that that was how they would be able to continue to influence the shift to primary care as they have been able to do through fundholding. They would do that at LHCC level rather than at practice level.

That sounded fine; there would be a partnership in which primary care would be favoured a bit more. The truth is that it has never existed. However, with the usual inventiveness of the service, the management executive issued a circular listing many things under the heading of JIF. Those are cases of trusts working across boundaries using waiting-list money and the design health care initiative. I will not underplay the importance of the design health care initiative, but it is not JIF.

Last night, I read in "General Practitioner" magazine that the Scottish GP committee and the chairman of the Royal College of General Practitioners in Scotland said that we should stop talking about JIF and produce a development fund. As we have £176 million—minus revenue from tobacco tax, that is £150 million—this is the time to do it. There needs to be a development fund and a national plan for what is done with that. I guess that disease management would get a strong pitch.

I do not want to steal Dr Wilkie's thunder about Finland, as she can tell you much about what we will do here. However, I will give you a flavour of what has been done in Finland. In Finland, there are national standards for food in the public sector—in schools and hospitals—so that every meal is healthy. We all carry our own health burden of risk factors. What makes the difference is the slope up which the individual pushes their risk factors. Society can decrease the angle of that slope and make it easier for the individual. The Finns have made it easier for people to live a healthy lifestyle. In any hospital or school canteen, there are simple healthy choices. One cannot smoke in public places in Finland and tobacco advertising is banned.

A series of things have been done in Finland. Finland and the way in which Finns think have been changed. They take more exercise and eat more healthily. They smoke less than people in any other European nation. It takes a lot of time and patience—there cannot be a three-year burst before moving on to something else. It has taken the Finns 25 years. They were the worst in the world and had the highest rate of heart attacks in the world. We were about second worst or third worst. They passed us long ago and have now passed England. The graph of the rate of decline in heart attacks in Finland is extraordinarily steep in the right direction. We have much to learn. We

have a health concordat with Finland, which is our twin country for health.

You asked about social work and bed blocking. I do not like to attribute blame as I see things in terms of systems and the interdependency of factors. The social work services do not yet have standards. We cannot get them to tell us how long it will take them to do something or to produce a plan. Health folks find that difficult, as, if there are no standards, performance cannot be measured.

I am not terribly well informed on this, but I gather that there will be a social work equivalent of the clinical standards board. It will make a big difference if we all understand what performance is supposed to be and if we can measure it.

Another thing that arises from the experience of many of us who were experimenting during the 1990s is that one needs people who work across the interface between health and social work and who understand both cultures and languages. It is usually nurses who are best at doing that. In Finland, there is joint social work funding, because health is run at a municipal rather than a national level, but the same cultural problems exist. Therefore, the cultural problems will not necessarily be solved by joint funding. That is why we will probably still have to recognise people who work across the interface and co-ordinate community care.

Mary Scanlon: I also wish to ask about GP morale. You mentioned that less than 3 per cent of GP work goes to acute trusts. We all know that GPs are the first port of call. Do you think that the balance has tipped away from the GP? You said that GP practices offered an approach that was more convenient for the patient, of higher quality and less expensive. Are we missing out on a resource by channelling people to a much more expensive and perhaps less effective resource?

Dr Dunbar: Yes. I have no doubt that the balance has shifted back to where it was, and that that is not good for the service's overall goals.

On GP morale, there was recently a conference of LHCCs. The LHCCs have done well. They include many innovators; they have their organisations set up; they have nurses, physiotherapists and everyone else engaged; they have had their awaydays; they have set their objectives—they have done well this year. However, the LHCCs themselves will say, "If we don't have something to show for this soon, we're going to give up." They set out to improve the quality of care and to improve services. In almost every area on which they were given promises, nothing much is happening. They were promised that services would be brought up to the level of innovative fundholding practices. I heard Sam Galbraith say that, and so did Dr Richard Simpson. If anything, that is withering on the vine.

LHCCs were told that JIF would be the mechanism for developing primary care, but it is not working. They have seen the drug budget go through the roof. That is nothing to do with them, and they could not control it. They saw that element of investment going, and they know that services that they set up—and access to tests—which allow them to manage patients are being blocked off, frequently through setting up one-stop clinics. There is no question but that things are shifting in the wrong direction.

Do not get me wrong: I am all in favour of partnership, but if it is unequal, it does not work terribly well.

Mary Scanlon: I would like you to explain something that you mentioned: I am not sure what you meant by integrated population-based care.

Dr Dunbar: If you think of general practice in the 1970s and early 1980s, the GP sat there and patients came in. The GP, or perhaps the nurse, dealt with what the patients brought them. We are moving towards identifying, within the practice population, people with asthma, heart disease and so on, and towards planned care for those people, so that, at a set interval, they are recalled and health-checked; the risk factors are dealt with. That is a shift from reactive care to planned and population-based care.

The Convener: I noticed that Dorothy-Grace Elder was wishing to speak, but Duncan Hamilton, Ben Wallace and Hugh Henry all indicated that they also wanted to contribute. Do you want to speak on specific points that have just been raised?

Several members *indicated agreement.*

The Convener: All of you? That is very helpful. Dorothy-Grace Elder will speak first.

Dorothy-Grace Elder (Glasgow) (SNP): Thank you very much, Dr Dunbar. This is a useful learning exercise for us.

I want to make a quick point about Finland. The Finns have very low unemployment, and I think that that is always a factor in better health. As you rightly say, Dr Dunbar, they have planned carefully over the past 25 years. Finland shares the Gulf of Finland with Russia, where there is some of the world's worst health and, now, the world's worst alcoholism problem. Nobody is caring about the people there and the unemployment is simply dreadful.

Dr Dunbar: Can I correct you about the unemployment? When the Berlin wall came down, the Finns' economy crashed. In 1992, they had to take 20 per cent off their health budget.

Dorothy-Grace Elder: But their economy has revived now. They have fought back. And they are a very small, independent nation.

Dr Dunbar: Even through the unemployment, they—

The Convener: We will let that one from Dorothy-Grace go.

Dorothy-Grace Elder: To get on to my next question—

The Convener: Yes, we should get to the nub.

Dorothy-Grace Elder: It is most welcome that you have pinpointed chronic disease management. A couple of issues are related to that. First, many multiple sclerosis patients are young or fairly young people, who could be kept on their feet; they are not always people who are going downhill all the way into their oldest possible years. In the whole of Scotland, I believe that there are only seven specialist care nurses for people with multiple sclerosis. Is that one area where we could progress through putting in funding?

Secondly, we recently had a most useful presentation from doctors in Glasgow, who discussed plans to keep older people in their homes for longer. However, the elderly were being charged for those services. The doctors—and some of us—viewed that as ironic, because the aim was to save on hospital bills.

Dr Dunbar: I am delighted to have a question on multiple sclerosis. I did not mention it as a chronic disease, because it is of a relatively low frequency in the population. However, the senior physiotherapist in the Borders, along with the Multiple Sclerosis Society of Great Britain and Northern Ireland, has done a lot of work on it. There is much unmet need in that group of the population, which could be met in the community. That fits exactly into chronic disease management, and the MS Society is, I think, prepared to pay half the cost of that. It is another area where we could get more from going into partnership. I absolutely take Dorothy-Grace Elder's point on MS.

It is extraordinarily perverse that we are asking people to pay for services that will reduce the cost for the health service. Many members will have seen the Dorothy Dobson-type exercise classes for older people. The research suggests that the health gain is enormous—we should pay people to take those classes.

10:15

Dorothy-Grace Elder: Do you have such classes in the Borders?

Dr Dunbar: Yes. We have an exercise scheme in all leisure centres, and it is linked with Scottish Borders Council.

Mr Duncan Hamilton (Highlands and Islands) (SNP): I want to return to what you said about Finland, about public health and about the cost-effectiveness of prevention. The priorities of the Health Education Board for Scotland are in the areas that you are talking about. They include coronary heart disease, stroke and mental health, for example. Do you think that the current remit and role for HEBS is as it should be? Is the current level of interaction between HEBS and all the various other agencies working as well as it could, or as well as the equivalent interaction works in other countries?

On finance, it always strikes me that HEBS has a remarkably small proportion of the budget. Given its capacity to save a great deal of money ultimately, do you think that its part of the budget should be increased?

Dr Dunbar: This is a moving picture, and you might well want to ask the same question of Dr Lesley Wilkie, who will speak after me. Health education is only one part of what the Finns use to change Finland. Indeed, the examples that I gave were not of health education.

We have relied almost solely on health education to try to shift Scotland: health education has a part to play but is not the whole answer. A lot more is about to happen, and much of that comes from "Towards a Healthier Scotland", from the public health review and from tobacco tax. I have picked out demonstrator projects, and Dr Wilkie will be the person to ask on them. The proposed national institute will, I hope, co-ordinate public health efforts. That is an idea borrowed from Finland: its national institute co-ordinates activity nationally. The institute feeds back information on precisely what is happening to the Finnish population every year. The Finns know that their average blood pressure has come down by so much and their cholesterol has come down by so much. It has become a national challenge to improve health. The authorities there seem to be able to get things through to people better.

People here know about eating five bits of fruit and veg a day. If we asked them why, however, we would not get the same answer as on the streets of Helsinki, where anyone will say, "Because fruit and vegetables contain chemicals called antioxidants, which prevent heart disease, stroke and cancer." They will give exactly that answer. We somehow do not seem to manage to get that across, despite our education system.

Mr Hamilton: What, then, would you propose to make progress? We talk about how well Finland does, and about how much we still have to learn, and we tend to take bits and pieces from the Finnish system, but is there something more radical that you might suggest?

Dr Dunbar: As far as I can guess at the moment, the bits and pieces for creating a good system for public health are there. Over the next two or three years, if everything goes well, and when everything is assembled, we will have the same tools for the job as the Finns.

Mr Hamilton: With adequate finance behind it?

Dr Dunbar: I would think that £26 million in tobacco tax is a pretty good start, along with what is already available—but we could always use more, of course.

Ben Wallace (North-East Scotland) (Con): I want to discuss the culture being separate between health and social work despite there being joint budgets. About 20 years ago, health and social work were combined in Northern Ireland, but it was not until two years ago that their management was combined. It was then found that things started to work out. From your knowledge, are health and social work in Finland combined, or are they still separate?

Dr Dunbar: That is a very good question. As far as I am aware, they are still separate.

Ben Wallace: On the matter of a joint budget, do you think that we should follow the Northern Ireland example and take steps to bring health and social work management together?

Dr Dunbar: I do not know enough about that, because I have heard mixed stories from Northern Ireland. However, the chief executive of the trust that I know best is a social worker; that trust has developed some superb joint projects on health and social work and won the premier award for quality improvement in health care. Where the process works, it works brilliantly; however, we do not yet know how much of that is down to individual leadership or to the system itself.

Ben Wallace: In Finland, the healthy eating campaign started through central Government providing free fruit and vegetables in schools. However, following such an example will require more than £26 million, which will have to come from central Government instead of health boards.

Dr Dunbar: You are absolutely right. In Finland, school meals are free; furthermore, the salad is free in all public sector canteens. Three years ago, when I was last in Finland, a school meal cost the state 50p.

Ben Wallace: Tobacco duty is hypothecated; however, there is every indication that the Chancellor of the Exchequer's estimation of that duty was £3 billion out last year, which will mean a 5 or 6 per cent reduction in the £26 million available for health the following year. Might it be best to include some form of JIF to make funding more flexible? The downside of hypothecation is that funding is fixed; perhaps disease management would benefit from a more flexible form of funding.

Dr Dunbar: Perhaps my comments have not been clear enough. I understand that the £26 million from tobacco tax will be spent on public health; chronic disease management will come out of the remaining primary care share of £150 million. Many medical directors and LHCC people say that disease management should have a prime call on that £150 million.

Hugh Henry (Paisley South) (Lab): Thank you for your precise presentation, which made it easier for people like me who have no great background in health to understand the process.

I was interested in your comments about the construction of the budget. For example, you mentioned that people did not know how decisions were made about winter expenditure. Do you think that the construction of health budgets lacks transparency; if so, what can be done to give the process greater transparency, to ensure that politicians, practitioners and recipients can understand the reasons for decisions and, more important, find out where the money is going? You seemed to suggest that you did not fully understand the second issue yourself.

Secondly, you suggested that disease management, which reduces morbidity and costs and increases patient satisfaction, was not laid out in the budget process. If such management is so effective, why are the people who construct budgets unwilling to give it the emphasis that you think that it needs?

Dr Dunbar: Although that is a complicated set of questions, I will do my best.

On your final point, chronic disease management might well be included in the budget headings; if the objectives were clearer—and the bullet points more specific—it would be easier to follow where the money goes. However, the counter-argument is that there should be some flexibility of funding at a local level.

The nub of my argument is that, as chronic disease management is perceived by so many people to be so important, we should take this one-off opportunity of new money to make such management a specific bullet point in the budget and to invest in it. As a result, it would be a national programme, although there might be local variations in its implementation.

Transparency is a much harder issue. Although, in theory, the process of producing health improvement plans is becoming more transparent as more people participate in it, the health service is still highly political. The fact is that, when stushies develop, funding is used to quell them.

As for expenditure on winter pressures, I am

able to say that medical directors were not involved in those decisions because, as a medical director, I was not involved in them. However, I know how decisions are made on most of the spending and am involved in the decision-making process.

The Convener: I want to pick up on a point made by Hugh Henry about quality indicators, if that is the right phrase. In your initial presentation, you mentioned that you want a service that is good on cost and quality and delivers patient satisfaction. Obviously, patient satisfaction can be measured in terms of positive outcomes, easy access to service and so on. Could quality indicators or some form of evaluation improve the process?

Dr Dunbar: Are you talking about just disease management?

The Convener: That could be used as an example; however, I am speaking more generally. Although we have bare figures, we know that other information lies behind them. For example, a general practitioner will be paid a capitation fee for a particular piece of work, whether it is done well or not; no quality factor is involved. You mentioned the lack of incentives for LHCCs; although people are trying to raise the quality of service, there is currently no mechanism that shows whether people have achieved such a level of quality—through an enhanced capitation fee, for example. We are back to a sausage factory situation, where the most important consideration is how many patients have been dealt with. Although it is not easy to examine the quality of the service, do you have any suggestions about doing so?

Dr Dunbar: One of the advantages of disease management is that we can have everything that you mentioned. For example, there could be a basic deal that outlines both the funding for disease management and the targets that must be met with that funding. I do not think that providing GPs with the incentive to carry out disease management is part of the problem—it is not that it involves a lot of work, in the same way as flu immunisation, because much of the work is done by nurses. It is about creating the resource for the GPs to get the work done.

I shall take diabetes as an example. In a number of health board areas in Scotland, including Borders, every practice participates and knows the diabetic control of every diabetic patient in the area; the information is anonymised, but they can see how they are doing in relation to the others. At the centre of the approach are a consultant, and a diabetic specialist nurse in each practice, who are specially trained in diabetes. One can see, without doubt, how they are doing on the issues that matter to the diabetic patient, from the medical viewpoint. It is not too difficult to survey those patients on how they feel about the service; they are expert on how well the service is provided from the customer's viewpoint.

One can build into all that a pretty good measurement of what people get; one can cost it pretty well; and one can be pretty sure that, if the service is being taken closer to the patients, they will vote for the convenience of that. All in all, there is a nice health economic case, because we are looking for gains in these terms: in relation to diabetes, the gains are in terms of limbs not having to be amputated, heart attacks that do not occur and people who do not require renal dialysis—it is major prevention.

10:30

Irene Oldfather (Cunninghame South) (Lab): Some 10 years ago, general practitioners were encouraged to set up many of those clinics—diabetes clinics, healthy heart clinics and even weight reduction clinics. Is the money that has been spent on those clinics improving the health of the nation? From what you have said about the experience in Finland, the Finns have gone back a few stages further and dealt with diet before health problems emerged—they are trying to have an influence at an early stage. Are the two approaches mutually exclusive, or do we need to take both? In budgetary terms, should we front-load the exercise on to the early stages?

Dr Dunbar: Both need to be done—that is the bad news. It is important to tackle the problem at population level, but there will still be people who have the diseases—rather than waiting until they are in hospital, we want to deal with people at high risk at practice level.

You are right about the clinics being set up in the early 1990s. That was a classic example of bad change management—GPs were forced into the change and no one explained what it was about. A few GPs thought that it was a good idea and demonstrated what could be done; after that, others started to catch on. Now, if one says, "disease management", everybody votes for it. It is one of those matters on which ideas have moved on with time. However, the investment is only a fraction of what we need to take the heat off the acute sector. It is not that we are not doing these things; it is that we are not doing them on anything like the scale that is needed.

Irene Oldfather: GPs are calling in people of a certain age to healthy heart clinics to have their blood pressure measured and their weight taken. Is that an effective use of medical time?

Dr Dunbar: Yes. For example, the members of the LHCC in the Borders agreed that they would share those clinics as a group; there would be one central database and all the patients would be

called to the practices, where their risk factors would be checked. There was an audit before the project started and a few weeks ago we got the results from the first year, which showed that there has been an improvement in relation to all the risk factors. How the scheme works varies from practice to practice, but all the practices have shown an improvement. That is clear from the number of admissions to hospital, especially those for heart disease. You do not need a health economist to examine that; you can look at the results and see that it works.

The Convener: On the Argyll and Bute LHCC, Mary Scanlon mentioned the changing role of the nursing profession in primary care. We were not told how many community and practice nurses were working in the service, yet they are fundamental to primary care practices, especially in chronic disease management. As you said in relation to diabetes, they are highly trained people with a critical role. Again, we may feel that there is something to be gained from seeing where there is a shift in staff numbers over time, so that we can find out whether LHCCs and other GP practices are moving from consisting just of a couple of GPs. Access to information on the staff composition of the team would give us a sense of how far there was wider access to services across Scotland.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): On the LHCCs, you have said a lot about GPs and diabetes nurses. One of the other target areas is mental health—I do not know whether the omission was deliberate, but you have not said how you think things should be taken forward holistically at a practice level, never mind at the LHCC level.

There seem to be professional jealousies, so no one feels able to bridge the gap and to examine a patient and say, "It may be that you have diabetes, but you also have a fundamental mental health problem, and we need to consider all those problems." People do not seem able to move across boundaries; everybody seems to remain in their professional compartment. That does not achieve anything in terms of budgets, never mind in using expertise.

Dr Dunbar: You are quite right. The health service does not make widgets, running a machine seven days a week, 24 hours a day; it is about people, and 70 per cent of the costs are people, so efficiency comes from teamwork. The matter is almost as simple as that. You are dead right about the division between community mental health nursing and what we call the primary health care team of the district nurse, health visitor, practice nurse and GP. Perhaps an improvement in teamwork will be brought about by primary care trusts, which have mental health and primary health care teams.

One of the things that I used the savings for was to include community mental health nurses in my practice. The difficulty is—as a medical director I have heard both sides of this case—that mental health workers would argue that, as their job is to look after the small number of people with serious illness, they must conserve that resource. Primary care workers would reply that that meant that the large number of people with small problems were suffering. The truth is that, in anything that we are tackling in chronic disease management and health, we achieve the greatest gains with the large number of people with small problems. The debate is continuing and I expect medical directors will try to do something to bring the two groups together.

Margaret Jamieson: There is a difficulty because of the significant reduction in the number of large institutions for people who have mental health problems. Those individuals are now cared for in the community. There do not seem to be enough people with the expertise to care for those patients, who seem to fall through the net. That relates to care in the community; a significant number of beds have been closed but trusts or—nine times out of 10—health boards continue to keep the funds without allocating them so that people can be properly cared for in the community. I do not know how the system works in the Borders, but in the west of Scotland there is a significant difficulty with that transfer of cash.

Dr Dunbar: One of the things that you might consider is the variation in the number of community nurses per head of population throughout Scotland. We are quite lucky in the Borders, where there is good investment. There is a register of all patients and a very thorough follow-up. That is not universally the case; in fact, the reverse may be the case in many places. If there are enough community and health nurses and social workers, and if it is known where they are, patients can be followed up.

Resource transfer is a thorny issue. The health board view is that, when the money goes to social work, what happens to it is unclear. There is a genuine difficulty in accounting for resource-transferred money when it goes to local government.

Margaret Jamieson: I am talking about what happens before that. There is evidence to suggest that the money has never been transferred.

Dr Dunbar: There probably is.

The Convener: I would like to finish off with a stinker of a question. When we produce our report for the Finance Committee, we have to ask a set of questions about the process. We must ask ourselves whether the targets that ministers have

identified are appropriate and realistic. The criteria for judging that will probably be based on the amount of money that will be spent.

The ministers are outlining their targets for halving deaths from coronary heart disease and for cutting the number of deaths from cancer by 20 per cent by 2010. Do you think that those targets are appropriate, realistic and achievable, based on the funding that is available and the way in which the matter is being addressed at the moment?

Dr Dunbar: That depends on how we invest the money. If we invest it in acute high-tech stuff, the targets will be hard to meet; however, if we continue to place the emphasis on prevention and chronic disease management, and if we fund the drugs that we need, we can achieve them.

The Convener: Thank you very much for your contribution this morning, Dr Dunbar. We have all learned a great deal from that clear presentation.

I now ask Dr Lesley Wilkie to address the committee. Dr Wilkie is the chair of the Directors of Public Health. We have touched on several public health issues in our discussion with Dr Dunbar. We may want to talk to Dr Wilkie about the £26 million that is coming from the extra tobacco tax. I may kick off our questioning with the final question that I asked Dr Dunbar—whether the public health targets that have been set are appropriate and realistic. I welcome you to the committee, Dr Wilkie. You may make a short presentation to us, after which we will ask you questions.

Dr Lesley Wilkie (Directors of Public Health): Thank you for inviting me to attend this morning. I shall begin as James Dunbar did, by explaining who I am. I am the chair of the Directors of Public Health, which comprises medically qualified people who have specialised in public health medicine and who work on public health boards. They are responsible for surveying, reporting and advising on the health of the population, as well as on the means by which that health can be improved. In some cases—James Dunbar mentioned communicable diseases—they can take direct action.

I shall try to relate my comments partly to the report that I was given and to the questionnaire that—in common parlance—I would call challenging. [*Laughter.*]

The Convener: We are at one on that issue.

Dr Wilkie: I regard the resources that are allocated to the national health service as being for improvements in health. That includes, but is not exclusively, the provision of health services—that is the main point that I want to make. As has been said, resources are required across a range of interventions to improve health, from general health promotion issues and intervention on life circumstances, to improving the dignity in long-term and palliative care for elderly people or those with terminal illness. There are initiatives to protect health, such as immunisation and early detection, and initiatives to promote healthy behaviour through health promotion activities. There are also initiatives to support effective, appropriate and accessible health services for all groups of the population.

10:45

I, too, welcome the hypothecated tax, although I thank the committee for explaining the dangers of hypothecation. The £26 million represents an encouraging and welcome commitment by the Executive to health programmes. It was an acknowledgement of the fact that real resources are needed to improve health and for the public health agenda. Exhortation and education are not enough; real resources must be applied.

Through the white paper on tobacco, a certain amount of money has been allocated to encourage people to give up smoking. That money is concentrated on disadvantaged groups and is an acknowledgement of the fact that the cost must be covered of nicotine replacement therapy—Nicorette, if I am allowed to use the brand name—for two weeks for disadvantaged groups. I am concerned that that might not be enough.

Simple initiatives such as breakfast clubs in schools have been shown to improve both the health and the education of children, at a cost to local authorities that must be paid to improve health. We must consider that cost in the national health service budget as well.

I, too, found the document, figures and spreadsheets rather challenging. Public health seems to be mentioned only under the heading "Other Health Services"; the reader is encouraged to think that the Health Education Board for Scotland represents the only investment in public health. That is not so, as Dr Dunbar said. Nevertheless, we must be aware that money is needed for investment in public health throughout hospital and community health services and family health services. The recent review of the public health function, which was also mentioned, endorsed the role of the health board as a public health organisation—which, as a director of public health, I find encouraging.

Other departments and committees may have a more significant impact on health. Those that are responsible for education, housing, employment and social inclusion all have a significant impact on health and require resourcing to address the basic causes of ill health—life circumstances and disadvantage. Policy in those areas should be examined for their potential positive and negative

impacts on health, in an overview of ways in which health can be improved.

Addressing inequalities is one of the major challenges and targets in public health. The inequalities that exist by geography, economic group, race and gender should be addressed. Addressing those inequalities and bringing the health of the most disadvantaged to the level of that of the most advantaged may be a key function of the Scottish Parliament.

Resource allocation should address the inequalities that exist in health experience, such as the different rates of heart disease and cancer within the groups that I have mentioned. It should also address the differences in health behaviours, such as smoking, taking exercise, and alcohol or other substance misuse. Why should the health service be less accessible to people in the disadvantaged groups, particularly in respect of preventive programmes? The challenge is for the NHS to come up with ways in which to make key services more accessible for disadvantaged groups, which would probably increase uptake. Finally, if there are inequalities in health service outcomes—the part of health experience resulting from the health service provided to a community—they need to be examined and the differences between areas, trusts and practitioners addressed.

Inequalities are a key issue for resource investment, so reducing them should be considered as a target for the NHS. We need to set up a suitable monitoring framework for that. I suspect, as was implied earlier, that the outcomes measured in some areas would tell us more about the value achieved from investment in the health service than would hospital work load and the number of people coming in and out, which are the figures that are commonly used, although I do not deny that collecting such information is a challenge. The local health care co-operatives may provide the structure that we need, as they focus more on public health and the community, considering the whole population at local level.

I would like targets to move away from bricks and mortar—the number of hospitals, or this or that, built. Targets should reflect improved health—health service outcomes, reduced health inequalities and improved patient experiences. That will mean asking people directly about their experience, about what they see in the health service and what they expect from it. Other policy documents—such as "Towards a Healthier Scotland"—could give us targets. We also need explicit targets in mental health, mental well-being and the health of older people. There is a danger, because some of the targets put too much emphasis on the acute sector, that the needs will be forgotten of more disadvantaged groups of people who do not fit in easily to targets for one-stop clinics or waiting times.

There is a need to optimise resource investment. There may be a benefit in secondary prevention of heart disease—giving preventive treatment to people who show the established signs of heart disease to stop them getting worse. However, research has shown that only 30 to 40 per cent of people who could benefit from such treatment do so. Setting a challenging target—to bring that figure up to 100 per cent, or 80 per cent—would bring clear health benefits. We could do that now. Rather than considering new initiatives, we should consider what could be maximised already. In Paisley, where I come from, we were lucky enough to get the demonstrator project for heart disease, which is one of the areas that we hope to tackle. We hope to show the resources that are required.

It would be wrong to say that priorities do not need to be set; the Executive will have to address that issue. However, when we set priorities and examine how resources are distributed across care programmes or to new initiatives, we need to consider the overall benefit to the health of the population, rather than ask whether individual things benefit. I do not know whether there are enough resources in health, but there is a danger that demand will outstrip supply. We need to stay focused on what we want to achieve—improved health—and to use that to decide about resources.

There may be a need to concentrate on those client groups that used to be called the cinderella groups—I do not know whether it is politically correct to call them that any more. Many will know whom I mean—people with mental health problems and learning disabilities, young, physically disabled people and elderly people. Such people do not demand services—they are not the ones shroud waving in the newspapers or making themselves known. Unless their needs are identified positively, there is a danger that they will become lost. It may therefore be necessary to set some targets in that area and to examine the balance of investment across programme areas, taking such groups as one area.

I agree fully with almost everything that Dr Dunbar said. Services delivered in a primary care setting by a variety of health professionals are the common experience of the health service for most people. Experiences of the acute sector are relatively common, as are experiences of institutional care in mental health. "Designed to Care" brought further opportunities to build on a method of care that is more responsive and closer to the patient.

Local health care co-operatives are the method for delivering such care, but morale is an important issue. It costs money to provide a good primary care service, which is no longer a little business,

but a key part of the health service. We need to examine the shift in resources, whether through JIF, which does not seem to exist, or through new investment. We also need to improve data collection to examine the impacts on primary care.

I note that the report, "Investing in You", emphasised what is being done in illegal drug misuse. That emphasis is to be commended. The targets in that area are appropriate. However, we must not forget other types of substance abuse, particularly misuse of alcohol. In my health board area, we estimated in 1994—so the figures will have multiplied—that at least £12 million in the hospital service was used to address the needs of people with alcohol-related conditions. An extra £1.5 million was spent in the ambulance service—I could go on and give figures for the amount spent in the primary care and other services. A lot of money is involved. If the needs were identified and preventive measures sought, think of the clear health benefits that there could be and about how that money could be used elsewhere.

Other policy documents put more emphasis on initiatives for young people and children. We must remember the opportunities that there are for health improvement and health promotion with young people, through peer support, building assertiveness, physical activity, sexual health and other life skills, although I do not mean to say that sexual health is a life skill.

The Convener: It probably is.

Dr Wilkie: We must also remember the particular needs of socially excluded, unemployed young people, who require a specific approach.

There has been a lot of talk about Finland. Exciting things are happening there and we are certainly looking to learn from Finland to help with the demonstrator project in Paisley. We hope that Paisley may be the new Finland of the UK. We certainly want it to be world renowned.

The Convener: That could be tomorrow's headline.

Dr Wilkie: I did not say that just because Hugh Henry is sitting here.

Dorothy-Grace Elder mentioned the 25-year history of the efforts in Finland. There is a long-term vision; improving health means playing the long game. There has been stability in Finland, which has allowed that long game to be played. That is what we must consider; it means that there will be no immediate payback or outcomes. We may need to consider interim indicators, such as smoking rates, although the long game will be the reduction of lung cancer, the figures for which, as we all heard, are stunning.

We must not forget that targets will be needed on life circumstances. Levels of education and employment are health indicators. We need to examine the resources that are available to meet such targets.

The World Health Organisation's Ottowa charter on health promotion, which all member countries, including the UK, have signed, says that to improve health we must build healthy public policy, create supportive environments, strengthen community action, develop personal skills—I have not mentioned health services yet—and reorient health services.

When the use of resources is considered, the key themes should be improving health, improving existing services, giving priority to the needs of groups that are unlikely to demand services, and responding to the demographic challenge of having a healthier older population who, quite rightly, expect more of the health services that they are entitled to receive.

11:00

The Convener: Thank you, Dr Wilkie. What you said about the Finnish experience was absolutely right. We will probably want to investigate that further, because it seems incredible. I have asked our researcher to give us more information, but I am not sure that our corporate body will be awfully happy about our taking a trip to Finland.

It will require a background of long-term stability, to use the word that I think you used. We should not be looking for a quick fix before the next election or for a chance to score points; we should be working on a 25-year canvas. Doing that would be an education for us all.

We are being asked to carry out a budget process, and what you said about public health gave a key example of a case in which it is very difficult to tell what we want to achieve from simply looking at the departmental budget. Talking about acute services, you said that better health is not just about bricks and mortar; but better health can be about bricks and mortar if you are talking about a decent house.

Dr Wilkie: Indeed it can.

The Convener: You talked about drug misuse and the even bigger problem in Scotland of alcohol misuse. Either this year or in coming years, we have to be able to draw out of the budget process what the Executive is doing on certain issues in a cross-departmental way. We may want to ask the Executive for annual examples of where the money is coming from to tackle, for example, alcohol misuse. Spending on public health is not covered solely by the figures that we have in front of us today. Are we right in thinking that we have to evaluate the cost-effectiveness in relation to public health of not only

the health pound, but the housing pound and the education pound?

Dr Wilkie: Joined-up working is important at all levels, and it is crucial at the Scottish Executive level. I have heard talk of an overall health strategy that would involve departments other than the health department. Cross-department commitment would give an impetus to improving health. That is also important, and certainly not easy to achieve, at a local level—at a health board level and at the very local level with the health co-operatives. Some members were talking about the difficulties with joined-up working in community care. For various reasons, it is difficult to achieve trust, sharing and, dare I say, pooling of resources, but we must drive towards that. The idea of considering what impacts on a particular health problem—and that will include things that are not covered in the health budget—is a good one. That would give a good idea of where health is going and of what resources are being committed to it.

Malcolm Chisholm: This question is probably not in order because, strictly speaking, we are considering next year's budget. What do you think this year's £26 million should be spent on?

Dr Wilkie: Gosh. I have read the press releases on the website. I read about a health promotion fund, although I do not know what that is; I read about something to help to consolidate the screening programmes for cervical and breast cancer; and I read about the public health institute for Scotland, which I think has been mentioned by Dr Dunbar. There has been talk of setting up structures to consolidate public health.

On the subject of the health promotion fund, I think that there is benefit in having an organisation that is focused on health, but it must be allowed to spend its money not only on health services. The fund could be used for a local project that is not a screening programme and is not a smoking cessation clinic. Money could be invested in a local community to give people skills to cope with disadvantage. The money could be the catalyst for the setting up of a community initiative. I would like there to be freedom to use money in the health budget on projects that may not be what are traditionally regarded as health projects.

Malcolm Chisholm: We all like the emphasis that you place on health inequalities. You have suggested that money should not be used simply on traditional health promotion campaigns, but should be skewed towards communities that suffer from health disadvantage. Could that include community health projects?

Dr Wilkie: Community health projects are generally targeted already in areas of disadvantage, whether in partnerships such as social inclusion partnerships or otherwise. To improve the health of the disadvantaged would be a health improvement for the whole population.

Malcolm Chisholm: You said that we had to have a suitable monitoring framework for health inequalities. What would be required for that?

Dr Wilkie: I am sure that our health board is no different from others in that we are working towards an inequalities strategy. We want first of all to identify where inequalities exist. The information is there already, but we have to involve the population more in arriving at definitions of what those inequalities are. Health boards should be asked to report on inequalities in the same way as they are asked to report on waiting times. The organisations—health boards and trusts and local health care co-operatives—should be held to account not only for waiting times or for throughput in hospitals, but for the ways in which they are narrowing the inequality gaps.

Malcolm Chisholm: Do you think that we should have specific inequalities targets in this document?

Dr Wilkie: Yes, I do.

Margaret Jamieson: Dr Wilkie, you talked about engaging other stakeholders in education, social work and so on. Do you think that responsibility for public health should remain in the health department, given that so many other departments are involved? Do you think that, if people were able to cross the professional barriers of jealousy or whatever, there would be a significant health gain for patients?

Dr Wilkie: There is debate in the public health field about the locus. A weighty committee has just considered the issue, and it concluded that health boards should have the responsibility, as health boards are redefined as public health organisations. There is a lot to be gained by having an organisation that is focused on health, but I will not deny that there are things that get in the way of that.

I can see the other side of the argument. I have just been looking at a report on the situation 100 years ago by one of my predecessors, the medical officer of health for Renfrewshire. At that time, we were emphatically within the local council, and it worked. So there are other models. However, an organisation that focuses only on health would be quite an exciting organisation to be part of, as long as it had the power to influence health and did not become some sort of ghetto.

Margaret Jamieson: You also mentioned health promotion. I would be concerned if health promotion remained confined to the area of health and did not feature in schools and in the

community. We talked about the money that will be available, and you indicated that you thought that the allocation would not always be within the area of health as traditionally defined. Do you think that there is scope for professionals in the area of health promotion to break down barriers that have existed for many years and have prevented people from being educated about their health?

Dr Wilkie: I am not a health promotion specialist, although we work very closely in an integrated team with health promotion specialists. Their raison d'être is to educate health promoters, who are usually teachers, nurses and doctors. There are relatively few health promotion specialists, and their job should be to pass on skills to others such as community workers. Community development is an increasingly important part of their role.

Health promotion specialists have a role to play, as they can work at a local level. I am a great one for ignoring barriers, but ignoring them does not make them go away. I am not an expert on what is the best management way of making them disappear. Professionals should act as if they do not exist, and health promotion specialists should be out in the community transferring skills.

Dorothy-Grace Elder: For a number of years, I have been concerned about the percentage of the overall NHS budget that is allocated to public health. It is all very well to talk today about seemingly grand sums such as £26 million, which depend on smokers continuing to provide that money in tobacco tax—

The Convener: You should keep smoking.

Dorothy-Grace Elder: Exactly. That is ironic, is it not? You talk about grand sums such as the one that I have mentioned, but what is the updated percentage of the NHS budget that is allocated to public health? I know that it is very small.

Dr Wilkie: It is small. It depends on what is defined as public health. The budgets for the departments that I head are buried in health board costs. The same applies to health promotion. One could argue that every GP, every nurse, every doctor and every teacher is carrying out public health initiatives, but that would be rather naive. The percentage of the budget for those who concern themselves only with public health is quite small.

Dorothy-Grace Elder: The figure that I saw a couple of years ago was 1 per cent.

The Convener: Perhaps we should try to find a way of digging out that figure.

Dorothy-Grace Elder: You now have more responsibilities than you did in the past. I have heard from public health departments that they do not have anything like the resources that they need to tackle problems that we want them to look into. You are, for instance, charged with dealing with toxic dumping and landfill sites, but you do not have the resources to conduct full studies. The problem of mobile phone masts is also being placed to some extent on the shoulders of public health departments. However, the general public usually hear about public health departments only when there is an outbreak of E coli. You lack good publicity, which would enable you to show the Government and the public how much you do and that you are our front-line guardians.

Dr Wilkie: We need to network together more and to make use of the academic departments that have more specific expertise in the areas that you mention. I hope that investment in the public health institute will go some way towards enabling that to happen. Dorothy-Grace Elder is right. When a specific problem occurs, we want either to have spotted it before it happens or to be able to do an assessment of the health risks to the population or to the local authority. However, we often struggle to find the resources that would be needed for that.

11:15

Dorothy-Grace Elder: Do you hear from your colleagues that there are things that you should do that you simply cannot do?

Dr Wilkie: Yes, especially in the area of communicable disease, which is rising. Departments of public health maintain and survey the incidence of communicable disease and immunisation rates for those who are included in immunisation programmes. They also respond, with local authority environmental health departments, to outbreaks of E coli or salmonella. Implementing the meningitis C immunisation programme was one of the busiest short periods of activity that I can remember, but I am not sure whether people were aware of how busy the public health department was. They probably see how busy general practices and clinics get, but they are not aware of the impact of outbreaks on our work. We always need more resources. The review of the public health function provides a template for all of us to study, and we want to work more closely with other organisations.

Mary Scanlon: Dr Dunbar talked about teamworking. I do not have a health background, but the only time that I hear about public health directors is when there is an outbreak of E coli. Are you being proactive enough in engaging in prevention, or is yours a reactive crisis management role? We all know what the problems are, but why are not we addressing those problems? What advice could you give us on priorities in budget setting? How can we prioritise and shift resources within the budget to address

the enormous public health deficit in Scotland?

Dorothy-Grace Elder and Dr Dunbar touched on patient management. If more money goes to public health and all we do is preach to people, that will not work. How do we engage in a partnership with people? How do we encourage women who have had eight letters inviting them to get a cervical smear and have not turned up? How do we encourage parents to give their children the measles, mumps and rubella injection, when we still have not given them a clear message to dispel fears about autism? I believe that 90 per cent is the critical rate of inoculation to avoid an epidemic and that, in the western isles, MMR inoculation rates are down to 80 per cent. Are we working as a team, how can we stop preaching and start engaging, and what should we do in the budget to address the problems that we have all identified?

Dr Wilkie: You asked whether we are just reactive. The only time people hear about our work is when there is a problem. Prevention and steady work are not sexy and do not hit the headlines. Our work is not like that of an intensive care unit, but it goes on. Much work is done by members of my department in looking to prevent the ill effects of AIDS, hepatitis B and other infectious diseases, but that does not hit the headlines and people do not hear about it.

The only time we hit the newspapers may be when there is an E coli outbreak, but work in the field of communicable diseases, which is not exciting but steady and important, is going on all the time. We are proactive as a speciality and as a function in public health. I often say that what we are about is looking for trouble, not waiting for it to hit us. That is evidenced by our work on alcohol. We looked for a problem and found it.

Public health work involves teamworking and should be multi-disciplinary and multi-agency. Like all those who work in health care, I know that that is not easy, but it is the only way to work. Often, we work more with other agencies than within the health service, and people in the health service, such as health promotion workers, do not always see that. Before I did this job, I was a general practitioner and teamworking was my main aim. I do not think that we can work without that.

I picked up the point about the Health Education Board for Scotland because health promotion is not just about preaching—it is not enough simply to tell people. Everybody must know that smoking is bad for one's health, yet smoking rates among young women are rising. As Dr Dunbar mentioned, we must make it easy for people to take healthy choices by surrounding them with healthy public policies at a national and local level. We must make the environment supportive to allow people to take the appropriate actions. For example, cheap food needs to be available locally, not two bus rides away. That is not preaching, nor is it obviously the work of public health. There are health education campaigns, but they are only a part of public health.

Mrs Scanlon has a point about the MMR issue. We need to engage people. The other day I heard a radio programme on the subject, which was excellent. We need to say that all immunisations carry a risk, but that people must balance that small risk against the larger risk of the disease that immunisation seeks to prevent. We have probably not been good enough in that respect. Going into a bunker, insisting on MMR and telling people to forget about autism will not work. People are intelligent and will make their own decisions.

Mary Scanlon: You are the crucial link between the Executive's priorities and the engagement of the public in those priorities. How could you encourage people to take more responsibility in such decisions? Ask anyone in Scotland why they should eat five pieces of fruit or vegetables a day and they will not be able to answer, although they might know that HEBS says that it is good for you. The message is not getting through clearly and we must all take responsibility for that. How could you improve that?

Dr Wilkie: We will have to improve it to justify the £6.5 million that the project in Paisley has just been given to tackle heart disease. We will be held to account for that. People need the knowledge, the attitude and the belief that it is worth while; they need to be empowered to do that. If the only joy of a single mother in a multi-storey is a cigarette at the end of the day and we say that she is a bad person and should stop smoking, the message will probably not get through.

We need to speak to people and discover what motivates them to change behaviour. We need to know whether people need better access, whether there is an economic barrier, whether they feel confident enough or whether they actually like what they are doing. Most public health programmes are defining people's motivation and examining how to work on that.

Mary Scanlon: Is that what you will be doing in Paisley?

Dr Wilkie: Yes.

Mary Scanlon: Is it an individual approach?

Dr Wilkie: No, it is not an individual approach, although individuals are crucial to it. We take a community approach. The local health care co-operative is right in the middle of the community. There is partnership with the local council, SIPs, trusts and voluntary organisations, and action is linked between them with a public health overview. It is an integrated approach. The project in Paisley is a step forward in chronic disease management,

to try to change the atmosphere in a large town, to empower people and find out what motivates them, and to increase action from the community—letting the community, rather than us, decide.

The Convener: Before Hugh Henry asks his question, I have a point of information for the committee. Following yesterday's meeting of the Public Petitions Committee, a petition is winging its way towards us on the question of MMR vaccinations and autism. That is an issue that we will discuss in the coming weeks.

Hugh Henry: I was delighted to hear some of the comments that Lesley Wilkie made. I am familiar with some of the detail of the project in Paisley of which she spoke. It is an exciting opportunity for us to consider what can be done.

One thing concerns me. You spoke about addressing inequality of access, and then said that we need to examine outcomes and move our targets away from bricks and mortar. You said specifically, in relation to Paisley, that we need to justify the investment of £6.5 million. However, both you and Dr Dunbar referred to the fact that, in Finland, the results were not achieved overnight.

How can we show that a pilot project works, and justify our investment, if that type of approach takes years to have an effect? Five years down the line, the outcomes of that project will be required to be made known. I am not saying that the project is doomed to failure, as I hope that it is a success and I am looking forward to playing an active part in shaping and developing it. None the less, how can you justify the investment if we take a short-term approach?

You have planted in my mind some thoughts about the budget process for the next few years. If this committee and the Parliament are to make any contribution to the health of the nation, over the next three years we should return to the fundamentals. We will still argue about health boards and their contribution and about vaccination programmes for specific diseases, but perhaps we need to ask whether our investment in health is working. Is it being used to best effect? I would be interested in hearing more from you about whether our money is being used effectively. Can we use our health budget more effectively to produce better health for our nation?

We all welcome the additional expenditure on health, and we would welcome more. However, even if we were to receive no more investment, could we—in Scotland and in the Parliament—get better results from what we are investing now? This may sound like heresy to you, but I have begun to wonder whether we are doing the right thing by talking about health promotion and a budget for public health. Unless we make the promotion of public health organic to the whole process, people will always be able to regard it as an add-on.

As long as we preach at people—about the rise in the incidence of smoking in young girls, or about healthy diets—we will have no effect. Duncan Hamilton has suggested to me that we need an explanation, from the Executive, of what it is doing. The initiative in Finland was not about preaching at people, but about going back to fundamentals and changing the whole lifestyle.

I would be interested to hear whether we could use the budget to better effect. What should we be doing to change the attitude to health expenditure? Unless we change the attitude of the politicians and health professionals, every year we will simply argue about whether one budget heading is more appropriate than another, while the fundamentals pass us by.

Dr Wilkie: Well—

The Convener: A yes would do.

11:30

Dr Wilkie: I will try to be brief. I agree with the last point. We need to consider what we are trying to do for Scotland, which is to improve health. We are doing X, Y and Z and must consider how much should go to primary care and how much to secondary care. There is scope to start on a small scale by considering how money is being spent to tackle heart disease, for example. We could ask where we are impacting on heart disease. It may be that that comes from outwith the health budget—that is something that we must realise. We must ask whether we are getting value for money from within the health budget and whether there are inequalities throughout Scotland. We should consider the overall picture, including primary and secondary prevention and rehabilitation, rather than just focusing on whether there are enough heart operations. Perhaps I should not mention heart surgery today.

There is an issue about the three years of the project in Paisley. In evaluation, we have been considering interim process measures. We will not achieve the results of the long-term Finnish experience in three years. We hope to set Paisley on track and to share with the rest of Scotland. We need to measure whether policies in health trusts, the local authority and business have changed and whether community groups have been set up to address local health issues. Those are the interim process measures. We will also consider the health status at the beginning and at the end, especially in terms of health behaviours such as smoking rates. We expect to see a shift.

I agree with Mr Henry. We are in it for the long

term. However, we will not see that 25-year improvement over three years.

Mr Hamilton: We are touching on several different points. There is real tension between the desire for cross-cutting—the big vision—and the need for transparency, which is what we are trying to pursue today, to find out what budget goes where. We want to know where the money goes and we want joined-up working, but you seem to be saying that we cannot have both. I am sure that you would not want to go down the route suggested by Hugh Henry, whereby you would not have a set budget but would always have to fight your own corner. How would you resolve that tension? We cannot be all things to all people.

I would welcome more comment on HEBS, promotion and education. We need more financial information from both above and below. We need information from above on those aspects that are outside the health budget and therefore not included in the document. The detail from below would come from figures that are buried within the figures. If it is true that the HEBS budget is rising to £6 million or £7 million, which—from what you say—is only the tip of the iceberg, I presume that you think the committee should investigate the health boards' figures. I am sure that we have all experienced great frustration when we ask a question and the answer comes back that the information requested is not held centrally. I would be a wealthy man if I had a pound for every time I have received that answer. How can we access those health board figures? Perhaps you could give us a steer on that point.

I want to raise a final, and quite separate, point on your suggestion that targets should be set on health inequalities and access to health. You represent a health board that serves a mixed rural and urban community. Would you support the idea of a series of targets on access to health and on the facilities that are offered to rural communities? If so, what should those targets be?

Dr Wilkie: It would be managerial chaos if we did not have separate budgets, because people must be held to account for what they do. However, we have an overall vision, and, while I am not a expert on budgets at the Scottish Executive level, we should approach our work by agreeing in advance different departments' contributions, which could feed down to the constituent organisations that receive their funding from the Executive.

At a local level, most health boards run health improvement programmes jointly with the local authority and so on, although those programmes are not perfect by any means. However, they are heading in the direction of my suggested approach, even if all that is involved is people sitting down together and agreeing the different contributions. While health boards find it easy to form partnerships with local authorities or social inclusion partnerships, they never bring any money to the table, because the money is all hypothecated to health services. That does not make for good partnership working. Being able to bring something, however small, to the partnership agenda on public health would help partnerships work and would also mean that the health budget was being used in an identified way—local authorities should also be able to take that approach. There should be agreement about, and transparency in, the contributions that are made by the different partners and about what the partners are trying to achieve jointly, although those contributions may come from different budgets.

The HEBS budget is easy to identify because HEBS is a special health board. Not only does it carry out health education campaigns, but it does much of the health promotion and community action work that I mentioned. Health promotion departments in health boards work closely with HEBS and could not exist without it. However, to take my health board as an example, it is possible to identify the public health department. It is confusing that it may not be only the public health department that does public health work. Public health departments cannot function without information services departments to help with analysis. It is more complicated than one might think, but targets are achievable.

I was concerned that the document seemed to assume that only HEBS undertook public health work, because that is not the case—I think that most health boards would agree with my view.

We provide services to a mixed urban and rural community. At one time, the access time for ambulance services in Tighnabruaich was about 10 minutes, which was not feasible, and we had to examine that target. Often, there is a balance to be struck between access and outcome. We must adopt a different attitude when considering rural areas, although the rural population should not be unnecessarily disadvantaged by living in a rural area. In my area, general practitioners and community hospitals have different skills to those that are found in urban situations. There is much to be said for specifying the outcome that one wants to achieve, but not specifying how it will be achieved. For example, rather than seeing a consultant cardiologist, one might see a general practitioner who has received different training. We have not cracked rural deprivation—we must consider what that means in more detail. The analyses that we are conducting may not be sensitive to that issue, although much activity is taking place on considering exactly what rural deprivation means and how it should be defined.

Mr Hamilton: Do you support specific targets—

Dr Wilkie: Yes, but those targets must be different for rural areas. We must acknowledge the difference.

Ben Wallace: My first question is very basic. We heard from Dr Dunbar that often the person who shouts loudest, or who is successful at using the press in a time of shortage or crisis, will be heard. At board level, do you think that you are listened to enough to get your profile across? Your position is important—as Hugh Henry said, it is often more important than is recognised, especially when budgets are decided or when NHS priorities are set. Should we put pressure on the Executive to ensure that your area of work is given a higher priority than at present?

Dr Wilkie: I feel that I am listened to and am able to influence the board. The increasing emphasis on a health improvement programme, which encourages us to examine overall health, means that we are listened to. I agree with Dr Dunbar and do not disparage those who speak out about having a crisis in an intensive care unit, because that is an important area of the health service. Often, it is easier to identify an immediate flow of resources than a public health issue.

The situation has improved, but people often find it difficult to consider the long term. If investment in a public health matter is made now, we will see the benefits in 25 years. Politicians and others may find that concept difficult, and the committee could contribute to that debate by saying, "We have to take the long-term view". That would mean treating the sick—we must do that, as they will not go away—but trying to emphasise the long term.

There was a time when, as a director of public health, I could not have said that, but we feel that our opportunities for influencing the debate are increasing, although the situation is not perfect.

The Convener: I will take Dorothy-Grace Elder next and then—

Ben Wallace: I have not yet finished.

The Convener: We are meant to finish by 12 o'clock, and we have other agenda items, which I do not anticipate will take too long. If members still have questions and are happy to go beyond 12 o'clock by 10 or 15 minutes, so am I.

Ben Wallace: I will keep it short. I want to expand my question.

I am greatly impressed by the idea of extending the health promotion fund beyond the NHS. If we are to get to the roots of the problem, as happened in Finland, we will need that type of funding—drawing on education and social services budgets—to go into schools and to change attitudes. Is the way forward to make the health promotion fund, or a similar concept, more separate? I hope that, by being more separate, it would be able to gain support from other sectors.

Dr Wilkie: Colleagues with whom I have discussed the matter have said that there should be no more ring fencing, no more projects and no more bidding process, and that local people should be allowed to determine local priorities. As I said earlier, partnership work is easier if one comes to the table with some visible resources, rather than saying, "Here is my expertise and here are some resources in kind." I do not know if local authorities, which also seem pretty short of cash, would talk up having a health promotion fund. If we take a smoking project as an example, we should be saying, "Let's look beyond that project at what we're trying to do in the long-term and, by the way, here is some targeted money. Let's have some positive discrimination." I find that approach attractive, although within the services there is ring fencing and bidding fatigue. The general feeling is against ring fencing and for positive discrimination.

Dorothy-Grace Elder: I was glad to hear you mention breakfast clubs, which I think you said are part of the new project. That is a practical line to take. I do not know what you feel, but my guess is that the general public find health propaganda in videos and written works intensely boring and feel that it is finger wagging. People do not like to be finger-wagged; it makes them more stressed. What you are doing with breakfast clubs and what people are doing in other areas, notably Clydebank, is practical and immediate and you can build on it.

11:45

I am also thinking about this matter from an historic perspective, because I once did a series on food in history. We are now talking about 20-year plans, but at times of national emergency we were able to go for a quick fix to improve the dietary health of people so that they could man the factories and fight. For instance, at the start of the second world war, free orange juice was issued to children from toddlers up to six years of age, which greatly improved their health.

Mary Scanlon: You are not suggesting rationing.

Dorothy-Grace Elder: Mary, your own Churchill said:

"There is no finer investment for any community than putting milk into babies."

Dr Wilkie, are you thinking of expanding along those practical lines, such as the free salads that were mentioned earlier? The view was not that school meals in Finland were free, but that salads were offered free. Is that right?

Ben Wallace: In Finland they cut out unhealthy food. The only meals that were on offer were healthy and that was free.

Dorothy-Grace Elder: Someone said that the salads were free.

Ben Wallace: That was in public sector canteens.

Dorothy-Grace Elder: Would it be useful in Scotland to expand along those lines, given that we have a bit of a malnutrition crisis on our hands? It has been a creeping one, but it is a crisis.

The Convener: Irene Oldfather's question dovetails with Dorothy-Grace's.

Irene Oldfather: My question is about the nutritional needs of the elderly. You mentioned the cinderella services. I welcome the idea of breakfast clubs, but it is difficult to get funding for lunch clubs, for example, because they are not seen as health activities. In health improvement programmes, the nutritional needs of the elderly are sometimes highlighted as a priority, but it is difficult to translate that into funding from health boards.

I am attracted to the idea of a health promotion budget that would encompass various socially deprived groups. I would include many elderly people living in the community in that, because in some cases breakfast or lunch clubs keep people living independently in the community and save us tremendous amounts of money in hospital and residential services.

Dr Wilkie: In relation to free food, the important thing is not to import something from Finland if it does not work in Paisley. As I said, finding out what Paisley or Scotland want is more important than saying, "That worked there, so let's import it here." I do not know whether the Finnish intervention would be effective here. It is attractive, and needs to be examined. I am not sure what it would cost. As Mr Henry said, we have to change how we do things and not rely on projects, because projects finish.

With regard to the Paisley project, if we do not address sustainability from the start we will not have demonstrated value for money, because there may not be continuing funding. That might mean diverting resources from elsewhere if it is proven to be effective. That has to be the way in which we do things. I mentioned the breakfast club in Stirling, but such clubs are common and have proven to be good. If they are effective, go for it, but on whether to bring in a blanket policy for Scotland we have to ask, "Does that suit Scotland? Does that suit Paisley? Does that suit Stirling?"

Hugh Henry: Dr Wilkie is saying that it may not suit the whole of Scotland, but the results from Finland are so striking—and the similarities between the two countries are so striking—that we need more information. Duncan Hamilton said to me that perhaps we need a briefing paper on what has happened in Finland—

The Convener: I asked for that from our researcher about an hour ago. It is on its way.

Hugh Henry: We also need a briefing paper on the budget and the way in which the budget in Finland is constructed. I would also be keen to receive periodic progress reports from the project in Paisley, setting out what it plans to do and how it is going about it so that that can influence our thinking. At some stage in the future, I would like to hear more about this matter.

The Convener: I agree. From the figures and background that we have on the Finnish project, a radical approach that says, "This is how we do it" is called for. People should be able to walk into their hospital canteen and easily make a healthy choice and not look at the salad and say, "That is £1.60, or I can buy a pork pie for 90p." If the salad is free, everybody will take the salad, but that is radical and would have a cost attached to it.

I would also like some information on the public reaction in Finland over 25 years and on whether there was initially resistance to the project or a sense of despair that nothing that could be done, because I sense despair among all of us in Scotland that our health is just the way it is and that that is the way it will stay. Yes, we can improve on the number of people who are getting heart operations, but essentially we are a sick society. That is our position, but it should not be. I wonder whether that was the attitude of the Finns as well. Any initiatives must be easy for people to take part in. They should not feel that they are opting into something: it should just be there. This issue is also about attitude and saying, "We want to improve our health."

One issue follows on from the comments that were made, and we have been asked by the Finance Committee to address it. We hear about the sustainability of projects from time to time, anecdotally and in a range of different ways. You mentioned it yourself. With three-year projects, the tendency—this is an anecdotal comment—appears to be to say, "There is a really good project. Let's get a lot of good high-profile publicity out of the fact that we have put this together." When it comes to an end, instead of taking it forward and perhaps spreading it across the country, effort is put into moving on to the next high-profile project that the politicians or whoever can get another bit of good publicity out of. There does not seem to be a well-thought-through policy for sustaining these expensive projects when they come to an end.

The committee has heard examples of that. I have heard of projects in my constituency where there have been good health projects that try to encourage older members of the community to stay in the community. It requires relatively small amounts of money to retain them in their own homes and to help them, but then the project comes to an end and that is it—bingo. Well, they cannot go to the bingo any more because they are in hospital. We have to find a way through that. Do you have any sense of how the Paisley project will be taken forward at the end?

Dr Wilkie: I assume that the money will disappear at the end of the project. That is all that you can assume. I do not know the source of the funding, but that is what I am assuming. I assume that we will have to build in sustainability because what is the point of concentrating on Paisley if we do not get benefit—and what is the point for Scotland? That means that the project will have to become part of the health improvement programme, which allocates resources at a local level, and presumably—and not inconsiderably—become part of the community planning process that is led by local authorities.

The only way to ensure sustainability is to redirect resources. That has proven to be an effective way of making an impact, and that is what we are looking at in this project. Time will tell if we are doing it.

If we make it the null hypothesis that we will not receive this money after three years, sustainability will benefit only if we receive more money. Projects in my area have disappeared because the money is not available. However, it will be difficult to switch resources from acute services.

The Convener: Irene Oldfather made the same point about lunch clubs. We might be able to examine work by local authorities and voluntary sector organisations and label them as partner projects. Any evaluation should be seen more in the context of community health recognising that even though a project might not be funded by the health board, it might still have a beneficial health impact. We must have a more overarching community health view of projects that might be funded by voluntary sector organisations. That might be crucial for the elderly in rural areas, for example.

Irene Oldfather: A project in my area that is personed by Age Concern keeps 35 people in the local community who would otherwise be in residential care. In addition to the lunch clubs, the project delivers meals on wheels at tea-time. It cannot get any mainstream funding, even though it has worked hard to receive some core allocation. Although the nutritional needs of the elderly are identified in the health improvement plan, the project is perceived as having more of a social welfare function and as not meeting real health need. We must change our thinking on some of these issues.

Dr Wilkie: Some people—a cardiac surgeon, for example—would say that that is not a valid use of a hard-earned health service budget. However, public health projects are meant to reduce demand on the health service by transferring responsibility to the community and there might have been some pump-priming to help that process. I would welcome using a small part of the total health budget for public health projects.

Irene Oldfather: Are the nutritional needs of the elderly are an important aspect of this health promotion?

Dr Wilkie: The elderly tend to be ignored; indeed, some of our health targets are for people under 65. Presumably Dr Williams has recently spoken to you about the needs of the elderly. There is a feeling that there is an agist attitude to the matter. Certainly our local dieticians have conducted their own survey and found that the elderly's nutritional needs are not being met, which is perhaps a universal finding.

The Convener: Dr Wilkie, thank you for your useful and informative contribution. You can tell from the range of questions that your evidence has set us off down several roads, not all of them leading to Paisley or Finland. I also thank committee members for their questions. In light of the fact that this was our first proper discussion about the budget, the discussion was useful and raised some very interesting lines of questioning.

Subordinate Legislation

The Convener: The second item on the agenda is consideration of subordinate legislation. The first instrument, the National Health Service (Travelling Expenses and Remission of Charges) (Scotland) Amendment Regulations 2000, is a negative instrument. As no motion has been lodged recommending that nothing further be done, I suggest that the committee does not wish to make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement.*

The Convener: The next instrument is the National Assistance (Sums for Personal Requirements) (Scotland) Regulations 2000. This is another negative instrument and no motion has been lodged recommending that nothing further be done. Again I suggest that the committee does not wish to make any recommendation in relation to this instrument. Is that agreed?

Members *indicated agreement.*

The Convener: The third instrument is the Genetically Modified and Novel Foods (Labelling) (Scotland) Regulations 2000. Again, no motion has been lodged recommending that nothing further be done under the instrument and I suggest that the committee does not wish to make any recommendation in relation to this instrument. Is that agreed?

Members *indicated agreement.*

Petition

The Convener: The next item on the agenda is consideration of petition PE80 from Mr Frank Harvey calling for the Scottish Parliament to order a public inquiry into the NHS in Scotland to establish what facilities are needed and how long people are waiting for treatment. My suggested recommendation is to note the petition.

Members *indicated agreement.*

The Convener: Thank you very much. As far as I am aware, that is the end of the meeting.

Meeting closed at 12:01.

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