HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 31 May 2000
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE
† 15th 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 MEMBERS ALSO ATTENDED:

Christine Grahame (South of Scotland) (SNP)
Iain Gray (Deputy Minister for Community Care)

WITNESS

Sir Stewart Sutherland (University of Edinburgh)

CLERK TEAM LEADER

Jennifer Smart

SENIOR ASSISTANT CLERK

Irene Fleming

LOCATION

Committee Room 1

† 14th Meeting 2000, Session 1—held in private.

Scottish Parliament

Health and Community Care Committee

Wednesday 31 May 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:40*]

The Convener (Mrs Margaret Smith): The first item on the agenda is to decide whether we wish to take agenda item 6 in private. Is everyone agreed that we take that item in private?

Members *indicated agreement.*

The Convener: Is everyone happy that the time limit for agenda item 2 be five minutes rather than 15 minutes?

Members *indicated agreement.*

Subordinate Legislation

The Convener: Good morning, minister. You are here to move a motion on an affirmative instrument, the Scotland Act 1998 (Transfer of Functions to the Scottish Ministers etc) Order 2000 (SSI 2000/draft). Will you formally move that motion?

The Deputy Minister for Community Care (Iain Gray): Good morning. Before I move the motion, I want to say a couple of things. I do not want to go through the whole order, but I will give a word of explanation.

The Scotland Act 1998 recognised that in some cases it would be appropriate for Scottish ministers to be able to exercise executive powers in areas in which primary legislation continues to be a matter for Westminster. The order covers one area that is of particular interest to the committee: the Nurses, Midwives and Health Visitors Act 1997.

The National Board for Nursing, Midwifery and Health Visiting for Scotland is an executive non-departmental public body. During the passage of the Scotland Act 1998, it had been assumed that control of the board would be devolved to the Scottish Parliament and Executive. That did not happen, as the board is part of the UK regulatory framework for the nursing professions, which is a reserved matter.

The UK Government and the Executive agree that, to give the board a particular Scottish role, responsibility for it should rest with Scottish ministers. Therefore, the purpose of the order in this area is to transfer to Scottish ministers all the ministerial functions under the Nurses, Midwives and Health Visitors Act 1997 as they relate to the National Board for Nursing, Midwifery and Health Visiting for Scotland.

I do not propose to talk about the other entries in the order, the details of which have been set out in the Executive note, but I am happy to respond to any comments that members may have.

The Convener: Does anyone have any questions or points of clarification?

Dr Richard Simpson (Ochil) (Lab): Can the minister confirm that the functions of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, which is the registration body, will remain with the UK? Will the board be able to determine the work—the appropriateness of particular tasks—of nurses and midwives?

Iain Gray: The regulation will indeed remain with the UKCC, which is a reserved body under the Scotland Act 1998. The most important function of the board is probably nursing and midwifery education. As the Executive note explains, it is intended that the board will be abolished in autumn next year, when it will be replaced by a Scottish nursing and midwifery education council, which will bring education in these professional areas clearly under devolved responsibility.

Dr Simpson: That is helpful.

The Convener: If there are no more points, I shall ask the minister to move the motion formally.

Motion moved,

That the Parliament's Health and Community Care Committee in consideration of The Scotland Act 1998 (Transfer of Functions to the Scottish Ministers etc) Order 2000 (SSI 2000/draft) recommend that the Order be approved.—[*Iain Gray.*]

Motion agreed to.

The Convener: The next item relates to two negative instruments. The first is Food for Special Medical Purposes (Scotland) Regulations 2000 (SSI 2000/130). No motion has been lodged recommending that nothing further be done under the instrument. After consideration of the instrument, the Subordinate Legislation Committee determined that the attention of Parliament need not be drawn to it. I suggest that the committee should not make any recommendation in relation to this instrument. Is that agreed?

Members *indicated agreement.*

09:45

The Convener: No motion has been lodged recommending that nothing further be done under

the second negative instrument, the Colours in Food (Amendment) (Scotland) Regulations 2000 (SSI 2000/131). After consideration of the instrument, the Subordinate Legislation Committee determined that the attention of Parliament need not be drawn to it. Again, I suggest that the committee should not make any recommendation in relation to this instrument. Is that agreed?

Members *indicated agreement.*

Community Care

The Convener: We will move to agenda item 5, which is evidence from Sir Stewart Sutherland to our community care inquiry.

Good morning, Sir Stewart. Do you wish to make a statement before we ask questions?

Sir Stewart Sutherland (University of Edinburgh): I will happily make two or three points to set the context. I delivered some bullet points to the clerk of the committee, which members may have seen. I will run through them.

I start by giving a little vignette and a symbol. Our students are all taking examinations at the moment, so as I walked along Chambers Street to come here, they were flowing towards the examination halls. In such circumstances, one overhears conversations and single sentences out of context. The sentence that I heard was, "I find all that aging stuff a bit depressing—don't you?" Out of context, one can understand various things by that. It could tell us that aging is a bit depressing for some people—I suppose that if one is under 23 one is not thinking what it is like to be just over 80. The implication is that we are not too keen to talk about the subject. That is one of the points of context that should be firmly understood.

Another interpretation is that those students could have been medics, social workers or nurses—or they could just have been people who are a bit reflective. Although the notion of aging may be depressing, I have found that it is an issue that has to be pressed—we have to face up to realities that we would rather went away.

The symbol on the front of the Sutherland report is a Rubik's Cube. The choice of that symbol was deliberate. We have got many of the squares on the cube in position, but we do not have them all in position—the context is shifting. There are many issues in this area that one could not deal with, even in a year's work or in the lifetime of the committee. There will always be snags in the corners.

However, a big picture did emerge—there is a picture of granny with grandchild. The context that is indicated is the demography that we are facing. Over the next 10, 15, 20 or 30 years—we were asked to consider the position until 2050—the shifting pattern is dramatic. The report gives the number of people aged over 65 in the past century—there has been a good census record, with only one or two gaps. The increase in the number of people aged over 65 has been very dramatic.

An interesting fact to note is that the demographic shift has been gradual—it has taken

place over 70 or 80 years. We have coped with that—not as well as we should—but it is not a time bomb. The shift continues. It is always dangerous to make predictions, but we estimate that, on current projections, by about 2050 the number of people in the population over 85 will be three times greater than it is now. That is a big shift, and it makes a huge difference to how we view the change in the shape of the population and the importance of, if not the problem, then the issue that faces this committee.

I would like to pick out two or three things that I regard as important and that the committee may want to focus on at some point. The first is the issue of national health service and local authority funding streams, which is, I know, of interest to the committee and which was a major element of our report—although it was not fastened on to in the way that other aspects of the report were. Those funding streams must be brought together. Individuals who are looking for care for themselves, their relatives, their neighbours or their friends need a single point of entry. If there is a single point of entry, there must also be a single point of commissioning, which would probably be team commissioning. Logically, that takes us on to a single point of funding. The way in which the money is put into the system at the moment is inefficient and we do not get as much for our money as we should. As long as that is the case and there are people in need, it is an administrative scandal.

Secondly, more money is needed. We were up front about that. We could have asked for £8 billion a year, because if we had put together all the reasonable requests that we received, that is what they would have added up to. We could have asked for £4 billion, because there was a very strong case for asking for that—if one includes support for carers, for example. However, we paid attention to our remit, which was to take account of the financial situation, and pressed the sum down to £1 billion in 1995 prices. That sounds like a lot, but I am happy to defend the figure, if the committee would like me to do so. Additional funding is an issue that must be faced. It is the one issue that the Westminster Government has not yet shown any signs of facing.

The report's comments on the role of the private sector are one aspect that has not been picked up. However, the possibilities of public-private partnership would be significantly enhanced, and streams of investment from the private sector could be levered up, if our proposals were taken on board. That would not be injurious—quite the reverse. One of the difficulties with the delay in responding financially to the report is that there is at the moment a potential stream of money from the private sector that is not being invested. We may pay for that in future years. There are some very good private sector care homes. There are some that are not so good, but the same is true of the public sector. If the private sector stream of funding has seized up because of uncertainty, money is being lost to those who need the infrastructure to be in place.

I will stop there, as I have highlighted some of the key issues that need to be raised.

The Convener: Thank you very much, Sir Stewart. I am glad that it is your students sitting exams and not me. It is depressing that when they spoke about aging they were probably thinking about people around my age as much as about people aged 80.

As you can imagine, every member of the committee would like to ask you at least one question. We have until about 11.30 am to get through them.

Kay Ullrich (West of Scotland) (SNP): Sir Stewart, could you outline for us the time scale that was envisaged for the implementation of the key findings of the royal commission?

Sir Stewart Sutherland: The current Government came into office in May three years ago. In late July or early August I, along with two or three others, was approached about the possibility of serving as chair of the committee. There was pressure for me to say yes or no very quickly, with a view to setting up the committee very quickly. We agreed that the work of the commission should take one year. In fact, for various reasons—I do not know all the details—the commission was not set up until December 1997. However, we had a year's work in 1998, which involved one meeting a month along with everything that went on in between. By the end of 1998 we had agreed our main conclusions; it took a couple of months to dot the i's, cross the t's, get the report printed, get the Queen's permission, and get the report out. We assumed that real speed was needed, so we got on with the work. Sadly, it has been a year and two or three months since we reported and the big issues have not been faced.

Kay Ullrich: Have you any opinions on why that is the case? The report was to be done within a year and it seemed as though the Government intended to push this issue forward. However, as you say, it has been a case of hurry up and wait.

Sir Stewart Sutherland: Yes. Maybe, like my students, the Government finds talking about this issue depressing, because tackling it will cost money. I would not like to speculate on why there has been a delay. We did a job, to the best of our ability and on time, and it is the Government's duty to respond. I have been reassured that there will be a response in the summer, in connection with the comprehensive spending review. I have also

been told—and I can see how this could be the case—that the advancement of the comprehensive spending review one year meant that the report would best be taken in that context. Had the comprehensive spending review not been brought forward a year, there might have been a stronger case to push for a quicker reaction than we have had.

Kay Ullrich: We have been talking about the Westminster Government. What role do you see for the Scottish Executive in implementing the report?

Sir Stewart Sutherland: I hope that you will give strong support to the relevant spending departments—whether in Whitehall or in Holyrood—that will make the case for increased spending in this area. That is probably the most important thing that you could do at the moment. I hope that that will mean that a reasonable proportion of funds will be made available for care of the elderly.

I would be reluctant to suggest—although some people have asked for this, and it may lie behind the member's question—that the Scottish Parliament should say, "We will spend X on this now." It is important that we should get a share of the UK cake, which is where most of the money is currently found. However, if there were any indication that money was being made available for care of the elderly, I hope that the Parliament and the committee would be ready to move very quickly to implement the report.

Kay Ullrich: Are you saying that, if it found the money, the Scottish Executive could implement the report's main recommendation—the abolition of charges for personal care?

Sir Stewart Sutherland: If it took the money out of something else, it could. That is a matter for the Executive and members of the Scottish Parliament. However, it is important that we increase the flow of funds into Scotland specifically to serve this sector.

Kay Ullrich: Of course we should get our share of the UK cake. As I assume you are aware, we have had numerous debates on community care. The Executive always insists that it is implementing parts of the commission's report. What is your opinion of what has happened so far?

Sir Stewart Sutherland: The moves that have been made to deal with one of our main recommendations—that there should be a national care commission—represent a good start. There have been moves in that direction both here and, to some extent, at Westminster; announcements were made around the same time in December.

One of our key findings related to the variation from one local authority to the next in provision of care for people who require it. That is why my list includes the bullet point, "Post-codes and Long Term Care". The fact that the Scottish Parliament has moved to put in place a system that will produce national benchmarks, so that every old person in Scotland can have comparable expectations of care, is tremendously important. The work that has been done on that is very positive.

It is also important that quality-assurance mechanisms should be put in place. Some moves are being made in that direction. We were not convinced that the current situation was a sensible way of proceeding, as it involves local authorities, many of which do an excellent job within their budgets—I am not canning them—both quality-assuring other institutions and being in the market. We felt that there should be a separate, independent way of testing how good the provision was, whoever provided it. As I understand it, specific proposals have been made to deal with those key points; all credit to you for that.

Kay Ullrich: Has anything else that the Scottish Executive has done so far met with your approval?

Sir Stewart Sutherland: Oh, lots of things—

Kay Ullrich: I mean in relation to the work in your report.

10:00

Sir Stewart Sutherland: The most encouraging thing, to my mind—and this committee has led the Scottish Executive in this—is the level and quality of debate in Scotland. Our commission, operating across the whole of the UK, remarked on the quality of evidence that came from the various constituents in Scotland—people in the charities, the health sector, the Government, and the local authorities. I did not have to point out to my colleagues south of the border that group X or Y had sent a very good paper; they knew.

The evidence showed that people really were concerned about these issues and that the debate had advanced significantly in the past year. That is to the credit of the Scottish Executive; I assume that this committee had taken a lead in pushing that. I have appreciated the direct interest that has been taken by many of you around the table and by many other MSPs as well. The Scottish population has noticed the level of your concern.

The Convener: The committee has been keen to play its part in ensuring that this issue is kept on the agenda. When we came to the Parliament last year, some of us were concerned that it had been popped up on the shelf in the hope—because of the £1 billion that your recommendations might cost—that it would go away. I would like to ask

you about your willingness to defend that figure of £1 billion. Is that a realistic figure?

In relation to the area covered by your report, we want to know what is in the remit of Westminster and cannot be taken away from Westminster, and what can and should be done in the Scottish Parliament. I think that you are saying that, at this point, it is reasonable to do what the Executive is doing and wait till the summer and the comprehensive spending review. You are also saying that some of the work that the Executive has done on these issues is to be welcomed. What do you think the timetable of the Executive and the Parliament should be? What about the cost of implementing your suggestions? What should the Executive and the Parliament be doing? The answer to that is important, given that there could be a difference of opinion between Scotland and Westminster. These issues are of great importance to the people of Scotland and across the parties in the Parliament.

Sir Stewart Sutherland: We have waited 15 months since the report was published and I have been assured—doubtless you have as well—that the CSR is due to be complete this summer. That means waiting another two months, so I do not think that it would be sensible to say that we should suddenly, in those two months, do all the things that some of think should have been done a year ago. It would be sensible to wait and see what money will come through.

If more money comes through for health in general—and all the signs and public statements have led us to believe that it will—I hope that the case for this area of health care will be strongly made to your ministers. That is very important. I believe that ministers are seized of the importance of this issue—their mailbags are full because Scottish people have kept up the correspondence.

As soon as the CSR is announced, there should be pressure to determine how much money will go towards this issue. Many of the recommendations that we made can be developed without further legislation. Some of them may require legislation, although I do not know the intricacies of whether that would happen here or at Westminster. For example, you could still encourage a single stream of funding, even though that might take some time to bring about legislatively.

Good experiments and pilot schemes are going on around the country, and that could be accelerated. Why do you not do a bit of pump-priming for those who are making moves and getting ahead with the business of a single stream of funding? For a comparatively small sum of money, you might learn a great deal. There are people in Scotland and elsewhere who are working hard on single streams of funding. We could be finding out what difficulties they are having. We could be getting on with that now—I hope that we are getting on with it now. Is there a central perspective on how well the work is being done and on where the best practice is? There will be best practice, so let us find it and use it as a model for the future. That is something specific that could be going on; it would be good preparation for considering budgets again in future.

The Convener: Do you still stand by the figure of £1 billion? Is it still a reasonable figure to attach to your recommendations?

Sir Stewart Sutherland: Yes. A worry that was expressed to me—although not as openly as it should have been, as it was muttered in the background to journalists—was that if the figure is carried forward for 50 years it looks massive. If you carry current practice forward for 50 years it looks massive. Even on current expenditure, our reckoning was that, 40 years on, the figure would go up to £27 billion. However, if you look at it not in hard cash terms, but as either a percentage of gross domestic product or as a percentage of the tax take on earnings, pensions and investment—not just pay-as-you-earn tax—the percentage is not huge and it does not vary over the years. We are asking for 0.1 per cent of GDP—only 0.1 per cent—for an increasingly large proportion of the population. That 0.1 per cent remains a constant throughout the 50 years of our projections.

The numbers have been crawled over by those who would love to have found mistakes in them. If there had been mistakes, we would have heard about them on day two. There are no mistakes in the numbers. I have been cross-examined by other committees elsewhere and in public meetings by folk who have been ministers in Westminster. They know that our assumptions about growth and GDP on all public spending are the same as those used by the Treasury. If our assumptions are out, you can look forward to cataclysm.

Dorothy-Grace Elder (Glasgow) (SNP): What are the projected population figures that you—

The Convener: Dorothy-Grace, please speak through the chair. Richard was lined up to ask a supplementary.

Dorothy-Grace Elder: I am so sorry, Richard.

Dr Simpson: That is all right.

Sir Stewart Sutherland: I look to the convener for which question I should answer.

The Convener: Answer Dorothy-Grace's question, and then we will come to Richard.

Sir Stewart Sutherland: In 1995, about 9.5 million people were over the age of 65. I am sorry, but we did not get disaggregated figures for

Scotland. I asked for them, but apparently they are not easy to provide.

The Convener: That is a common problem.

Kay Ullrich: As ever, "These figures are not held centrally."

The Convener: That will be on our tombstones.

Sir Stewart Sutherland: That is the answer that we ran into as well. The figure was 9.5 million; five years on, it is more than 10.5 million. We projected that it would rise to 15 million by 2030 to 2040 and that that would be 25 per cent of the UK population. I have no reason to think that the Scottish figures will be disproportionate, so you can do your own sums.

Dr Simpson: I have to declare that I am a member of the Royal College of General Practitioners, I am a director of a nursing home company and I have research interests in dementia.

You have spoken of single entry, single commissioning and single funding streams, which are important. The Scottish Executive is funding some pilot schemes—in Perth and Kinross, for example. There is also a project in Aberdeen involving a long-stay hospital that is now run jointly by the health board and the social work department. Those are important schemes.

My question is about equity, and it relates to your concept of single access for everything. If long stay for the elderly is retained—and some will be—should that not be funded on a similar basis to the rest of your proposals? If it is not, we will continue to have an inequitable situation, in which some people are fully funded within the health service for care that is being provided, sometimes almost to the same level, by the independent sector, the local authority sector and at home, where the costs are met according to a different pattern. Did your committee consider that as a way of reducing the costs and producing a horizontal pattern of equity to replace the current inequity?

Sir Stewart Sutherland: Yes. We went back to basic principles, as you have clearly done in your thinking. We started with someone in need. We discovered quickly that if a person is in need, the amount that they pay for the care that they receive depends on where they are. If they happen to be in a national health service hospital, the care comes free, except that their pension book is taken away from them—pensioners are the only section of the population who are treated that way. If they happen to be at home, help is means-tested and depends on the local authority's policy, willingness and the amount of money that it has. Whether and how much you pay depends on where you are.

We agreed with the principle, which is implicit in what you are saying, that there should be a single table. Means-testing should apply to the roof over your head, the food you eat and heat, wherever you are, but personal care should be free, wherever it is provided. There is an important principle of equity behind that. For a variety of reasons, we believed that the principle that informs the national health service—spreading the risk over the whole population—should apply. The danger of a catastrophe befalling an individual should not be compounded by the fact that if the particular catastrophe is Alzheimer's or dementia rather than a heart attack, the individual will have to pay for their care. That seemed quite inequitable.

We also thought about efficiency of spend and studied the situation in the United States. It is much more efficient in terms of the gross national product to spread the risk over the whole population. The USA spends more per head on long-term care than we do, but the money is spent in bits and pieces and the risk is spread across the health service in a variety of ways. They get less for their dollar than we do for the equivalent pound. Nick Barr has done interesting research on that. We took that principle and said that it was more efficient to spread the risk over the whole population—you get more for your money and it is more equitable.

Dr Simpson: When you pool the budgets, as you propose, do you include the total long-stay health service budget?

Sir Stewart Sutherland: Yes.

Dr Simpson: If that is included in the £1.1 million, it takes into account what I suggested in my first question, that the system of payment for long-stay health care would change.

Sir Stewart Sutherland: That is right.

Dr Simpson: That is an important principle. It is interesting that it was recently reported that 40 per cent of bankruptcies in the United States are due to medical bills. Whatever we do, we want to avoid that.

Sir Stewart Sutherland: Yes.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): The recommendation on personal care has been the most controversial. Do you envisage any difficulties in implementing that definition of personal care?

Sir Stewart Sutherland: Yes. [*Laughter.*] Shall I go on?

There will be a commitment to providing resource. If there is not, there will be an almighty hullabaloo among the electorate—we should be plain about that. If I were in charge of the money,

and had a mean mind, I would say that expenditure could be reduced by defining down personal care, and eliminating certain things. As members are well aware, the definition of personal care is a complex and contentious matter. That is why we spent a lot of time on it. There is a whole chapter in the report on the definition of personal care.

We believe that our definition can be used practically. Our proposal was not that care be given free on demand, but on assessment. Assessed need will be the definition for the release of care resource, which is important. The haggling that will go on will be over how personal care is defined. If it is defined simply in terms of nursing care as that is provided within the NHS, the recommendations in the report will be significantly undermined.

Malcolm Chisholm: There have been some trails to that effect, but I hope that they are not accurate. What would your response be if the announcement in July was that only nursing care would be free?

Sir Stewart Sutherland: If only nursing care as currently defined is free, a dual funding system will still be in place, which will bring the inefficiencies to which I have alluded. There will also be a dual commissioning system. Who gives the famous bed bath? A nurse or a social worker? If it is a nurse, it is free and if it is a social worker it is not. If you are 75 and suffering from dementia, you can do without complications like that. On top of that, administrative resource is wasted, because everything has to be accounted separately. If the definition is nursing care as currently provided free in the health service, most of the main problems will remain and the Government will have to come back to the issue in three years' time.

10:15

Mary Scanlon (Highlands and Islands) (Con): My question is about which obstacles you thought were most likely to arise in the implementation of the key recommendations. Finance is obviously a major obstacle, so I seek some clarification of the figures before I ask about any other obstacles. When you talk about £1 billion, you mean UK-wide. Am I right that we are talking about £110 million in Scotland?

Sir Stewart Sutherland: That is the figure my long division sum came up with.

Mary Scanlon: It is therefore slightly scary and misleading to talk about £1 billion here.

We are attempting to unravel the NHS budget in Scotland. Does the £110 million allocation have to be new money? I remember the famous £750 million that went into a black hole. Is it not the case that if patients were properly and appropriately treated, there could be a shift of resources from elsewhere? Is there an opportunity to take the money from elsewhere?

Sir Stewart Sutherland: There are two elements to that. We did not press the point too strongly because we could provide hard figures for the £1 billion. The Treasury puts headings on various columns for education, pre-nursery schooling, social work, housing benefit and so on and the local authority gets the sum of those columns as a single line budget. It is up to the local authority—properly, because that is what local democracy is about—to decide what money is spent on any one of those headings. That is how the local authority budget is calculated. I presume that it is much the same in Scotland.

As you suggested, at the time, £700 million was being pencilled in for long-term care of the elderly in England and Wales. We discovered that if there were cuts—local authorities were all under pressure—the budget for long-term care of the elderly was quite systematically raided. There was a gap of £700 million between what was pencilled in and what was spent, which is a lot of money. Statutorily, it is a matter for the local authority, but if everyone is raiding the same budget, it could be because it is depressing to talk about old age and there are other things that catch the eye better.

Mary Scanlon: If we took the figure for Scotland, we would be two thirds of the way towards funding your recommendations.

Sir Stewart Sutherland: I drew the matter to the attention of ministers in the new Executive early on and they were already examining it. If the same applies in Scotland, it would be reasonable for members to pursue it with them to find out whether the situation is the same here and, if so, whether there is any way of redirecting the money to where it was initially intended to go. That is one element. Since the money was a contentious matter and I had non-elected advisers telling me we had got our numbers wrong and we were misunderstanding—although we did not get it wrong and we were not misunderstanding—I thought there was no point in majoring on it because that would then become the point of argument, rather than the needs of old people.

The sheer inefficiency of the perverse incentives built into two funding streams suggests a second area of possible other resources. Again, we could not put a hard figure on it because we did not have time to do the research to support such a figure, but if that inefficiency could be taken out of the system, there is bound to be money there as well. I did not want to do anything to encourage the Government to say that the money is all in place, because it is not and there must be new thinking. However, you are right—there are ways in which

some money in the current budget could be redirected more effectively and, as a taxpayer, I would welcome that.

Mary Scanlon: The single point of entry and of funding would reduce duplication in the service and bring some savings. If I could move on—

The Convener: Kay Ullrich has a supplementary question on this issue.

Kay Ullrich: I agree with Sir Stewart. It is very depressing to see, in the recent cutbacks, how many local authorities have cut services to the elderly and packages for long-term care. Evidence we had from the Association of Directors of Social Work acknowledged that, in many local authorities, funding earmarked for community care was being spent on other areas of social work. As an ex-social worker, I understand the problem they raised of the statutory duties in child protection and family work, but is there not a statutory duty on local authorities to provide community care?

Sir Stewart Sutherland: It is one of their statutory duties. When I pressed that point in public last September, some social work departments felt I was getting at them. I was not; I understand the pressures that they are under. The money is being spent on real needs. I am not criticising that, but if there is not enough money and it is all being trimmed from roughly the same area, that has to be corrected.

Kay Ullrich: An average local authority will have perhaps 150 people on a waiting list for long-term residential or nursing care and we had local authorities saying last year that they had enough funding to offer that care to five or six people a month. Those local authorities are now saying that because of cutbacks they are only able to provide for two or three more people a month. That creates a waiting list that will never shorten, only grow.

Sir Stewart Sutherland: Yes. I have a question. Could I have a cup of coffee?

The Convener: Dorothy-Grace, will you do the honours? She is one of our more versatile members. She will get the coffee.

Dorothy-Grace Elder: He deserves a cup of coffee.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): When your commission was taking evidence, did you discuss with health authorities how they transfer money from long-term care establishments that they are closing down to projects in the community? Perhaps there are pointers you can give us since some of us have problems with health authorities that say that the money has been transferred yet we cannot find it.

Sir Stewart Sutherland: We employed equal opportunities in our critical questioning and everybody came under the commission's scrutiny. There are problems because, as we know, health authorities are staggering under major demands and sometimes there are fluctuations over the year with flu crises or whatever. One of the points we stressed is that if our recommendations were adopted, a number of beds currently filled by people who could reasonably move out of relatively expensive hospital care could be emptied, which would ease the pressure on other areas of the health service. That is one of the efficiencies that could be built into the system if there were not two funding streams.

I am not criticising particular executives or officers. They have a hard job. If you are a budget holder you are, quite properly, responsible for spending that budget with a pretty narrow focus. We are saying that those fairly narrow points of focus need to be brought together so that you get more for the money.

Kay Ullrich: We discussed the wide variations in home care services earlier. Different authorities have different charging rates, which is not fair. What can be done to bring more equity into the system?

Sir Stewart Sutherland: I endorse what you said about the difficulties of variation. I still get quite a lot of unprompted post from all over the country. People with problems write to me—it is a kind of constituency postbag. One of the things those letters show clearly is that people are treated differently in different parts of Scotland, England and Wales. That really will not do. What can and should be done is to set a national benchmark of expectation for the whole country, just as in principle we should have and, by and large, do have in the health service, so that, wherever you are, you know what you are entitled to and so that the local authorities or health services know what they are required to provide. That is a role for the care commission and is the first and most important step.

Kay Ullrich: Can anything be done on guidelines on upper and lower limits for payments for services?

Sir Stewart Sutherland: That would be part of the benchmark in expectation. That could be done whatever was done about the rest of the proposals—saying that there has to be an equitable expectation, which means that charges should be comparable and a similar system of means-testing, if that is retained, should be used.

Margaret Jamieson: Do you think there should be a timetable for the Scottish commission for the regulation of care to make an impact on the quality of services?

Sir Stewart Sutherland: In principle, yes. I am no longer supplied with detailed information on what this or the Westminster Parliament is doing so I have no details on that other than press reports. That is the difference between being chairman of a commission and someone for whom it is the night job, so to speak. If there are particular points you would like me to comment on that would require me to read some of the detailed information, I would be happy to do so and to give you a written reply.

Margaret Jamieson: My personal observation is that the commission has been side-tracked before it is up and running by being given other areas to look at, such as pre-five education. That widens the concept of community care and may present the commission with some problems.

Sir Stewart Sutherland: I would be sorry to see that but I can see the pressures that might lead to that.

Malcolm Chisholm: From what you understand about the Scottish commission for the regulation of care, are there any key elements of your recommendation for a national care commission that have not been taken up and that we should press for?

Sir Stewart Sutherland: A major element of our proposals for a national care commission has not been picked up here or at Westminster. That relates to something that we called the funnel of doubt. That is apparently an expression that economists use: as one projects the future, the variables that one uses may vary hugely. If one tries to plot a graph, either on population growth or expenditure, depending on the variables one can either be wildly out optimistically or wildly out pessimistically. That is the funnel of doubt as it appears on a graph.

10:30

Predicting the future is a fool's game, but one must try to do it. One of the things that we intended the care commission to do was to consider how the variables changed over time and, as a result, come to a fresh and independent view of what the bills would be as those variables shifted. Of the national bills for care provision, some might shift in one direction and some might shift in another. For example, there will no doubt be significant shifts in the treatment of Alzheimer's in the time period that we are talking about. To cite another example, the cost of treating ulcers on the health service has been reduced dramatically, as people no longer have to have major operations.

Depending on the shifts that take place in the treatment of other illnesses, costs could go down. Equally, the number of people who are in the post-65 age range is rising, so the costs could go up. It is on such variations that, over three, five or 10 years, we wanted the care commission to consider and provide independent—and I stress that word—advice to the Government. That is what the Royal Commission on Long-Term Care was intended to provide, and we foresee the need for that to continue in the future. That is a major element that has not been picked up.

Mary Scanlon: We have talked quite a lot about financing and resources. Did the Royal Commission on Long-Term Care envisage any other obstacles arising from the implementation of its recommendations?

Sir Steward Sutherland: Obstacles? Well, human nature. Folk do not like spending money. There are also entrenched positions. I would not want to make too great a song and dance about this, but one of the good things about the commission was that it included people who had long experience of working in nursing, medicine, social work, general practice and hospital medicine. We had to bring their minds together, which was one of the delightful functions of the commission.

Over the year, those minds came together. They heard all the siren voices from their own professions—that is always a difficulty—but those professions all signed up to the recommendations of the commission. The royal colleges of nursing, medicine, surgery and general practice all signed up. In the same way, the social work departments and the Association of Directors of Social Work signed up. We brought all those entrenched interests together. We were lucky—we did it through a broad-brush approach. Those professionals must now come together at the grass roots, and, while they are still defending their budgets—as they are required to, which is why the single stream is so important—that will continue to be a difficulty.

Mary Scanlon: In the evidence that we received, I was alarmed to hear phrases such as "cultural incompatibility" and "attitude professional preciousness". As the chairman of the Royal Commission on Long-Term Care, how would you recommend we knock those heads together and get the professionals to put patients first?

Sir Stewart Sutherland: I believe in education. You should continue to educate. However, the blunt way in which to get the professionals together is to take the budgets out of their hands and put the money into a single pot. However you organise the distribution of that budget, that would sure shift people's cultural prejudices.

Mary Scanlon: I am glad that you said that. I think that that is what we are looking for.

Sir Stewart Sutherland: Should I have a prompt sheet? [*Laughter.*]

Mary Scanlon: Earlier, you mentioned primary legislation and said that a single stream of funding could be introduced, which would ensure the adoption of best practice. Are there any specific elements of your paper for which you feel that we would need primary legislation in Scotland?

Sir Stewart Sutherland: Particularly for the single stream of funding, so that it becomes that on more than a voluntary and local basis. That is the key to the central concerns of the report.

Mary Scanlon: Let me put the question another way. Do you still believe that it is not necessary to introduce primary legislation to implement most of your recommendations?

Sir Stewart Sutherland: Primary legislation may be necessary for a great many of those recommendations, especially for those that are associated with the care commission, the setting of benchmark standards and the new monitoring processes. However, I do not know whether specific points of legislation are for this Parliament or for Westminster.

For example, the commission wanted local authorities to have the power to make modest loans of some £1,000 against the value of a house. Someone who can no longer climb stairs may be living in a house with two storeys. For a small sum of money, a downstairs shower and bathroom can be installed and they can continue to live there. Some people are prepared to borrow money to do that, against the value of the house that they own. For local authorities to be able to make such a loan—and I understand that the threshold was £1,000—legislation would be required. You would have to consider what sort of legislation would be necessary here. What a difference that would make, though. People would remain where they want to be—in their own home—and it could maintain the quality of their life for 10 years or so.

The Convener: We all receive letters about that kind of situation, from people who are waiting for a shower or a step-in bath. Some people cannot stay in their own homes because they do not have a stairlift, which would be quite cheap to buy. If the alternative is to put them into a long-stay bed, which would cost £1,000 a week, buying the stair-lift and allowing them to remain in their own homes with their families is a much cheaper option.

It comes down to a lack of common sense. What you are saying is that we should try to find a way to bring all the services together through having one funding pot, to tackle some of that stupidity. Irene Oldfather has a supplementary question, which may take us back a stage.

Irene Oldfather (Cunninghame South) (Lab): Over the course of our inquiry, we have found that policies are not always translated into action. You have mentioned the establishing of national benchmarks and the pooling of budgets, which would ensure that quality control. However, witnesses have spoken to us about the need for local democratic control over health service providers. Did your commission consider that? Was that within your remit, and did you experience any problems with that?

Sir Stewart Sutherland: It was slightly outside our remit, but was connected to it.

I have stressed the need for national benchmarks. It was put to us that national benchmarks are fine, but conditions vary in different parts of the country, and I accept that completely. Although the national benchmark might say that everyone must live within half an hour of an acute hospital, it would not apply to people on Barra and Skye, and in other remote places. There will be local variations, and a natural way of taking those into account would be to involve the local community in deciding which of the variations apply. A benchmark cannot be varied simply by administrative fiat, and I am sure that you are considering the appropriate mechanisms for involving the community in deciding whether a variation is reasonable.

Irene Oldfather: Do you have any views on how that might be done? Would it be through the pooling of budgets, drawing together social work and health departments and introducing councillors, or would it be through community councils? Do you have any expectations?

Sir Stewart Sutherland: It could be done through the pooling of budgets—that is a theme that I keep to, as it is central to everything in this discussion apart from the additional cash.

The other means of monitoring the situation concern all the things that should apply in democracies: the transparency of activities and spending and the availability of information in a readily digestible form. You are here because you are elected; you will stand for election again and will be judged on what you have done.

The Convener: Thanks for reminding us. It never does us any harm to be reminded of that.

Could you tell us in sharp terms exactly how the pooling of budgets will happen? Who will hold the purse-strings? Who will control that pot? Will it be the health department or the local authority? How will that happen in reality?

Sir Stewart Sutherland: There are various levels of control, but this is not included in the report for two reasons. First, we did not have time to go into this matter. Secondly, it was outside our remit, as we are now talking about administrative restructuring. We pointed to the need, then blandly said that there are many people who are more

expert than us, including this committee.

I was pressed on this question by a select committee some 400 miles from here, which took the view that the new primary care trusts are a natural way of putting money into a single pot. My view—although this is not the view of the commission—is that that is the natural avenue to explore. However, the remit of the primary care trusts would have to be extended so that it was clearly more than what was traditionally provided under the NHS. Good, large practices operate with teams of people. There is a lot of experience about how those teams operate. Pilot studies should be undertaken to find out the right size and shape of a team.

The Convener: Studying the primary care trusts would be a good starting point for further examination of the local health care co-operatives and so on.

Margaret Jamieson: There are difficulties with the size and shape of local health care co-operatives. Some of them have no natural boundaries. The one that covers my constituency includes part of another constituency, for example. It does not even follow the local authority boundary.

Did you examine the way in which provision is organised in Northern Ireland, where social services and health services have been combined for some time? Should we consider using that system in Scotland?

Sir Stewart Sutherland: We examined the situation in Northern Ireland and think that there is much that can be learned from it. We did not think that the model could simply be transferred, although we did not have time to go into all of the snags that might be involved. A commissioner from Northern Ireland was able to arrange for a small team to examine the situation in detail.

We also ran into the issue of local health care co-operatives' boundaries. We had maps drawn that show the boundaries' failure to match up with boundaries of health authorities, local authorities and so on. The Scottish Executive must take a view on where the boundaries should lie and whether they are to be coincident. If they are not coincident, problems will arise. A bit of rational thinking would help and funding for the needs of old people should not be put off until that is done.

Margaret Jamieson: Do you think that the support that is provided for informal carers is the same as it was when the commission examined the matter? Have we moved on since then?

Sir Stewart Sutherland: I do not know. Strong cases were made for support for informal carers. We included an illustrative assessment of how much it would cost nationally to provide a number of days of respite for carers. We also examined the situation in Germany, where a system was introduced four or five years ago for the provision of long-term care. That system grants a certain amount of care or, alternatively, a cash sum that can be used in accordance with guidelines. The money can be used to release a member of the family from employment, for example.

We realised, through talking to carers, that they have differing needs. Some said that even if they were allowed to take a fortnight's holiday, they could not go away. There is no simple answer, but there is a need for resources to provide support. If someone could go to the house for a few hours, the carer could go shopping, see a film, play tennis and so on.

There are a few dangers. The system could, for example, become extremely expensive and the loss might not merely be financial: there are a lot of decent people in Scotland who are prepared to care for their relatives, hard though that might be. They do not necessarily want that duty taken away from them by some new system. If a system were designed that took that responsibility away, there could be a decline in the quality of care. It is a difficult area to work in and we need to continue to explore ways of providing the kind of support that people want.

10:45

Margaret Jamieson: We must remember that we have to provide the support that the individual wants. We have all had times in our lives when we had to provide care, so we would all have different ideas about what support we would need. I know that the issue of informal carers relates mainly to the elderly population but we should also bear in mind that there are young carers who do not have adequate support. Did the commission examine that issue in detail?

Sir Stewart Sutherland: Not in detail, other than in relation to the illustrative numbers that would be required to provide respite days. We would have liked to spend more time on the issue, but we were operating under time constraints. The major issue with which we were concerned was the provision of care. The issue that you raise followed on from that, though not in a trivial way.

The Convener: You mentioned a figure of £1 billion and said that that was a realistic figure. If a range of carer services were included—planned respite care as well as crisis respite care—what would that cost?

Sir Stewart Sutherland: The illustrative sum that we came up with for a certain number of days' respite a year amounted to £200 million. Accountants have analysed the cost of providing professionals to replace carers—that cost would

be more than £30 billion. That is, however, a soft number as assumptions were made about how much people would be paid an hour. Even if that assumed sum were halved, we would still be talking about tens of billions.

It would be a mistake—in terms of quality of care and in financial terms—to deter families from involving themselves in caring.

Dorothy-Grace Elder: I want to ask about what might happen if your recommendations are not implemented. However, before I do so, I want to ask you how much of a role age discrimination and agist thinking has played in the fate of the elderly. Bearing in mind that that generation has probably paid more than any other has—many will have worked and contributed to the state for 50 years—did you find that there was resentment among the elderly? I would like you to address discrimination before we move on to the question of what will happen if the recommendations are not implemented.

Sir Stewart Sutherland: We did not find people going round sticking up posters or putting agist material through letterboxes—there was no discrimination of that kind. The example that I gave of £700 million being trimmed from budgets is a tacit sign of the values with which people operate. If you are asking me where folks who are post-retirement age are placed in the value system, I would have to say that our country does not have a view at the moment. However, although it does not have a view, it always has reasons for spending money on other sectors of the population, which results in real loss to the elderly. That is something that I could go on about for quite some time. I am still working and thinking about that philosophically, because there is a question about viewing human beings as whole beings from the cradle to the grave, rather than from the cradle to the time when they retire.

Are you ready for a joke?

Dorothy-Grace Elder: Yes.

The Convener: We always are.

Sir Stewart Sutherland: Members will be familiar with the philosophical definition that was given by Descartes in answer to the question, "How do I know who I am?" He came up with the Latin tag, "Cogito ergo sum," or, "I think, therefore I am." The modern version of that is, "Tesco ergo sum," or, "I consume, therefore I am." [*Laughter.*]

That might be a joke, but it makes the point that we do not have a picture of what constitutes fulfilment in what are known as non-productive lives. As long as that is the case, our value system will be deficient and that is the basis of what Dorothy-Grace Elder refers to as discrimination. It is deeply embedded in our culture. It is not an easy problem to resolve, but is one that we must begin to consider. That is my project for future years.

Elderly people are a little resentful because they believe that they have paid for their care. If one examines the terms of the National Health Service Act 1946 and the National Insurance Act 1951, however, one can see that that is not the case. No one made a big deal of pointing that out until the cost of care began to rise dramatically. In 1993, legislation was brought in under which a person's assets, not just their income, would be taken into account through means testing. That is when the balloon, which had been waiting to be inflated, went up. People are deeply resentful about that because they thought that they had been paying all their lives for their care.

The current generation of older people is very self-effacing. Those people do not want to make a fuss and be troublesome to their families or others. That is something that we heard quite often. Although there is some resentment, the most anger came frequently from the people who care for those older people, who live with them and who see what was happening. That is probably a good thing, because it can be used to channel energy. As politicians, members should be aware of that.

If the recommendations are not implemented, the Government will have to come back to the issue. Although it sounds terribly arrogant, we considered all the options. Folk wanted a cheap option that was delivered through the private sector, through private savings and so on. Such things would contribute to a solution, but there is no cheap option. The shape of the issues that confront the Parliament and any future Scottish Executive mean that if we do not follow the main options—at least roughly, although no doubt we will make mistakes at the edges—there will be no alternatives. I suspect that other people have been following our lines of thought, but have taken a few months longer to get there. They have realised that the situation is not as some people have spun it, which is as a soft option that is presented by a bunch of bleeding-heart liberals. We will have to return to the issue if our recommendations are not implemented.

Malcolm Chisholm: I suspect—or fear—that some of my Westminster colleagues might be attracted to the minority report. Could you comment on the minority report and what you see as its deficiencies?

Sir Stewart Sutherland: If Westminster members are attracted to the minority report, they might benefit from doing some sums. The minority report, despite its billing as the cheap option, runs to £800 million without tackling the main problems.

One of the main problems that it does not tackle

is the different attitude people have to age-related illness. Take, for example, the case of someone who had an accident in which they broke their hip, leg, arm or shoulder. If that accident were the result of falling off a mountain because the person was engaged in exciting climbing activities, their treatment would be free. If a person ruins their liver with too much alcohol, if they abuse tobacco and get an illness as a result, or if they get any of the many illnesses to which people fall prey, their treatment and care is free.

If a person has dementia or Alzheimer's, however, they are means tested. No one can understand why there is that gap or what the justification is for it, apart from the fact that care of such cases amounts to a significant bill. That issue is not dealt with in the minority report, which wants to constrain the definition of care to a form of nursing.

Malcolm Chisholm: I do not agree with the minority report, but I can see that some people might be attracted by the idea that if we have £1 billion to spend it should be spent on extra services rather than on helping people pay for services that already exist. That suggestion might be attractive to some people.

Sir Stewart Sutherland: There is great deal of overlap between the minority comment and what the commission said. The two reports have many recommendations in common—the author of the minority report said that 90 to 95 per cent of the recommendations were shared. However, the minority report steps back from the key recommendation, which is that the provision of personal care should be free.

The minority report does not accept the principle of spreading the risk. If one says that the money could be spent on other things, one sets aside the NHS principle of spreading the risk across the whole community. That would lead to the development of a system whereby those who have misfortunes will be doubly penalised, because they will have had a catastrophe and then they will be means tested and have to pay for care. The inefficiencies in the current system will persist because some of the funding stream will go one way and some of it will go another.

There would also be a huge incentive to build a two-tier system. Those who can afford to pay will get adequate treatment and those who cannot afford to pay—who might be less articulate and less able to press their case—will not. If that is such a great idea, why do not we introduce it into the health service? A two-tier system is both inefficient and unjust.

Kay Ullrich: Dementia is not treated in the same way as other illnesses or accidents because it is a disease that affects mainly the elderly. Do you agree that that is an example of age discrimination?

Sir Stewart Sutherland: In practical terms, yes. If one does not deal with a problem that is far higher in terms of the percentage of presentation in the over-65 age group, one is, effectively, valuing that group's needs less.

Christine Grahame (South of Scotland) (SNP): That was part of my point. I asked the First Minister about that last week, but of course he did not say yes. Sir Stewart has seen my member's bill, so I am sure that he knows where I am coming from.

This week, there was a report in *The Herald*—on Monday, I think—in which Professor Midwinter of Strathclyde University talked about the squeeze in local government. You may not feel that you can comment on this, but Professor Midwinter said that the number of home-help clients and residential care places has been falling for several years. I know that local authorities have tight budgets and I am sympathetic to that, but do you think that older people are a soft target?

Sir Stewart Sutherland: Yes. The guide to reality is what actually happens. As long as such things happen, we are declaring our values and we are showing where we think cuts can be made most easily. Those cuts are made often where no protest will be offered. People who suffer from dementia do not protest, because they are not in a position to present their cases. If a sufferer is fortunate enough to have close friends and relatives living near them, one might hear protests, but one does not hear protests such as those from people in other sectors of the community.

Christine Grahame: You are developing what you said about age discrimination and presenting it as a form of institutionalised discrimination that is practised in Scotland, although perhaps that term is too strong.

Sir Stewart Sutherland: I am not sure how people define "institutionalised", which is why I use the language that I use. What we do shows something about our values and, if those are our values, we must think carefully about whether we are content with ourselves. Frankly, I am not content.

11:00

The Convener: You are saying that we do not make clear, positive and proactive statements about the value of older members of the community, despite the fact that without carers, the voluntary sector in Scotland would grind to a halt. Carers contribute in all sorts of other ways to their local communities and to their families. Therefore, there are all sorts of reasons why we

should value them. That puts to one side the argument of those people who say, "I've paid in my money all these years" because that argument is not as relevant as all the other good reasons why we should value old people.

You are saying that we have an almost neutral position in which we think, "Of course we like old people, don't we?" We do not have to say it. That attitude draws everyone's focus more towards children's services or whatever. Therefore, rather than age discrimination being institutionalised, it is brought about by the circumstances in which local authorities and others find themselves. The situation is not helped by the fact that there does not appear to be a clear steer coming from central Government that says, "There is a real need to value old people and to make sure that these statutory services are actually being provided."

Sir Stewart Sutherland: I hope that that steer will come. If it does not, however, it is your job as politicians to raise the questions.

I will give an example of an area that I am watching quite closely. We have policies on lifelong learning, but it remains to be seen whether lifelong learning or learning in relation to future jobs is being promoted. I do not underestimate learning for future jobs—it is important—but if we really mean lifelong learning, as the population structure changes we must provide the educational support that people will need for a long time after the official age of retirement. We will keep an eye on that and find out whether we mean what we say.

The Convener: People might live in excess of 30 years after retiring. Just as one would expect them to learn in their first 30 years, one would expect them to take part-time jobs or want to play a full part in the community in their last 30 years, with access to all the services and so on that other people have. Why should people be denied such opportunities and services in the third trimester of their lives?

Mary Scanlon: I have a supplementary question to that which was asked by Malcolm Chisholm. I am sorry for jumping back.

Sir Stewart, in your opening remarks you made a point that I would like you to clarify, given that funding is the hub of this issue. You mentioned that the potential stream of private sector funding was not being used. Can you explain what you meant by that?

Sir Stewart Sutherland: I will make one or two points about that. When the royal commission was set up, there was great hope that—somehow—we would persuade the insurance industry to produce comparatively cheap products that would insure people against their need for long-term care. We should not forget that, if one lives beyond the age of 65, one has a one-in-five chance of needing long-term care—for women, that becomes a one-in-three chance, because women tend to live longer. That is a significant risk.

It was hoped that the insurance industry would be prepared to insure against that risk in ways that large numbers of people could afford and we went into the matter in some detail. I do not wish to sound critical, but the insurance industry saw its job as making most of its money out of insuring cars and houses against theft. The industry's perception is that there might be a small market for long-term care insurance, but it wants to take the risk out of that market. As our knowledge of the genetic basis of various diseases grows, it becomes easy for insurers to eliminate risk when they receive that information. Therefore, we will find that insurers will be able to provide comparatively cheap insurance for the proportion of the population that is not significantly at risk. However, the people who are at risk are those who need insurance—that is where the tension comes in.

In north America—which one would have thought was the home of private support, private enterprise and private insurance—less than 10 per cent of long-term care is paid for through the insurance system. I was staggered when I heard that figure. I said, "I don't believe it—check it." We cross-checked that figure, which comes from evidence that was given to a Senate committee in Washington and which shows that America is not dealing with the matter by using the insurance industry. If that approach were to work anywhere, it would work there, but people are simply not buying the products. One needs to ask why that is, but although I could go on, I will not. The reality is that, when one looks at where the insurance industry would be likely to thrive—the USA—one finds that it is not thriving, or at least not in relation to care for the elderly.

However, if our proposals were taken on board, one would ask people to insure against the means-tested element of the cost, which for us is heat, light and home—whether a nursing home, one's own home or wherever. Real costs can be estimated for those factors and a product could be produced that would be comparatively affordable to a much larger proportion of the population. Our proposals would help to bring that about—at a cost. They would bring in the insurance sector where it was most prepared to come in and where it could perceive a viable product.

Another private sector area in which many people have invested is that of nursing and residential homes for the elderly. That market is volatile and I am not sure that those involved in it are always as well informed as they should be. I spoke to the main national associations, who said

that their main problem was people phoning up to say that they were thinking of investing in a residential home. The associations would first ask where the residential home was to be, to which the response would be, "Bournemouth", where there is over-provision of residential homes. Bournemouth is a nice place to live, but it is not where nursing or residential homes are needed.

The private sector is being hit increasingly hard. It is uncertain about which way the Government will jump and, as long as matters are uncertain, it will not attract investment—people will not put their money into it. I stress that there is some bad practice in the private sector and that there is some practice in the public sector that is not very great. There is also some good practice in the private sector and our recommendations would help those people who are prepared to put money into schemes that provide a good service. People would know the stream of funding that applied to a patient or to a person who came into care, if that was all that was needed. Therefore they would know which services to charge for. That would clarify the situation dramatically, but there is a hiatus in investment at the moment.

We also went to see some excellent projects in Scotland and the big development by the Rowntree Trust in York, where charitable money was invested. There is no reason why there should not be a mixture of private sector and public sector investment. If local authorities are thinking of spending money on housing, they should consider private-public funding as a way of investing in the creation of good living conditions for people who might need long-term care.

Mary Scanlon: Thank you—that was helpful.

Kay Ullrich: Sir Stewart, is not one of the reasons for over-capacity in private nursing care historic, in that direct funding from the Department of Social Security was almost a licence to print money? Nursing homes sprang up all over the place.

Sir Stewart Sutherland: While there is that historic element, equally there will be over-provision in some parts of the country and under-provision in others. Nursing homes might be established in those parts of the country where the climate is nicer or whatever, despite the fact that the need is in Liverpool, north Glasgow and elsewhere.

To be blunt, there were tensions between local authorities, which provided their own residential places, and the private sector. We heard many stories about that, although we did not have the capacity to investigate them in detail. Those matters, such as whether some local authorities were undercutting the private sector for reasons that have to do with the way in which housing benefit comes through the system and so on, remain for a care commission to examine.

The Convener: You talk about over-provision in certain areas but under-provision in areas of obvious need. Is there a part to be played by the Government in a kind of public-private way of working together and identifying areas of need?

Sir Stewart Sutherland: I do not want to go into too much detail because it would take too long, but I have various points to make in response to that question. If people want to invest in a residential home in a particular part of the country, it is not the Government's business to stop them. They are making a market judgment. Sometimes, because they are inexperienced in business, they get it wrong, which is a pity.

Equally, I am convinced that if the Government is doing its job properly, it will consider where the need will arise. That is partly the point of the report: considering, over the next 20 years, where the centres of population are, what the demand for care support will be and how much care we are willing to provide in people's own homes. We can now give some realistic costings.

There is a nice piece of research in one of the supplementary volumes, which shows the point at which it becomes more expensive to stay at home than to go into residential care. That should not settle the issue, but it is a factor. We did the research for that.

We can now do detailed work on the long-term needs and the ways in which, through policy, we will provide. We hear much about the new houses that will be built over the next few years. If there is to be public investment in that, some of it should be lined up for this particular need. There are real opportunities for public-private partnership.

Irene Oldfather: Most elderly people, given a choice, would probably wish to live independently in their own home. Has enough emphasis been given to the need for enhanced support for individuals in their own home, or does further work need to be done on that? Did you have the time to tackle that as much as you wanted?

Sir Stewart Sutherland: We gave a lot of attention to that. Early on, we set a high priority on being realistic about what could be provided at home. It was evident that many people wanted to be able to live at home; it adds to the quality of life, consideration of which was part of our remit.

There may be specialists in the committee who might wish to consider the research carried out by the Age Concern institute of gerontology at King's College London, which is in one of the supplementary research volumes. The research went into the issue of housing in detail. It considered the relative costs and what could be

done to supplement what is currently spent on housing, to make it possible for more people to live at home for longer, before their dependency requires them to be in a more sheltered situation.

Some of you may have seen the good examples around Scotland of joint venture schemes between charitable trusts and local authorities. There are mixed communities in which people of all ages live; there is one half a mile from here, where some of the flats in a series of blocks are serviced for a level of care. There is a warden, whose job it is to ensure that that service is provided as the need arises. It does not isolate people and does not take them out of the community—that is what people want.

Those possibilities, including the electronic support that will be important, should be built into future public housing. If that is built into all new flats and houses—at minimal cost—we will not have to rip out people's wallpaper to put in cables and to install monitoring systems.

Christine Grahame: I am sorry, but I cannot remember whether the commission addressed very sheltered accommodation.

Sir Stewart Sutherland: It did.

Christine Grahame: There is a great deficit in Scotland—I understand that there are only about 1,600 places and that places are needed by 10 times that number, or more. I hear what you are saying about new build and about adaptations and I fully support that, but I wish to hear your comments on very sheltered accommodation.

Sir Stewart Sutherland: I do not have the figures for Scotland, but we considered the need for very sheltered accommodation and included it in our total package. We stressed strongly that the current options—someone is in their own flat or house, or in a residence, in a nursing home, or in hospital—are the wrong way to go about it.

The current licensing pattern encourages that definition of difference. It is inefficient; there can be degrees of sheltered accommodation in the same complex. The support that someone needs can be catered for in their own place, without their moving house or flat. That is not possible in all houses and flats in Scotland, but it is possible in new build and through the adaptations that could be carried out.

11:15

Christine Grahame: But we need purpose-built very sheltered accommodation that is not just—

Sir Stewart Sutherland: We need accommodation that is capable of providing that degree of care but which is not necessarily dedicated to it.

Christine Grahame: Not isolated in that sense.

The Convener: It would be good if we could move towards building houses that are barrier-free, which accommodate people with any form of disability—whether physical or brought about by old age—and which are fit not only for most people to live in but for other people with disabilities to visit.

The demographics tell us that there will be an on-going need for that. It would seem reasonable to begin to meet the need now by building the kind of houses and flats that we should be building.

Dorothy-Grace Elder: Your figures show that there are 10.5 million people aged over 65 nowadays. That is not to say that they are all asking for or needing any assistance; in fact, 85,000 of them in Scotland are helping to care for others. However, your projection is that by 2030, the number will have increased to up to 15 million.

The more you have talked, the more concerned I have become that older people are being left out of family values, to use that trite expression. Do you foresee damage to the social fabric, and families being unable to cope, if older people are not aided now? I wish also to ask about your proposal for a national strategy on rehabilitation.

Sir Stewart Sutherland: It goes without saying—which means it should perhaps be said regularly—that rehabilitation and prevention are two wings of a single bird and that stress on both is essential. We believe that the current funding structure has led to less of an interest in rehabilitation. If it is not easy for someone to move quickly out of hospital into an alternative place, where they can have proper rehabilitation before returning home—if the current funding structure militates against that—we are creating further problems for ourselves. If folks do not have the opportunity for rehabilitation, they will continue in a state of high dependency that perhaps could have been dealt with. That is a mistake for them and it is a mistake for the health service and those who provide care.

I take the opportunity to stress prevention as well. That goes back to the more basic question of the value that we attach to the 30 years of life post-retirement. One of the most important things is to provide the potential for a life in which people can find fulfilment. That is probably the best form of prevention, short of a catastrophe occurring—which it does intermittently to many people.

Dorothy-Grace Elder: Happiness, in other words.

Ben Wallace (North-East Scotland) (Con): There was a brief part in the minority report about the priorities for saving. The Accounts Commission made the point that, overall, private

residential homes could contribute significant savings compared with local authorities and that if there had been a strategy to move away from local authority ownership of homes, considerable savings would have been made. Those savings would not be achieved by cutting the service provided. The Accounts Commission recognises that private homes provide a better service for best value. What is your comment on that?

Sir Stewart Sutherland: I do not think that there is a difference in principle on the view of the importance of the private sector. I was surprised when it was baldly implied that if all care were provided by the private sector, there would somehow automatically be savings. Markets operate in their own ways and do not necessarily produce savings—people might decide to go for profit. I am not against that; people have to make a living. However, I stress that I see a potential role under our proposals for the private sector, which would be more clearly defined for the reasons that I have given.

Providers would know what the element of risk was and therefore what the real investment costs were. One of the problems in the private sector is that people invested but did not invest sufficiently to cover the risk of having patients who grew more and more dependent. We have seen that happen in private sector homes. The folk running those homes were decent people who were at their wits' end as to what to do. When the first residents came in, their level of dependency could be coped with, and there was a margin. However, as dependency grew and the resources available to pay for the individual's care did not grow, there were huge problems.

One of the main legitimate worries for the private sector is that, if it is in competition with the local authorities and the local authorities have streams of funding that are not available to the private sector, it is not a level playing field. I am not implying that there is blame on either side, but it is a real problem that must be examined.

If there is to be separate and independent evaluation of the quality of care provided, it should be independent of local authorities and the private sector. That is something that we recommended and which should be sorted out. If that is done, there is no reason why the private sector should not continue and strengthen, but it would be properly regulated.

That is necessary because the people in those homes are more and more dependent, just as young children are very dependent. The greater their level of dementia, the more dependent patients are. They cannot speak for themselves, so there must be proper regulation.

I would have thought it quite reasonable for the private sector to begin to tender to offer services at home. I do not see why that should not happen, but again it must be regulated. If there is a set pool of money, one wants to lever as much with that pool of money as possible. There is a real role for the private sector in that area. One of the minority authors believed that he carried the flag for the private sector, but there is a lot in our report that would make it a much better and properly regulated sector.

Kay Ullrich: I was impressed by what your report said about rehabilitation. With the opportunity for a period of convalescence, assessment and rehabilitation, many more people would get what they want, which is to return to their own homes. Obviously, the introduction of a three-month, mandatory disregard followed by another nine months of discretionary disregard would go a long way to removing the existing barriers. If one leaves hospital and goes into some form of care, the clock starts ticking for one's house and other assets.

I do not think that we would need legislation for that. In Scotland, local authorities already have discretion, and the only difference would be that the disregard would now be mandatory. Should the removal of charging for personal care be implemented, would there no longer be any need for a three-month mandatory disregard?

Sir Stewart Sutherland: At the moment, if one needs rehabilitation, one is often stepping on to somebody else's budget. If one has to cross what I call a budget fence, there is a lot of administrative hassle and it depends on the size of the budget on the other side and how much claim has been made on that budget. It does not depend on one's need and it does not depend on a sensible outcome about what the long-term costs will be if rehabilitation is not provided. Under our proposals, the long-term costs would be reduced and, on the basis of need being met as assessed, no one would have to cross a budgetary fence into someone else's pocket.

Dr Simpson: Do you think that the care commission, as we are establishing it, will have sufficient powers to make recommendations about the need for different levels of care in residential and nursing homes and the funding of those different levels of care?

I am aware that people come into residential care at one level of dependency and their level of dependency can then rise substantially. Quite rightly, they do not wish to move, and homes are often quite happy to continue the care, but they require extra funding to provide that enhanced care and do not get it. Will the care commission have enough teeth to be able to say that an individual's level of care, as assessed in their care plan, warrants an additional funding stream?

Sir Stewart Sutherland: My frank opinion is that it will probably not have enough teeth. It must have the capacity to make an independent judgment at individual level, so that it can say, "There is a need here. We are not negotiating with you about what your budget is." According to the rules of the game, that need would have to be met. Suppose that you were a local GP and one of your patients was in a residential home. If that patient developed pneumonia, you would not ask yourself whether you had the power to recommend that that need be met. The need is there and, as a doctor, you would ensure that that patient was treated. It should be an all-fours process, without even the intervention of care commission-type activity.

Judgments will not be made only on an individual level. There will also be independent judgments about the national need or local area need. The local authority might say, "You are requiring us to do this, but we can't do it within our budget." Somebody would take an independent view of that situation, rather than having a turf war with the Executive.

Dr Simpson: Do you think that the care commission should have a right of appeal and the same responsibilities as the Mental Welfare Commission has for individual patients?

Sir Stewart Sutherland: I would need to think about that in detail, but much of that seems sensible to me, as long as the current situation remains in place. Until some more radical proposals are put into practice, there is probably a need for such an appeal mechanism.

Malcolm Chisholm: Some of the private care home owners who came to the committee were not happy about the effect on the private sector of the residential allowance being reallocated to local authorities. What do you think the effect will be?

Sir Stewart Sutherland: That point was put to us regularly by the private sector. Looking at the evidence, I had some sympathy with that view, but it involves individual cases. Unless you are down there with all the facts in front of you, individual cases are very hard to judge. The private care providers would cite examples of local authorities that use all their allowances to undercut the price that they are prepared to pay.

Local authorities say that they could provide care for, say, £140 a week, but the private sector home owners say that, realistically, that care would cost £240. Of course, if a residential allowance or housing benefit is flowing in that does not come out of the local authority budget directly, it is no longer a level playing field.

In principle, there is a danger that the private sector might be priced out of the market, which one should do only with great care. If one eliminates a proportion of the providers, where is the alternative provision to come from?

Malcolm Chisholm: You were discussing with Kay Ullrich which of your recommendations are subsumed by your central recommendation, and you said that the recommendation for a three-month disregard would be subsumed. The summary at the beginning of your report also states that the change in the limits of the means test would be subsumed by the main recommendation. Is that true? Given that people will still have to pay housing costs, surely those other recommendations will not be subsumed by the main one.

Sir Stewart Sutherland: In relation to the provision of free care, the means test and the three-month disregard would disappear. It would then be worth considering the effect of the much lower cost of providing heat, light, a roof over one's head, food and so on. We were not able to consider this in detail, but we heard from many folk who might be in need of care. They said, "I have provided for myself all my life and I want to continue to do so." However, they would go on, "But of late the means test has brought me a supplement." We assume that that would continue, but it would not necessarily have to take into account capital assets, because most of the people who were means-tested did not have private assets.

Malcolm Chisholm: Are you still proposing to raise the capital limit, even taking personal care into account?

Sir Stewart Sutherland: Yes, indeed. It was artificially low. At £16,000, it is the price of an average family car—in this country at least, but perhaps not on the continent.

The Convener: We are straying out of our remit with that point.

Margaret Jamieson: Sir Stewart, your report recommended the extension of direct payments to individuals over the age of 65. However, local authorities have been slow in using their discretion to implement direct payments for younger adults. What should be done to ensure that direct payments become more of a reality?

Sir Stewart Sutherland: Our remit was older rather than younger people, so I am not really competent to comment on that element of the question. However, that is one of the things that the care commission would monitor throughout the country. Wherever one lived in Scotland, one could have the same expectation and there would be a benchmark against which that could be assessed, as long as it was relevant to long-term care.

The Convener: Thank you, Sir Stewart, for answering our questions, for your report and for the informal support that you have given the committee to date. The vast majority of us are waiting with bated breath to see whether the comprehensive spending review does justice to the commission's report. Thank you for your contribution.

I shall now close the public part of this morning's Health and Community Care Committee meeting. We shall take agenda item 6 in private, as previously agreed.

11:32

Meeting continued in private until 12:26.

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