HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 25 April 2001
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
12th Meeting 2001, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
*Janis Hughes (Glasgow Rutherglen) (Lab)
*Mr John McAllion (Dundee East) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Ochil) (Lab)
Nicola Sturgeon (Glasgow) (SNP)

*attended

WITNESS

John Aldridge (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERKS

Irene Fleming
Peter McGrath

ASSISTANT CLERK

Joanna Hardy

LOCATION

Committee Room 1

Scottish Parliament

Health and Community Care Committee

Wednesday 25 April 2001

(*Morning*)

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

The Convener (Mrs Margaret Smith): Good morning to members and to the massed ranks of the public. Agenda item 1 is to ask the committee to consider in private items 5 and 6, which relate to a petition on single general practitioner practices, and the committee's measles, mumps and rubella report. It is normal practice to discuss reports in private until we take action on them. Is that agreed?

Members *indicated agreement*.

Budget 2002-03

The Convener: Agenda item 2 is the budget—here we go again. John Aldridge is probably running neck and neck with the minister on the number of times on which we have inflicted ourselves on him. Because this is an annual event, in future years we will have to do it all again. This time, we are building on the work that we have done in committee over year 1 of the budget—hopefully we have learned something from that experience. There are a number of questions on which we want to focus today.

I first welcome John Aldridge to the committee. Do you wish to make a statement on the budget document or go straight to answering questions?

John Aldridge (Scottish Executive Health Department): Thank you. I do not need to say much by way of introduction. I will introduce my colleagues. On my right is Sarah Melling, who I believe has appeared at the committee before. She deals with the financial control side of my directorate. On my left is David Palmer, who is my deputy director in the directorate of finance in the health department.

We found last year's comments by the committee very helpful—we have tried to take as many of them on board as we could in producing this year's document. For various reasons it has not been possible to take all the comments on board, but we have done what we can and I hope that we have made some progress. I am happy to answer the committee's questions.

The Convener: I will kick off on that general point before we ask more specific questions. Something that came out of the committee's consideration of the budget last year was that we felt that there was a lack of transparency in the budget documents. The foreword to "Investing in You: The Annual Report of the Scottish Executive" was about making the budget of the Scottish Executive accessible to the average man in the street but we felt, based on last year, that that was not going to happen.

I found the health section of this year's budget moderately more readable than last year's, but we are still talking about a document that is not as transparent as we would have expected after our comments on last year's. Do you feel that the section in the document on health and community care is more open and accessible? Does it do what we want it to do, which is to allow us to scrutinise where the money is going, what it is being used for and whether the Executive's outcomes and targets are being achieved?

John Aldridge: Members will have noted that we sought to provide more information in this

year's document. By using tables and so on, we have tried to show as clearly as possible what the money that has been spent in the past has achieved in terms of changes in the pattern of service and so on. We face difficulties—and will continue to do so—in being absolutely clear about what the money will be used for in future. Last year, we touched especially on the difficulty of separating—in a way that many people would like, but which is difficult to achieve—the resources that are devoted to the various clinical priorities.

For example, the services for people who suffer from coronary heart disease straddle primary care, acute services and community care, so it is difficult to identify—especially when we are considering future years—how much is being devoted to coronary heart disease. Any figure that we produce is likely to be inadequate and misleading.

09:45

Mr John McAllion (Dundee East) (Lab): I am not threatening you with it, but as I was not in the committee last year, this is a relatively new experience to me.

Thanks to the work of our advisers, we know that about £458 million of new money will be available in 2002-03. The allocation of that money is, by and large, to hospital, community and family health services, which means that it comes under the control of the local health boards and the local trusts' boards. Last year, the minister argued that she did not want to set targets for local spending decisions, but if we are to set targets for the boards and trusts, how will we know what key decisions the boards are taking about how the money is allocated?

John Aldridge: The view that the minister takes—and which has traditionally been taken—is that, in setting targets, we should concentrate not on the inputs or resources that are allocated for various purposes, but on the outputs. We are trying to develop that process. It is acknowledged in this year's document that the targets—which we have tried to make as output and outcome-oriented as possible—will develop in the light of the new document, "Our National Health: A plan for action, a plan for change", which was published in December.

The targets in this year's document stem from "Working together for Scotland: A Programme for Government". Although the time scale for producing that document did not allow us to take the targets in "Our National Health" fully into account this year, it will in future. I stress that the targets that the Executive—and Government generally—set should be based on outputs and outcomes, rather than inputs.

Mr McAllion: Surely in order to achieve targets for outputs and outcomes you must know what inputs are involved. Our adviser carried out a review of health improvement programmes in 2000-01 and discovered, from analysis of the programmes throughout trusts, that the shift away from the acute sector to primary care was relatively modest and could be accounted for almost entirely by the growth in primary care prescribing. I am sure that that was not one of the outcomes that the Executive was looking for.

Equally, our adviser found that that shift had been achieved largely at the expense of real terms growth in the acute sector—there was very little—and that most of the growth in the primary sector was, in any case, in the primary care drugs budget. It strikes me that inputs are not really being directed towards achieving the kind of outputs that the Executive wants and that the health department needs to exercise much greater influence over decisions that are made on the ground.

For example, of the £219 million of new money in 2000-01, 20 per cent went on pay awards, 25 per cent on price inflation, 13 per cent on financial pressures and 17 per cent on miscellaneous pressures that the trusts were under. Of the new money, 76 per cent was not going to the kind of outputs that the Executive wanted, but being put to other uses. Surely that cannot be allowed to continue. You must start to exercise some kind of control over local decision making.

John Aldridge: It is difficult to balance the income needs of the various parts of the health service. Inevitably, each year a substantial proportion of the extra resources that are made available for health spending in the health budget will be used for staff pay in particular, but also for price inflation. Seventy per cent of spending in the health service is on staff. Inevitably, a large proportion of any extra money is rightly invested in ensuring that staff are paid adequately and properly each year. A large proportion of the budget will always be used for such purposes. It is important to ensure that the output and outcome targets that the Government seeks are clear to the health service in Scotland. That is what "Our National Health" attempts to do.

Mr McAllion: It strikes me that there is a danger that the Executive or the Minister for Health and Community Care can sit down and say: "We want these targets, outcomes and outputs, but we are leaving it to health boards to achieve them. How they do that is a matter for them and we are not going to become involved in that. If they don't achieve them, we'll just blame them for not doing so."

John Aldridge: I hope that the Executive will not take quite that approach. The Executive tries to set the targets in a publication such as "Our

National Health" in order to give local health systems the money that it believes is sufficient for them to meet the output and outcome targets. Then—this is important—the Executive returns regularly to the health systems to check whether they are meeting the targets. The Executive checks that in the light of the performance management system, which is being reviewed at present. A new performance assessment framework will be published presently.

Mr McAllion: Do you accept that, in the past, the performance management system did not work properly and that the situation with Tayside Health Board and the Tayside trusts shows that to be the case?

John Aldridge: No performance management system is perfect.

Mr McAllion: This one did not work at all as far as I, the local member, could make out.

John Aldridge: I disagree that it did not work at all; it worked to an extent throughout Scotland.

Mr McAllion: It allowed a massive deficit to be incurred and services to be ravaged in Tayside. Nobody seemed to know where the money was being spent, including the health board and the trust boards.

John Aldridge: I do not know whether the convener wants to get into the Tayside issue now. There was a particular issue in Tayside over a period of time, particularly over the period in which the trusts were being re-organised. You are absolutely right that, in that period, the financial control in the local system and the national performance management system could have been a lot better and that they left an awful lot to be desired. That has rightly been highlighted by Audit Scotland's report and by the Audit Committee.

I do not believe that the position in Tayside was typical of that in Scotland as a whole, but that is for others to judge. I am reasonably confident that the new performance assessment framework will be better and that it will improve on the previous performance management system.

Mr McAllion: Is not there a major flaw in a system that leaves the key decisions about the allocation of moneys to projects to people who are appointed, not elected, and who are therefore not really answerable to anyone, other than to Parliament through the Minister for Health and Community Care? The performance management system does not seem to hold such people to account.

John Aldridge: I cannot comment on whether health boards should be elected or appointed. That is not within my remit, but I will say that the new governance arrangements for unified health boards, as proposed in "Our National Health", provide for substantially more local, elected representation on the health boards. That does not mean that the health boards are directly elected, but there will be substantial representation from relevant local authorities.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): We all know that the accountability reviews occur after the moneys have been spent and that those reviews take place in a room that is not open to the public and is certainly not open to local democratically elected representatives.

John McAllion has highlighted concerns about Tayside. Perhaps Tayside is not typical, but all members of the committee could point to similar issues in their local health board or health trusts. What assurances can you give the committee that the accountability review process—I understand that you are due to embark on it next week—will be open? Will we be allowed input to it?

John Aldridge: Margaret Jamieson is correct to say that the accountability review meetings are not open to the public; they are open only to people from the local health system, the chief executive from the Executive and the other people who are taking part in the process. We have tried to make the lead-up to accountability review meetings and their aftermath as public as possible. We hope to build on that in the development of the new performance assessment framework. Already, the letters that follow accountability review meetings, which set out what was discussed and what changes will be required as a result, are in the public domain—they are made public.

Margaret Jamieson: They are only public to those who are on the mailing list.

John Aldridge: No, they are public in the sense that they are presented in public session at the health board—

Margaret Jamieson: You need to be on the health board's mailing list to receive the papers. That is unacceptable.

John Aldridge: My colleagues who are dealing with the arrangements for governance and for performance assessments are happy to consider proposals to make the arrangements even more open and accountable. One of the principles behind the new performance assessment framework is that the elements within it, on which the local health systems will be judged, are to be publicly available. The performance of individual health systems against those elements will also be made public. Since those elements form the basis on which the accountability review will take place, that should help to make the system more open. I do not say that the framework cannot be improved further, but those things certainly could be done.

Margaret Jamieson: John McAllion highlighted problems that have accumulated over a number of years in Tayside, but we can all point to examples like that. If we, as elected representatives, were involved in the process, would not it be safe to say that such problems would have been pointed out in previous accountability reviews?

For many months I have sat on the committee discussing Arbuthnott funding, and I am dissatisfied because of the lack of openness and transparency about whether the extra moneys that were awarded to Ayrshire and Arran Primary Care NHS Trust were spent appropriately. To date, I have not received a suitable answer. In fact, on Monday the committee was told—not in public, but behind closed doors—that we were right and that that trust was wrong.

Health service organisations cannot, in this day and age, continue to evaluate themselves; evaluation must be open. If you believe that going through the budget process with the committee each year is part and parcel of that evaluation, you need to consider the matter further. Joe Public hears that £X million extra are going into the health service, but he cannot see the difference in his locality. We are looking for greater transparency and accountability.

John Aldridge: I hear what you say and take it on board, but, I cannot comment on how the health service should be managed, or on the representation on the various NHS bodies, because that is a political decision. It is not a matter for me, but for the minister. We must work within the present system.

Nevertheless, I accept entirely the point that, in presenting information about the resources that are available to the health service nationally, we must do the best that we can to make it as clear as possible to everybody where the money will go. Such an approach will involve being quite upfront and open about the fact that a large proportion of the money will, inevitably, be allocated to aspects such as pay increases, simply because 70 per cent of the costs are staff costs. After all, it is the staff that make the NHS work.

Dr Richard Simpson (Ochil) (Lab): I am slightly disappointed to hear you say that this year's budget is based on the programme for government, not on the new NHS plan. Page 91 of that plan states:

"The Health Department's budget is based on the delivery of the programme of action set out in *Our National Health: a plan for action, a plan for change*".

10:00

John Aldridge: I am sorry; I hope that I have not unintentionally misled the committee. I did not mean to say that the whole document was based on the programme for government, rather than on "Our National Health". I meant that the specific targets at the end of each section are taken from the programme for government, rather than from "Our National Health". However, we have taken the new NHS plan into account in the budget document.

Dr Simpson: Because things are always on the move and will continue to move, there will always be a problem with matching them up. Our central concern this year, as it was last year, is that at local level, the health improvement plans—HIPs—and trust implementation plans are still not linked to the budget. This year, we expected to find that the health boards would tell the health department their intentions, because the HIPs were more than a one-year programme and that—notwithstanding the new plans, which will change matters in future—this budget would contain a stronger link between local development and the national plan. I do not see that that is the case to any great extent in this document.

John McAllion referred to a more general example across a whole health board. However, I want to highlight a specific example. People are most concerned about the issue of postcode treatment. On a topical note, there are only five NHS-funded multiple sclerosis nurses in health boards throughout Scotland. There are seven in total, but two are funded by the Multiple Sclerosis Society. There has been no evidence of change in the HIPs or of progress in the budget to meet a small specific target for an issue that affects 10,500 Scots. We want to hear about some redress of the imbalance between the independence of local health boards and central performance management. For example, the document should say that boards that do not have MS nurses should show evidence that such nurses will be included in their HIPs over the following year or two. That should also be the case for epilepsy and other disease services. You have pointed out that although cardiovascular disease is a national priority, it is not easy to assess. However, unless such services are vertically integrated, costed locally and the costings presented to you, we will never be able to manage the health service. Although the health service has just received its greatest ever increase in funding, the money will simply disappear, like snow off a dyke.

John Aldridge: Although I hear your comments and will take them on board as far as I can, I should refer again to the changes that will happen through "Our National Health". The new performance assessment framework is designed to ensure that central Government has a much better grip on what happens locally and that it can take action—and require action to be taken—locally where services are not in line with national

targets. However, I should point out that the health section of the budget document is already substantially longer than any other section, and to attempt to cover every disease group would only make it longer. Although that might be desirable, it might make things unwieldy, and we must make a judgment about how much detail should be included in the document and how much should be discussed in other forums.

Dr Simpson: I am happy to go down the Oregon route of having a reasonably compact central document, that has as many appendices as it is felt would be necessary to demonstrate to us that effective disease management is taking place. Let us have an appendix on diabetes, or whatever, so that we can demonstrate that the centre has a grip on things.

Shona Robison (North-East Scotland) (SNP): You talked about taking action where you are unhappy with local performance. When would you take such action, and what action would you take? Has action been taken recently, when targets were not achieved by local health boards?

John Aldridge: Action would vary depending on the circumstances. I am sorry if that is vague; I shall try to supply more detail. A range of interventions can be made. Let us take finance as an example, which is the area that I deal with directly. Once the Scottish Executive learns, through the monitoring process, that financial targets are not likely to be met in the year, our first approach is to return to the local system and discuss with the people who are involved in it what has led to that forecast and what actions can be taken to put things right. The first step is to discuss what might be done and ask them to do that.

If the difficulties persist or the people in the local system say that they cannot do anything about the situation, we require them to produce a financial recovery plan that shows what steps need to be taken. If that does not deliver the goods, there are further interventions that involve offering help directly to the local system, up to the kind of involvement that took place in Tayside, where a task force was sent in.

Shona Robison: What about the meeting of performance targets, rather than of financial targets, which are easier to monitor and act on. Richard Simpson's point about the need to tackle postcode treatment is valid. How can you do that if so much power is being left with local health boards to decide whether to go down one road or another? How and when have the people at the centre taken action against a local health board because performance targets were not being met?

John Aldridge: A similar range of interventions is available to ensure that performance targets are met. A high-profile example has been waiting list targets, which are a key performance measure. A health system's performance is monitored and, if its performance is slipping away from the targets that have been set for it, discussions take place with the people who are involved.

A specialist group that is headed by the chief executive of one of the trusts in Scotland has been, and is, currently touring the country and meeting representatives of each health system and auditing the systems that are in place to ensure that performance targets are met. If there seem to be flaws in the local plans, that group identifies steps that can be taken to put things right, some of which can be taken locally and some of which might require national intervention in the form of, for example, extra capital investment in theatre capacity. The same range of interventions would apply across the board for any other targets.

The Scottish Executive does not have the capacity—it never will have—to send around the country specialist groups that are specific to every disease. That is why the Scottish Executive has identified key clinical and other priorities, such as coronary heart disease and stroke, cancer, mental illness and children and older people. Those priority areas will receive special attention. Other clinical areas will not be ignored, but there is a limit to what can be done with the resources that are available centrally.

The Convener: Dorothy-Grace Elder and Janis Hughes are waiting to ask questions. Mary Scanlon agreed in advance that she would talk about clinical priorities.

Dorothy-Grace Elder (Glasgow) (SNP): First, on the postcode medicine situation, are there proposals—would it be possible—to have a national mechanism, whereby health boards get together and try to push down the price of drugs such as beta interferon? The number of patients in different health board areas for whom beta interferon would be suitable is disparate, as you know.

Secondly, there is the issue of charities funding, or helping to fund, what we would have called NHS staff. As Dr Richard Simpson pointed out, there are seven NHS specialist nurses in MS care in the whole of Scotland. Sometimes the minister quotes the figure as eight, but at least two of those posts are funded by the Multiple Sclerosis Society. Should not it be declared fairly and openly in budgets which specialities are being funded by charities? Is not it rather dishonest for budgets to indicate that the NHS, the state and the Scottish Executive are providing that money?

The Convener: May I add a point on the back of Dorothy-Grace Elder's question? In informal briefings on cancer, the committee has heard that

key clinical oncology posts in the health service in Scotland are funded by charities. I spent yesterday morning with one of the MS nurses who is half-funded by the MS Society and half-funded by the NHS. We need greater openness about where staff are funded from, because if the charities pull out of those posts, key posts in, for example, cancer care, which is one of our clinical priorities, will be in serious difficulty.

John Aldridge: I will address the issues as they were raised. The first question was whether health boards could get together to purchase specific drugs. That has happened in some cases and it should happen more. It has happened with blood products, specifically recombinant factor VIII for haemophiliacs. Health boards got together and agreed a national protocol on who should have access to that product, which is purchased centrally and used as appropriate throughout Scotland. We encourage that to happen and it is happening more often.

The Health Technology Board for Scotland will work in co-operation with the National Institute for Clinical Excellence in England to identify national protocols, particularly on the use of new drugs, which should help to ensure that practice in the use of drugs is standard across Scotland. I know that NICE is working on beta interferon and that HTBS is in close contact on that issue, so I agree with the point that was made.

On whether discounts can be obtained if drugs are bought in bulk, in some cases the number of patients in Scotland who need a particular drug is fairly small. Scotland alone probably cannot generate sufficient bulk to get a discount, but nevertheless there are advantages in health boards getting together to ensure that protocols are common throughout Scotland.

Dorothy-Grace Elder: Could they also get together with the health boards in England?

John Aldridge: Indeed. For example, that was done on a UK basis when obtaining the flu vaccine for the flu vaccination campaign last year, so we got discounts on that vaccine.

Dorothy-Grace Elder: Many of us query the figure of £10,000 a year to treat a patient with beta interferon. That is a highly questionable figure, because we just do not know the cost.

Could you answer my question on charities?

John Aldridge: I have two points to make regarding charities. First, there is no doubt that the job of the Government and the Executive is to ensure that the services that people need are available in Scotland. I do not think that the Executive would ever wish to prevent charities from providing resources for posts in any area of the NHS. That is a welcome development, which the Executive will support. I take the point that it might be sensible to make clearer how much resource that contributes to the work of the NHS in Scotland comes from charitable sources. If that could be done—I do not know how difficult or easy it would be—there would be benefits.

10:15

Dorothy-Grace Elder: Do you agree that it is not acceptable for the Executive to state simply, among the welter of statistics, that Scotland has seven specially trained multiple sclerosis nurses? Such statistics are quoted regularly by the minister in an attempt to make it seem as though the Executive and the state are paying for staff when, to a great degree, they are not.

John Aldridge: The key issue is to ensure that people get treatment when they need it. I am sure that that can always be worked towards. The fact is that there are seven multiple sclerosis nurses in Scotland, providing specialist help for patients who need it, and it is not wrong to make that fact clear. Clearly, it would be wrong to assert that those nurses were all funded by the Government if that were not the case.

Dorothy-Grace Elder: That is the implication.

John Aldridge: It would be wrong to assert it explicitly. I am sure that the minister would not say so explicitly and has not done so.

The Convener: We might return to this line of questioning later.

Janis Hughes (Glasgow Rutherglen) (Lab): The matter comes down to transparency. I accept that, if there is any indication that the posts are not funded by the NHS, that should be stated.

I was concerned to hear you say in response to Richard Simpson's question that you did not think that it would be sensible to go into the funding for every disease group in detail. If we are talking about open and transparent government, we have to be specific. At a local level, politicians have to deal with issues such as beta interferon, MS nurses and digital hearing aids. I worked in the health service for 20 years and I know that, although we can throw infinite amounts of money at the health service, what matters is not how much money there is, but how it is used.

The Scottish Parliament is about having open and transparent government. Unless we allow people such as the members of this committee and other politicians to scrutinise exactly where the money is going, the NHS will leave itself open to criticism that decisions are being made and accountability reviews are being undertaken behind closed doors. It does not matter if we end up with a document that is eight inches thick—if people want to know specific details in order to

deal with specific areas of concern, they should be able to get access to them. I understand that this issue was raised last year, before I was a member of the committee, but I would like to hear whether there are plans to expand the level of detail the next time round.

John Aldridge: I agree that what matters is what is done with the money, not how much money there is. The changes in the document were made to make much clearer the targets that are set for the NHS and what we expect the service to deliver, and to ensure that a robust performance assessment framework is in place.

On the question of being clear about where the money goes, the Executive would not wish to say that, of the extra £450 million or whatever that goes to the NHS in a given year, £100 million must be spent on cancer, £50 million on coronary heart disease, £20 million on multiple sclerosis and so on. That would not take proper account of local needs, which differ from area to area. Even fairly large chunks of money, such as those for GPs, can vary a lot, because the number of GPs varies from area to area. In primary care, there is a need for more investment in some areas than there is in others. The Executive has taken the view that those decisions are best taken locally.

The more money that is ring-fenced and has a label on it when it goes out from the centre, the less room there is for local flexibility to meet local circumstances and local needs. That does not get away from the overriding job of central Government to be absolutely clear about the targets that need to be delivered, in terms of inputs and outcomes. Nor does it get away from the Executive's clear job of ensuring that those targets are delivered on the ground.

Mary Scanlon (Highlands and Islands) (Con): Having had the pleasure of meeting you last year, Mr Aldridge, I would like to continue, one year down the line, with some of the topics that we raised. You promised that there would be more openness and that the document would be easier to read. You said that Joe Average in the street would be able to read it and say that he thinks that not enough money is being spent in certain areas. You also said that monitoring would be much more open and accountable.

I am quite concerned about the points that John McAllion and others have raised, and my colleague, Margaret Jamieson, was quite vocal about this subject last year. It is not enough for us to say that we cannot monitor what councils and health boards are spending. You are the link, Mr Aldridge.

John Aldridge: Indeed.

Mary Scanlon: You are the monitor. If something is going wrong between the minister's clinical priorities and what is happening out there, you are the guy that picks up the responsibility. It is no one else's responsibility. Am I correct?

John Aldridge: I agree that it is the Executive's job. I just need to be slightly careful here, because it is not just me who is responsible.

Mary Scanlon: You are in charge.

John Aldridge: I am in charge of the finances and I am certainly responsible as far as the use of resources is concerned. As far as other issues, such as clinical governance and management issues, are concerned, other colleagues in the Executive are responsible. However, I certainly accept the point that the Scottish Executive health department is the responsible body.

Mary Scanlon: If we are ever to move towards a system of greater openness, people must be willing to accept responsibility and you do have a responsibility there.

John Aldridge: Indeed, yes.

Mary Scanlon: That is the point.

John Aldridge: I certainly have a responsibility to monitor what is going on and to take action.

Mary Scanlon: I come back to the point about shuffling around between inputs and outcomes. You need inputs in order to achieve outcomes. That is a major point.

John Aldridge: Absolutely.

Mary Scanlon: I want to look at the clinical priorities. According to our adviser, spending on public health is down 3 per cent, £1 million of new money has been allocated for heart disease and stroke out of £6 billion, £2 million of new money has been allocated for cancer, and £6 million has been allocated for waiting times. How can you justify the clinical priorities—heart disease and cancer—getting £1 million and £2 million, and how does the waiting time money fit in with clinical priorities?

John Aldridge: I am not sure of the source of those figures.

Mary Scanlon: They are from the health improvement programmes. That is the link between the Executive and the health boards and trusts.

John Aldridge: So that is an assessment of the additional resources that are being promised in individual health improvement programmes?

Mary Scanlon: Our adviser has gone through the health improvement programmes for the mainland health boards. There is a huge gap between what you are saying in the budget document and what is happening on the ground, and I am trying to establish where responsibility for

that lies. Cancer and heart disease are two of the three clinical priorities, but in the 11 mainland health boards, £2 million of new money is being allocated for cancer and £1 million for heart disease.

John Aldridge: I have not got all the health improvement programmes here, nor do I have them all in my head.

Mary Scanlon: I think that we can trust our adviser.

John Aldridge: It depends on the circumstances of what that new money is for. Existing developments will already be in hand in local areas. Some developments will have happened in previous years. Approximately 70 per cent of the extra money is likely to go on pay, simply because pay accounts for 70 per cent of NHS costs. Pay is not money lost or money that is not invested in new services and improved services. Proper pay for NHS staff who work in cancer and coronary heart disease ensures that services are delivered properly to patients who need cancer and coronary heart disease treatment.

I suspect that those figures do not include capital investment in cancer and coronary heart disease. In the cancer area, for example, there is substantial investment in new or replacement linear accelerators. I understand that that investment will be substantially more than £1 million this year—it will be several millions of pounds. I do not have the figures with me, but I can let the committee know.

Mary Scanlon: Are you shocked that, with a budget of £6 billion, we have the dubious pleasure of being top of the league in Europe for heart disease and cancer? Are you shocked to discover that our adviser has gone through the health improvement programmes and capital for 11 mainland health boards and found that there is £1 million for heart disease and strokes? There is £2 million for cancer, but £6 million for waiting times. How do waiting times fit in with clinical priorities? Are you shocked at that figure?

John Aldridge: Waiting times cover cancer and coronary heart disease as well as other specialties. I do not think that you can contrast the figures.

Mary Scanlon: Where does clinical priority fit in with the waiting time money?

John Aldridge: Some of the extra money will be labelled specifically for cancer and coronary heart disease, but much of the other extra money will contribute to improving services and will remain in cancer and coronary heart disease and the other clinical priorities.

Mary Scanlon: You are the finance expert, but you say that perhaps there is some money here and some there. All that the committee has is what is in front of it. How can elected representatives scrutinise a budget when all that we can find is £1 million for heart disease and we are told that there may be a wee bit of money here and wee bit there? That is what Joe Public sees.

Last year, you promised us openness, honesty and transparency. This year, when I ask you about the major priority, you say that that might come under other headings. There is none of the openness and the information for us to scrutinise that you promised.

John Aldridge: Last year, I undertook to do what we could to improve the openness and transparency of the document. I hope that we have made some progress, but that is for others to judge.

I also said last year that it would be very difficult, particularly in looking at the money to be allocated for future years, to break down that money by disease group, even by clinical priorities. That remains my position now. I understand the committee's desire for information in that form, but it is genuinely very difficult to provide that in a way that gives a comprehensive picture.

Mary Scanlon: Frustration might be a better word than desire. The point is that the minister allocates money in a specific way and the committee's and MSPs' responsibility is to scrutinise. That is not being made easy.

Spending on public health is down by 3 per cent in one year. Several areas, including the mental illness specific grant, show no real-terms growth. That was the one recommendation that we made last year. Why were welfare foods, services for people with disabilities, the health improvement fund and the capital budget given a lower priority? Will there be funding from other sources so that those services and activities can be maintained?

In case I cannot ask another question later, I will ask now about Arbuthnott. The Highlands were the greatest gainer from Arbuthnott funding. When I ask how that money is being spent—I have managed to get more information than my colleague, Margaret Jamieson—I am told that whatever is spent on health benefits people in the Highlands. That is fair enough. However, we are talking about very remote communities, such as Helmsdale, Dunbeath and Lybster, which are finding that they do not have a local GP and do not have access to the health services that they want. Women from Wick, Sutherland and Tongue are now being asked to travel over more than 150 miles of seriously bad roads to have their babies in Inverness. Given that rurality is a major element of the Arbuthnott formula, do you not think that some of the money should go to the local health care co-

operatives, local GPs and maternity services, particularly where women's and babies' lives are at risk?

10:30

John Aldridge: I will deal with the two issues separately. The first issue relates to table 5.21 on the distribution of spending on other health services—the public health areas. Mary Scanlon is right to say that some of the lines in the table look unusual because they appear to be flat. For example, the Mental Welfare Commission budget was flat for two years. Similarly, the grants to voluntary organisations appear to be the same. That is because, unfortunately—I regret this—at the time that the budget document was being produced, final decisions had not been taken about those elements of the programme and they were rolled forward flat. Decisions have now been taken and I would be happy to let the committee have a copy of an updated table, which shows the proposed increases.

Mary Scanlon mentioned welfare food services in particular. That is a special part of the programme and we simply pay what we are asked. The welfare food scheme is a UK-wide scheme and we do not determine how much is spent on it. The current information that we have is that it will amount to £14 million a year. If that changes, we will change the amount in the budget. The figure could increase or decrease, because welfare foods is a demand-led service.

The Convener: Can I clarify the public health figure in table 5.21? Mary Scanlon made the point that the table shows a drop in the public health budget from 2000-01 to 2001-02. Would that change as a result of your revised figures?

John Aldridge: That does not change.

The Convener: What is the rationale behind the drop in public health spending?

John Aldridge: It would be wrong for me to speculate on that just now. Could I write to the committee on that?

The Convener: Okay.

Mary Scanlon: Could I have an answer to my question on Arbuthnott?

John Aldridge: Yes. Mary Scanlon is right to say that Highland Health Board gained under Arbuthnott and has a substantial increase in resources in this financial year—an increase of 9.75 per cent in its unified budget. The local system in Highland has been deciding on the best way to use those resources. In the first instance, it is for the local system to decide how to balance the various interests, but there will be several competing pressures. We will know more when we see Highland Health Board's final proposals—its accountability review is coming up shortly and that is an issue that will be touched on.

It is clear that the Executive expects the additional money that is going to several health boards as a result of Arbuthnott to be used for certain things, including tackling those areas that Arbuthnott suggested were being under-resourced in the past—primarily factors relating to deprivation and rurality. We would expect Highland Health Board to address that. It is difficult for me to comment on specifics, particularly the Wick maternity services, because that has certain consequences. The problems in Wick arise to a large extent because of the difficulty of recruiting consultant staff.

Mary Scanlon: You mentioned deprivation and rurality, but some people cannot afford to put petrol in the car to drive 150 miles to see a doctor. Do you agree that considerations of accessibility and rurality should mean that people are able to access NHS services nearer their own doorstep, which would make those services affordable to those people? Consultants could travel, for example—there are many options. Are you concerned, as I am, that so much of the money has gone into Raigmore hospital, although that is a worthy cause? As I said, some people do not have money to pay for petrol for their car or for the bus fare; for many people, seeing a doctor means that they must stay overnight in Inverness.

My point is that health boards can spend as they please. When I ask about spending on Raigmore hospital, I am told, "Well, better services in the acute sector in Raigmore hospital helps everyone." I am inclined to agree, but Arbuthnott was all about deprivation and rurality—that is why the health boards got the money. Local communities are losing their doctors and many people in those communities cannot afford to travel 50 or 100 miles to see a general practitioner.

John Aldridge: I agree with a great deal of Mary Scanlon's comments. In particular, I agree that accessibility is a key factor that health boards must address when using all their resources, not just the extra money that they receive as a result of Arbuthnott. That is an important issue.

Highland Health Board must take into account the fact that some people live a long way from Inverness; those people must be able to access services that are closer. There are various ways in which that can be achieved and new technology will help over time.

Mary Scanlon: How will you monitor the Arbuthnott money to ensure that it is spent in a way that addresses deprivation and accessibility?

John Aldridge: I was coming on to that point.

The performance assessment framework is designed to monitor that expenditure, among many other things.

Dr Simpson: Will that information be published?

John Aldridge: Yes, and the outcome will be published.

Dr Simpson: Are you saying that the Executive will make public a specific report that indicates where Arbuthnott money has been used to address inequalities?

John Aldridge: That is not what I said.

The Convener: What did you mean by "published"?

John Aldridge: I said that the performance assessment framework generally will be published and that that will address the issues covered by Arbuthnott. The performance of local health systems against that performance assessment framework will be published.

Margaret Jamieson: Obviously, that will happen after GPs are away and consultants have moved on, or whatever.

I am concerned that we might wait for too long. When the budgets for unified health trusts are announced, as they are now known, we should have an input into the expected use of that money, rather than wait until it has been allocated. Not so many years ago, people were living on a wing and a prayer for four months every year before the budgets were allocated.

My proposal would not be too different from what happened in the past, but knowing that a system of checks and balances was in place before these moneys were committed would give us some comfort. I am convinced that if you were to examine how two or three health boards have disbursed the specific Arbuthnott moneys that were allocated last year, you would be lucky if 20 per cent of that money was spent on what you had directed it to be spent on.

John Aldridge: I do not want to suggest that we simply publish the performance assessment framework, wait until the end of the year and then publish the results. There will continue to be regular contact and performance monitoring during the year as part of the system.

Margaret Jamieson: We are saying that we are dissatisfied with a system in which the minister makes announcements and the health department sends out back-up letters, when what we see on the ground in our health board areas bears no resemblance to the initial announcement.

Dorothy-Grace Elder: We must all remember, Mr Aldridge, that you are not the minister and that you are from the civil service. I will ask you about two points. Could we have an assessment of need from the health boards next time? Do you agree that under the Arbuthnott scheme we are talking only about sharing out more evenly between 1 and 2 per cent of the general Scottish health budget, which is about £458 million of new money in real terms? The Arbuthnott committee's brief was to share out more evenly only 1 to 2 per cent of the budget. Do you agree that that brief hampered you or the boards? Will you or someone else consider an assessment of need submission from the health boards before your next production of figures?

John Aldridge: Dorothy-Grace Elder asks about two issues. The first is assessment of need. It is the health boards' job to conduct assessments of need across the range of health services they provide and to identify needs in their areas. Then, they must identify what must be done to address those needs.

You are right to say that Arbuthnott considered the distribution of the resources that are made available through the political process for the health budget. That will always be the system. The job of local health systems is to manage within the resources that are allocated to them—they depend on a political decision—in the best way and in the interests of meeting the needs of their local populations.

Dorothy-Grace Elder: Would you favour health boards conducting their own assessments of what they need? They have been confined to so doing under the Arbuthnott limitations. What about allowing the health boards to submit their list of needs to you next time?

John Aldridge: A health board's job is to manage within the resources that it is given. I am sorry, but I find it difficult to answer your question. You are asking me to get into more difficult ground.

Mr McAllion: The department has hailed NHS 24 as a new and innovative success, yet according to our figures for 2002-03 that service will experience a cut of more than £1 million. How is that explained?

John Aldridge: NHS 24 is being established. That involves initial costs in recruiting staff, getting the call centres up and running—NHS 24 will operate through them—and other matters. Thereafter, a more constant level of running cost will be incurred.

The figures that are in the document—£12.8 million followed by £11.5 million—were best estimates of the cost and were made last year. The £12.8 million takes into account set-up costs. The amounts for the later years are general running costs. The costs will be subject to change as NHS 24 develops. The service is at the stage of

the detailed project brief and is nearing finalisation. After that, the precise costs will be clearer.

Mr McAllion: Are you saying that the service will be demand led and that the figures are just guesses?

John Aldridge: The service will not be demand led in the sense that there will be no control over it, because various means can be used to control the costs of any system such as NHS 24 and are used with NHS Direct down south. However, you are right that the detailed design brief will enable us to take a better view of the likely demand. Then, a political decision will be taken about whether to meet that demand without question or to try to manage that demand.

Mr McAllion: You publish in the budget information targets for eight new, modern hospitals by 2003 and a new generation of walk-in, walk-out hospitals by 2002. No extra money is going to the capital budget. How will the new generation of walk-in, walk-out hospitals and modern hospital developments be funded? Will the funding come through private finance initiatives, or will it be a mixture? If so, what will the mixture be?

John Aldridge: No. There has been a substantial increase in the capital budget.

Mr McAllion: Not according to our figures.

John Aldridge: It is increasing from about £238 million last year to roughly £300 million in each of the following three years. That is a substantial increase in the capital budget.

Mr McAllion: Does that include private money?

John Aldridge: No, that does not include money that is generated through PFI.

Mr McAllion: How many of the eight new hospitals are being funded by PFI money?

John Aldridge: They are listed in the document, but I shall run through them. PFI developed the new Edinburgh royal infirmary, the new Wishaw hospital, the new Hairmyres hospital and the East Ayrshire hospital. Four of the hospitals were funded by PFI and the other four are publicly funded.

10:45

Mr McAllion: What about the new generation of walk-in, walk-out hospitals? Will they all be publicly funded?

John Aldridge: As with any capital development in the NHS, all sources of possible funding must be investigated. Whichever option of PFI or public funding provides better value for money will be the option that is used. A rigorous test must be undertaken to show which is the better option.

Mr McAllion: The document says that a new generation of walk-in, walk-out hospitals will have been built by 2002. That is not far away.

John Aldridge: No, it is not far away.

Mr McAllion: What decisions have been made? What is meant by a new generation? How many hospitals are we talking about?

John Aldridge: The commitment is to establish new ambulatory care units—that is the other phrase that is used to describe the hospitals. There are well-advanced plans for ambulatory care units in a number of areas of Scotland, notably in parts of Glasgow.

Mr McAllion: Has their development been held up by the acute services review?

John Aldridge: Indeed, although other factors have influenced how far it has been possible to develop them.

Mr McAllion: Is not 2002 unrealistic for a new generation of walk-in, walk-out hospitals?

John Aldridge: I would find it difficult to comment on that.

Mr McAllion: I am just asking whether it can be done. Will we have a new generation of walk-in, walk-out hospitals by 2002?

John Aldridge: That is not impossible.

Mr McAllion: Is it likely?

John Aldridge: I suspect that it will be difficult to have a large number of them in place by then.

Shona Robison: I have a couple of questions about targets, but first I would like clarification of what would be covered under "Miscellaneous other health services".

John Aldridge: In table 5.21?

Shona Robison: Yes. It says that the category

"covers a large number of relatively minor spending lines."

John Aldridge: That is right. The 2001 figure is relatively small and covers a number of minor things such as the money that we pay for the National Radiological Protection Board. The reason for the increase in later years is, as I explained earlier, that final decisions about some of the other lines—such as grants to voluntary organisations—had not been made when this document was put together. The table that I shall supply to the committee later shows that the "Miscellaneous other health services" line has been reduced and that other lines have increased as a result. That accounts for a large proportion of the money. The table that I intend to circulate to committee members includes the full list of what is included in that line.

Shona Robison: That will be helpful. You are basically saying that re-categorisation accounts for the reduction in that line.

John Aldridge: Yes. I shall circulate that table, which will save me running through each element of that line. The table will provide that detail.

Shona Robison: Let me push you on the issue of targets. You said that the Executive's programme is driven by an output agenda rather than an input agenda. We have heard about the importance of knowing what the costs are. Do you have any estimate of the cost of achieving the targets that have been set?

John Aldridge: It depends on the targets. It is possible to estimate the cost for some targets. Do you mean the targets that are set out in the budget documents or more general targets?

Shona Robison: I mean those that are set out in the Scottish budget or the national plan.

John Aldridge: Output targets such as to increase the number of coronary artery bypass grafts, which has been a target for some time, are relatively easy to cost. Targets in health improvement, such as reductions in the incidence of heart disease over a 10-year period, are clearly much more difficult to cost.

Shona Robison: Could you provide us with information on those that you have managed to cost?

John Aldridge: We can check what information there is. I will examine that and provide what we can.

Shona Robison: That would be helpful. How do you go about setting the targets in the first place?

John Aldridge: We set the targets by a number of different processes, usually by consultation with experts in the health community to identify what is appropriate. To take the example of coronary artery bypass grafts again, we set up a small group that examined the amount of coronary artery bypass graft surgery that was taking place in Scotland. In the context of the incidence of coronary heart disease in Scotland, the group compared the amount of surgery done here with what is done in other parts of the United Kingdom and the rest of the world and reached a conclusion as to what an appropriate target would be in Scotland.

Shona Robison: Have the targets that were set out in "Investing in You: The Annual Report of the Scottish Executive" been achieved?

John Aldridge: In so far as they were due to be achieved in the past financial year, they have been, largely. There may be some slippage on some of them.

Shona Robison: Where will that success or failure be set out?

John Aldridge: The targets were taken directly from the programme for government. The latest programme for government, "Working together for Scotland: A Programme for Government", which was published just at the beginning of this year, had an update section on the position on all those targets. That shows how far they have been achieved and how far they are still in the process of being achieved.

The Convener: Shona Robison asked whether it would be possible for you to estimate the costs of achieving some of the targets that are in the national plan and therefore follow through into the budget. You said that in some cases you can estimate the costs and that in some others it is not quite so easy. For those for which you have been able to estimate the costs, do you pass that information on to health boards and trusts to give them at least an indication of how much money you think coronary artery bypass graft surgery, for example, will cost? You may have a national figure that says that a target will cost £X, but a lot of the time such figures do not appear in the budget.

My second point concerns outputs. In the budget documents, there seems to be a lack of focus in the outputs. Many of the output targets that are in the documents are strategic, such as the

"Wait for elective in-patient surgery to be no more than 9 months by 2003",

but there is no indication of how that will be achieved and what the cost will be.

We have also picked up on the target:

"Financial allocation to health boards to be at Arbuthnott target levels by 2007".

That is an output target. What we have heard today is that unless we focus in much more detail on how such targets will be achieved, we will be considering the strategic level and almost the input level rather than what is happening on the ground.

The committee's briefing paper shows about half a dozen such targets, which appear to lack focus. They are certainly not concerned with outputs, as the committee would like them to be. They are certainly not concerned with the level that would be useful to indicate to health boards and trusts exactly what the Executive wants them to achieve. It would be useful for the health boards and trusts to have an indication for how much the Executive feels they have to contribute to achieving some of the outputs and outcomes that the Executive wants.

John Aldridge: Where we can, we share information with local health systems. That is quite straightforward on, for example, coronary artery bypass grafts, because it is about specific

operations that we expect to be done. We can get an average cost per operation and follow it up, so that information can be shared. It is more difficult in the case of, for example, public health targets. The ways in which local health systems will go about achieving the targets may differ from area to area.

As we discussed last year, across Scotland there are four demonstration projects in public health that should bear fruit by showing the best way, or successful and effective ways, of achieving the targets. It may be possible, on the back of those, to identify the sums that need to be invested to achieve progress in those ways. The demonstration projects are still in hand.

Convener, you mentioned the targets in the document and said, if I can put words in your mouth, that some are better than others. I agree: we want to improve them and make them more output focused. A dilemma on output targets in the NHS has always been that it would be quite easy to set output targets in terms of the number of patients seen, the number of visits to GPs and so on, but they are not necessarily a good measure of the success of the health service. We have a lot of information about the number of patients seen and the number of operations carried out.

Lots of data are available in the Scottish health service statistics documents but, on the issue that the convener mentioned in relation to Arbuthnott, saying that we have carried out 200 more operations last year does not tell you whether the operations were successful and whether the people needed the operations or could have been treated in a different way. We have always had great difficulty, in the health system, finding measures that are crunchy enough, if you like, that are clear enough to be easily understood but nevertheless give a picture of the success of the health service. We are working on that and hope that the performances estimate framework, which is trying to take into account not only hard data but soft data on the operation of the NHS, will help. That should be reflected in future versions of the budget document.

The Convener: The committee is of the view that there must be an approach to Scotland's health that considers the qualitative aspect of care and the public health aspect, not only the quantitative aspect.

Mary Scanlon: The health plan states that

"the Health Improvement Fund will invest more than £100 million between 2000-01 and 2003-04".

How can we measure whether health has been improved by that investment?

The second example that I would like to use—I am asking you how we can measure this—is the investment of

"£4 million over three years in a campaign to promote positive mental health and wellbeing".

How do we measure those spending pledges by outcomes rather than by inputs?

John Aldridge: On the £26 million a year that is going into the health improvement fund, it is difficult to measure progress in public health over as short a period as even four years; the benefits of programmes such as free fruit in schools and free toothbrushes for children will be felt in 10 or 20 years, not in three or four years.

When we set up the health improvement fund, it would have been an easy option to have invested the money instead in extra operations or acute services, for example, where a result can be seen straight away as somebody is cured and out of hospital. We will not be able to see the success of investing the money in health improvement for some time. On the basis of experience in some areas of Scotland and elsewhere, we can be reasonably hopeful that a lot of those interventions will result in an improvement in health. However, it will be some time before we know that that is the case, or before we have the data to prove it.

Mary Scanlon: On the second point, how can we measure the positive outcomes of the investment in mental health and well-being to ensure that the money goes to those who need it?

John Aldridge: Improvements in mental health are much more difficult to measure than improvements in physical health. The mental health and well-being support group is, among other things, considering what measures might be appropriate for measuring improvements in mental health. That difficulty is not unique to Scotland.

11:00

Mary Scanlon: You are telling us to concentrate not on inputs but on outcomes or outputs. I agree with you on that. However, you are also telling us that you have no measure for those outputs. How can we concentrate on measuring outputs, which we all want to do, when you do not have a formula that would allow outputs to be measured?

John Aldridge: We can have some proxies—

Mary Scanlon: What is a proxy?

John Aldridge: A proxy is a measure that does not measure directly the improvement in mental health but that can be seen to be an indicator of an improvement in mental health. Proxies can be things such as the trends in admission to mental illness hospitals. Using that as an indicator does not measure in its entirety the mental health and well-being of the population but, if the trends are upwards, that suggests that mental health and

well-being are getting worse. The converse also holds, although it does not prove the case absolutely. What is much more difficult to get a hold of is a measure that directly measures improvements in mental health across Scotland.

Dr Simpson: I appreciate the difficulties that John Aldridge has with hard and soft data and in determining short-term and long-term targets. However, there are some areas where it is possible to have short-term targets. One of those—delayed discharges—is not to be found in your submission. The Scottish Executive health department's work in producing statistics on that last year was highly commendable; we are well ahead of other regions of the United Kingdom in that respect. However, those statistics set us the target of dealing with more than 3,000 delayed discharges. I cannot remember the exact figures but, from that total, something like 200 or 300 people had sat in a hospital bed for more than a year. We can argue about the reasons for that, but nowhere in the document do I see a target for the reduction in delayed discharges.

The 2003 target for in-patient admission is nine months. However, we do not have a target that says that no one should have to stay in a hospital bed for more than nine months. As far as I can see in the document, although I may have missed it, there is no allocation of funds to deal with in-patient waiting times. In previous years, the Executive has given money to local authorities and health boards not specifically for delayed discharges, but with the implication that it should be used for that purpose. What target is the department setting for the number of delayed discharges and for the length of time that any Scot has to sit in a hospital bed? As those patients are often aged, that is a bad situation for them.

John Aldridge: Dr Simpson is right on the first issue that he raised. The document does not have a specific budget line for delayed discharges. However, the resources that were issued last year for tackling winter problems, including delayed discharge, and the £10 million that was allocated to local authorities are recurrent and are in health boards' and local authorities' budgets. We expect to see the developments that were funded by that extra money continuing into future years; that would be monitored.

We are collecting information on the effect that the extra money that was invested last year has had across Scotland over the winter. In the light of that information, we will decide what further steps, including further investment, might be taken. That process will include considering what steps should be taken to set targets.

Dr Simpson: Would you welcome it if the committee, as one of its specific recommendations, were to suggest that further funds be allocated? We would have to say where the funds would come from. For example, NHS 24 will be slow in coming on line, so there may be an opportunity to reallocate at least £6 million. Would it be unreasonable of the committee to address that area or to discuss it further with you?

John Aldridge: It would not be unreasonable. My only qualification is that the Executive is keen that dealing with delayed discharges should become part of the mainstream work of health systems and local authorities. There is a risk, when we make plans for the winter, that if we continue to have specially labelled amounts of money to deal with problems such as delayed discharges, the local systems—in the health and local authority sectors—will expect extra money before they will take any action on that problem. That is one reason why we are trying to move away from such special labelling. Nevertheless, that is a matter for the committee to consider. Delayed discharges remain an issue of great concern to the Executive.

Dr Simpson: I have just come back from looking at the problem of delayed discharges in Manchester, which has a similar population to Scotland's and had similar problems two or three years ago. It is calculated that Manchester has between 200 and 300 delayed discharges. South Manchester University Hospitals NHS Trust, which is managed by an ex-manager of a Scottish health trust, has got the figures down to 15 cases in which the target was met and 15 cases in which the target was not met. Its target is 10 days, not six weeks. I am surprised that there is nothing forward-looking in the budget for dealing with the massive problem of delayed discharges, which causes us huge resource difficulties.

John Aldridge: I have tried to explain that we are reviewing what happened over the winter and will be taking action on that.

Dr Simpson: I understand.

The Convener: I have to bring questioning to a close—we have run over by about 35 minutes. I am sure that we can pass on in writing to John Aldridge and the others any questions that we did not ask. Thank you for attending the meeting this morning and for the other information that you will give us in due course.

Subordinate Legislation

The Convener: Agenda item 3 is subordinate legislation. The first instrument for consideration is the National Health Service (Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2001 (SSI 2001/67), which was circulated to members on 6 April. No comments have been received from members. The Subordinate Legislation Committee notes that the Executive has agreed to work towards consolidation of the regulations. The Subordinate Legislation Committee would like progress to be made in that area and for the regulations to be drafted in plain English to make them intelligible to the lay reader—that probably means us as well. No motion to annul has been lodged, so I suggest that the committee make no recommendation in relation to the instrument. Do members agree to that suggestion?

Members *indicated agreement*.

The Convener: The National Health Service (Dental Charges) (Scotland) Amendment Regulations 2001 (SSI 2001/69) were also circulated on 6 April. No comments have been received from members. The Subordinate Legislation Committee notes the Executive's comments regarding the breach of the 21-day rule and recommends that the Executive should make a particular effort to avoid that where an instrument is of direct relevance to the general public. No motion to annul has been lodged, so I suggest that the committee make no recommendation. Do members agree to that suggestion?

Members *indicated agreement*.

The Convener: The Miscellaneous Food Additives (Amendment) (Scotland) Regulations 2001 (SSI 2001/103) were circulated on 13 March. No comments have been received from members, the Subordinate Legislation Committee has made no comments and no motion to annul has been lodged, so I suggest that the committee make no recommendation. Is that agreed?

Members *indicated agreement*.

The Convener: The Feeding Stuffs (Sampling and Analysis) Amendment (Scotland) Regulations 2001 (SSI 2001/104) were circulated on 6 April. No comments have been received from members. The Subordinate Legislation Committee has raised the matter of doubtful vires, which means that the instrument raises a devolution issue. The Subordinate Legislation Committee intends to explore the matter further with the Executive. The Rural Development Committee has nothing to add. No motion to annul has been lodged, so I suggest that the committee make no recommendation. Is that agreed?

Members *indicated agreement.*

The Convener: The National Assistance (Assessment of Resources) Amendment (No 2) (Scotland) Regulations 2001 (SSI 2001/105) was circulated on 6 April. No comments have been received from members. The Subordinate Legislation Committee has noted that, because of defective drafting, which the Executive has acknowledged, the Executive intends to revoke and remake the instrument. No motion to annul has been lodged, so I recommend that the committee make no recommendation. Is that agreed?

Members *indicated agreement.*

The Convener: The National Health Service (General Medical Services) (Scotland) Amendment Regulations 2001 (2001/119) was circulated on 6 April. No comments from members have been received. The Subordinate Legislation Committee is happy with the instrument. No motion to annul has been lodged, so I recommend that the committee make no recommendation. Is that agreed?

Members *indicated agreement.*

Petitions

The Convener: Members will recall that, periodically, we consider new petitions that have been received and consider the progress that has been made in dealing with petitions that we have previously received. In passing, I say that the Health and Community Care Committee gets its fair share of petitions and has a good record of dealing with them effectively—I am not saying that only for the benefit of the Public Petitions Committee's convener, who is also a member of this committee.

Two members of the committee have commented on petition PE320, from John Watson on behalf of the World Development Movement Scotland. It calls on the Health and Community Care Committee to examine the implications for health policy in Scotland of the World Trade Organisation's liberalisation of trade in services. John McAllion has suggested that we hold an inquiry on the matter and Richard Simpson has suggested that we call for a debate in the chamber. It is worth pointing out to members that a motion on the matter was lodged by Linda Fabiani some time ago and has attracted 53 names in support. The view that the matter should be examined seems to have general support in the Scottish Parliament.

Mary Scanlon: I have not read as many background papers as John McAllion and Richard Simpson have so I would like someone to explain to me the ways in which the WTO's liberalisation of trade impacts on health policy in Scotland. I seem to have missed that.

The Convener: John, would you like to do that? I could have a stab at it, but I think that you are much more of an expert.

Mr McAllion: The issue is causing a great deal of concern both inside and outside the Parliament. The WTO is seeking to come to a new agreement on trade and services. The majority of the members of the WTO have private health systems or part-private and part-public health systems and want to open up public services, in particular health and education, to competition. The UK is a member of the WTO and will be able to contribute to that debate but, if the member states decide to open up our core public services to competition, the private sector will be able to compete to provide such services. To an extent, that already happens—we heard this morning that four of the new hospitals will be built using a public-private partnership agreement under which the private sector will run the hospitals and the ancillary services. The new generation of walk-in-walk-out hospitals will be open to the same process as well.

The Health and Community Care Committee should examine the implications for Scotland of the WTO's proposals so that we can inform the UK about the representations that it has to make to the WTO. We should determine whether the Scottish Parliament agrees that our public services should be opened up to competition in the way that the WTO suggests. I do not believe that they should be and I think that we should send a clear message to the UK that Scotland is opposed to any such opening-up of the public sector to private competition.

The Convener: The examples that you mentioned suggest that the issue is to do with buildings rather than with clinical services.

Mr McAllion: The liberalisation that is proposed by the WTO would include clinical services.

Dr Simpson: If the regulations that are proposed by the WTO are accepted in their current form, countries would not be able to run a state national health service without allowing private companies to compete for services. To take the example of an ambulatory care and diagnostic unit, we have already opened up to competition the construction of the building and the running of the maintenance and cleaning services, although the national plan shows that we are trying to pull back from having competition in relation to the latter service. However, under the proposals, the clinical service of the ACAD would also have to be opened up to competition.

The subject is worthy of further consideration and perhaps of an inquiry. As a first step, however, we should have a debate in the chamber. The matter is a lot more important than some of the—sorry, I will stop there, as we are not in private session.

11:15

The Convener: The members of the committee can fill in the end of that sentence appropriately; I think that we would all agree with you, Richard.

Margaret Jamieson: What is the House of Commons Health Committee doing in relation to the matter? Obviously, the WTO's proposals will have an impact on the rest of Britain. It might be useful to find out what is being done in England, Wales and Northern Ireland. That would ensure that, before we decided what to do, we were all examining the issue from the same point of view.

Dorothy-Grace Elder: Anyone would agree that there should be an inquiry into the issue, but who should conduct it? We no longer have any bodies to spare, so we might not be able to assign a reporter to the inquiry. I agree with those who favour having a debate in the chamber first.

Mr McAllion: One of the problems with that is

that the debate would not be as well-informed as one that took place after an inquiry. It is important that we get in contact with the Executive and with the UK Government to find out what their positions are. We should also contact the World Development Movement to put together the arguments for and against the WTO's proposals so that we can take an objective view.

Mary Scanlon: I do not have problems with people coming to Scotland for operations, for example, but I understand my colleagues' points of view. However, as trade and industry policy is a reserved power—it is part of the remit of the Department of Trade and Industry—we would be better off examining what is being done in Westminster. There is no point in our having a debate about something that is not going to happen anyway. We need some guidance on that before progressing.

The Convener: First, we need a steer about what is happening in Westminster, not only what the Government's input into the negotiations will be but what the House of Commons Health Committee is doing. Once we have that information, we could return to the matter. Bearing in mind what I have said about the Westminster dimension, I agree with my colleagues that, although the matter is a trade issue, it has clear implications for Scotland's health service, which is not a reserved matter.

As John McAllion said, we need to think seriously about whether having a debate before we have had an inquiry would be a good idea. I think that the issue requires further work to be done and that this committee is one of the best-placed groups to do that work.

We will return to the matter once we have got more information on the Westminster dimension. Meanwhile, I ask members to give the matter some thought. If anyone is interested in being a reporter on the issue, they should make that known.

Mr McAllion: I would be happy to work on the report.

The Convener: I was going to say that if I had not received an indication from a member, there would have been a timing implication and an issue about work load. However, as John McAllion has indicated that he is prepared to take on board that work, the question is whether it would be useful for us and, more widely, for our colleagues both in the Parliament and elsewhere in Scotland, for the committee to do some work on that issue, bearing in mind what is going on at Westminster. Once we have received information about the Westminster dimension, we will return to the issue.

Mary Scanlon: I also need to know what the time scale will be for the liberalisation policy.

The Convener: Do members agree that we should confirm that information with Westminster first?

Members *indicated agreement*.

The Convener: The second new petition is from the Scottish Organisation Relating to the Retention of Organs and calls for the Scottish Parliament to initiate a public inquiry into the practice of organ retention at post mortem without the appropriate parental consent.

Richard Simpson suggests that the committee should examine and comment on the review group's report. John McAllion suggests that we should seek information on reactions to the report, including those of the Executive.

Dr Simpson: I am quite happy with John McAllion's approach. The report has been published—I think that the final part of it is out now. The report is in two parts: an initial rapid report by Sheila McLean and a more considered report of the implications of organ retention. Timing is important and, ultimately, we will need to comment on the report. The balanced decision that we must make is whether we comment as part of the Executive's consultation that will arise from the report or whether we do so once the Executive publishes its view.

Mary Scanlon: I understand that guidance was issued in January, in the form of a code of practice, and that recommendations about consent, removal and retention will be announced in the autumn. I would like the issue to be put back on the agenda in September or October, so that we can ask whether those recommendations address the issues that have been raised in Geraldine MacDonald's petition. Although that is a wee bit of time away, should not we wait for those recommendations?

The Convener: We can follow the John McAllion line by seeking further information on the situation. When we have obtained that information, we will be able to decide when and if we want to return to the petition. As Richard Simpson said, there may well be an opportunity for the committee to comment during the consultation exercise.

We will ask for further information first and once that information has been gathered, we will return to the petition.

Mary Scanlon: As the code of practice might have addressed SORRO's concerns, would it be appropriate to ask the organisation for its response to the code?

The Convener: We could ask whether the organisation wishes to make further comments at this stage.

Although the papers that we have are useful—

they were submitted to the Public Petitions Committee when the petition was submitted—they were several months out of date by the time that they reached us. Petitioners' views alter as developments take place, and it would be useful to have information about such changes.

We now move on to on-going petitions. Petition PE192, from Mr Doherty, calls on the Scottish Parliament to order the Mental Welfare Commission for Scotland to regard all its records as health records and to comply with the Access to Health Records Act 1990 by allowing those defined as eligible in that act to have access to records.

In December, the committee noted correspondence from the Mental Welfare Commission and forwarded that correspondence to the Millan committee, which published its report in January. In the fullness of time, that report will metamorphose into a new mental health act, which will come to the committee, no doubt. I suggest that we consider compliance with the legislation on access to mental health records at that time.

Mary Scanlon: Could I ask the more knowledgeable member on my right—Richard Simpson—whether the two points raised by the petitioner have been addressed by the Millan committee in its huge report?

The Convener: I think that, to an extent, the report covers the second point raised by the petitioner. However, I am able to say that only anecdotally, as I have read the report only once.

Dorothy-Grace Elder: I believe that the second point raised by the petitioner is already covered by the Data Protection Act 1998. The petitioner can force access—

Margaret Jamieson: Does not that act cover computer records only?

Dorothy-Grace Elder: No. It covers documents as well.

The Convener: Do members agree to take on board the issues raised in the petition and to consider access to records when we do further work on the new mental health legislation?

Members *indicated agreement*.

The Convener: Petition PE214 is about the Scottish cardiac transplant unit. Did members receive today the new letter from the Executive, which provides an update of the situation?

The Scottish cardiac transplant unit in Glasgow has reopened, about which the Minister for Health and Community Care made an announcement. She is considering expanding the service to enable heart-lung and lung transplants to take place and has increased the annual funding of the unit by £600,000, to secure its long-term future. That means that it will no longer have only one consultant—that was a major problem in the past—as a four-consultant team will be in place. That is a good-news story for those who were concerned about the long-term future of the unit.

Dorothy-Grace Elder: It is almost exactly a year since the unit at Glasgow royal infirmary closed. We should consider writing to the minister to ask on which exact date—or even in which month—the unit will reopen.

The Convener: Has not the unit reopened already?

Dorothy-Grace Elder: I do not think so.

Mary Scanlon: I support Dorothy-Grace Elder's proposal. It appears that the minister intends to make a full statement about the work of the unit in the near future.

Margaret Jamieson: The text of the minister's announcement, which was issued on 30 March, says that the unit

"will resume heart transplant operations within the next three to six months".

Dorothy-Grace Elder: There were delays last year.

Margaret Jamieson: I accept that, but you cannot hand-knit consultants and staff for the unit.

Dorothy-Grace Elder: When the unit closed, there was no declaration that it would remain closed for as long as a year. Since patients have had to go to Newcastle, which handles only a handful of operations, the operation rate has dropped drastically.

The Convener: Reading between the lines, I think that, had the unit reopened as a single-handed, one-consultant unit, it could have reopened earlier. However, the Executive is proposing a massive increase in the unit's funding and a fourfold increase in staffing, and those staff have yet to be put in place.

I seek guidance from members. Personally, I think that the Executive has addressed the issue raised in the petition.

Janis Hughes: I agree. I was involved in the issue when the unit closed, and the timing of exactly when to reopen the unit must be a clinical decision. It would not be possible to put in place four senior consultants tomorrow and expect them to work as a team immediately. That must be planned clinically, rather than being planned by a minister. I am sure that the team at the unit will let the minister know as soon as the unit is ready. The four consultants will not just sit there if it is possible for them to do heart transplants, because they have skills to maintain and will be keen to

start work.

It would also be pertinent for us to look at the documents that we received today. I note that Anne Dundas, the spokesperson of the heart transplant patients support group, welcomes the decision to reopen the unit. As she is a representative of the patients, her welcome comes from the patients themselves. I am happy that what has been put in place so far allows us to be optimistic, and I am sure that a clinical decision to reopen the unit will be taken as soon as it is clinically possible to do so.

Mary Scanlon: I read the Executive's letter of 23 March, which, to be honest, I thought was a bit vague. However, this morning, we have been circulated with a copy of the minister's statement, dated 30 March. When I made my earlier comments, I was unaware of that statement, and I am sorry about those comments. We have been given a full outline of what is happening and I hope that the petitioner will be happy with that information.

Members *indicated agreement*.

The Convener: That is excellent.

Petitions PE45 and PE185, from the Haemophilia Society and Mr Thomas McKissock, are about haemophilia and hepatitis C. The issue is on-going. Further information is being sought, and the minister has been invited to attend the meeting of 23 May. Committee members will be aware that a debate is scheduled for Thursday. I asked for information from the Scottish Parliament information centre about the implications of the latest legal decisions in England, as other members did. A member of the SPICe team is here to bring members up to speed after today's meeting if they would find it helpful to be made aware of the legal situation following the decisions.

11:30

Margaret Jamieson: On parties raising issues for debate, this is the second time that the committee has been involved in taking evidence and a debate has been called in the Parliament before we have completed the process. It makes a mockery of the committee system for that continually to happen. We will be involved in a debate tomorrow when we have not even heard from the minister. She may well make comments tomorrow that would otherwise have been made to the committee on 23 May. The matter must be raised at the conveners group. It is not helpful at all.

Shona Robison: On the point of principle, each party decides which subject it wants to debate. That has always been the case and the Executive does likewise. The committee's on-going inquiry has been wide ranging and has looked back over a number of years. This week's debate is on the specific subject on which we will hear information from SPICe later. The Health and Community Care Committee's inquiry has been broad; the subject for debate this week is specific, so I do not think that Margaret Jamieson's comments are relevant.

Mary Scanlon: I have not seen the motion yet, so I am not sure what it is about.

The Convener: It is about compensation.

Mary Scanlon: I have a lot of difficulty with this. We have been working hard and had an excellent session with the Scottish National Blood Transfusion Service and the Haemophilia Society. We asked them to send further information and asked the minister for her response. It is sad—very disappointing—that we are being bounced into taking lines.

I have not had an opportunity to discuss the matter with my colleagues in the Conservative group. It is important that I can give them the on-going evidence. We tried to discuss the matter last night, but we did not have all the information and we have not had a ministerial response. I am finding it difficult to discuss the issue with members of my group so that I can take their advice as their representative on the committee. I am being bounced into a debate tomorrow, which I do not yet feel ready for. I have information from London and from the House of Lords. I find this a complex issue; I am totally confused about it.

I am sorry that the Scottish National Party did not pay the Health and Community Care Committee the courtesy of allowing members, whatever their party politics, to finish an inquiry into this sensitive, emotional, compassionate and complex subject. To be honest, I am quite angry about it.

Shona Robison: That is a bit rich, given what the Tories did over Sutherland—bringing forward a debate in the middle of an inquiry. Whether Mary Scanlon feels ready to discuss her view on compensation is a matter for her. I know that the people out there with hepatitis C are ready for a debate in the Parliament, and they want it as soon as possible. That is clear. They come first. Quite frankly, Mary Scanlon should practise what she preaches.

Mary Scanlon: We have a committee system. I feel strongly about my party politics too, but the people of Scotland expect us to put their health before our party politics. I am sorry, but I think that Shona Robison has to learn the lesson that when we come to the committee, we work together.

The Convener: I know that a number of members want to have their say, but I am intent on

bringing the matter to a close. I am quite proud of the fact that, to a large extent, members of the committee—both past and present—have left their party politics and dogma at the door. They have considered the issues, taken the evidence and, in some cases, voted against their party line as a result of the work that we have done in committee. That has value, which I do not like to see abused.

I have discussed situations such as this with the Scottish National Party in the past and I take Shona Robison's point about the Conservative debate on Sutherland. I agree with Margaret Jamieson that the matter should be discussed at the conveners group. It has been raised before. All parties, including Executive parties, must be aware that committees do detailed work. This matter is particularly complex and is about much more than compensation.

The argument works both ways. Compensation can be picked out and considered on its own, but it must also be put in context. We should look not only at the popular stuff, but at the whole question of screening over several years, which we addressed with the SNBTS. There are a number of issues. As a committee that will produce a report, we could give due recognition to all the different strands and, as we have done so many times in the past, put our party politics to one side to produce a committee report that has greater standing as a result. I will not prejudice the committee's view on hepatitis C. We might produce a unanimous committee report that suggests that the moral and legal way forward is to give compensation for hepatitis C to haemophiliacs.

Dr Simpson: Or we might not.

The Convener: Or we might not. I feel frustrated that all parties have, at some point, chosen to have debates in a manner that frustrates the committee process. The correct place to discuss that is, first, among the conveners of all parties and then at the Procedures Committee and the Parliamentary Bureau. We must try to find a way to work together. It is not useful for the meeting to descend into a squabble. We are talking about a petition on which we have so far all done incredibly good work.

Shona Robison: Convener, it is your job to stop the discussion if you feel that that is appropriate.

The Convener: That is what I am saying; I am stopping the discussion. I will raise the matter at the conveners group and will ask the Procedures Committee, the Parliamentary Bureau and the Scottish Parliamentary Corporate Body—if that would be useful—to consider it. That is my recommendation.

Dr Simpson: Will there be an appeal against the judgment?

The Convener: We will come to that. That is the substantive point.

Dr Simpson: It is important in relation to our considerations.

The Convener: As of yesterday, I understand from very good sources that there will not be an appeal against the judgment.

Dr Simpson: It would be helpful to know.

The Convener: That is my understanding.

Dr Simpson: Has time run out for the appeal?

The Convener: No; it has been decided that there will not be an appeal.

Dr Simpson: So it has been announced that there will not be an appeal.

The Convener: I do not know whether it has been announced. It has been announced at ministerial level that the decision for England will not be appealed. We must make a decision in that context.

The next petition is PE145. The MMR—measles, mumps and rubella—report has now been published. We can take some credit there.

Petition PE123 is on the warm homes campaign. Initially, Malcolm Chisholm was dealing with that. It has now been handed to Dorothy-Grace Elder, who will report to us on 25 April.

Margaret Jamieson: That is today.

Dorothy-Grace Elder: No, she will not. The report has been delayed. I am sorry about that.

The Convener: It has been delayed. That shows that I am just reading my notes without thinking. Dorothy-Grace will report in the near future.

I think that I am correct in saying that we will be hearing about the next petition, PE217, on single-handed GPs, in a private agenda item.

Petition PE247, from the Epilepsy Association of Scotland, calls on the Scottish Parliament to ensure that there are co-ordinated health and social services that will benefit people with epilepsy. We agreed to await the acute services review, which is still not complete. Are members happy to continue with that course of action?

Members *indicated agreement.*

The Convener: Petition PE223, from Mr and Mrs McQuire, calls on the Scottish Parliament to ensure that multiple sclerosis sufferers in Lothian are not denied the opportunity to be prescribed beta interferon. We agreed that we would await the National Institute for Clinical Excellence report and the Health Technology Board for Scotland report. Are members happy to maintain that

position?

Mary Scanlon: I would just like to note that NICE has put the report back until about October or November. The last I heard, it was November, but it has certainly been delayed.

Dr Simpson: I think that it is September. The HTBS will then have another six or eight weeks after that. So, for us, it will be October or November.

The Convener: I certainly thought that it was October or November, but that might be the date for the HTBS. I do not see that there is any benefit to the committee in making a statement on beta interferon in advance of the NICE and HTBS statements.

Dorothy-Grace Elder: Do we have a reason for such a long delay?

Dr Simpson: Yes. You can question how valid it is, but the reason is that the original report that was about to be published was not thought to have enough appropriate health economic data or modelling—our adviser might agree with such criticism in another context. NICE therefore put out to tender a research project to look at the health economic modelling. The results will not come in until August, and it will therefore be September by the time that NICE can report. There will then be eight weeks beyond that for the HTBS to look at the report. You can argue about the validity of that reason, but that is why there are all those delays.

Dorothy-Grace Elder: Does anybody know how far on the HTBS was before—

Dr Simpson: The HTBS, quite correctly, has made a decision to work with NICE. If NICE is undertaking an investigation, the HTBS will not replicate it in Scotland. That would be a waste of resources. However, the HTBS will comment on the NICE report. Without wishing to anticipate the report, there is much more MS in Scotland than there is in England. There are therefore arguments for saying that we need to look at the situation separately and make our own decisions. However, we should do so on the back of the UK evidence. The delay is, understandably, very unacceptable to MS sufferers and their families, who are dismayed by the delay.

Dorothy-Grace Elder: Dismay is the word. I feel dismayed, too. I have to declare an interest as honorary president of Glasgow and North East MS Society. As you know, some MS cases degenerate so rapidly that six months is crucial. Sometimes it can take only two or three months.

Dr Simpson: The other thing to remember is that the cost of beta interferon is exorbitant in the UK. We have failed to negotiate adequate prices, but that is another matter. Prices here are much higher than they are in the rest of the world, and people are now buying it over the internet at two thirds of the price that we pay for it as a country. That is another issue.

The Convener: We shall await those reports. In responding to those reports, the committee will probably want to comment on the petition.

The final petition, PE148, from Mr Anderson, calls on the Scottish Parliament to investigate issues around organophosphates. We agreed to take no further action on the petition, on the understanding that the matter was being reviewed at Westminster. A research proposal will shortly be agreed between the UK Department of Health and the Ministry of Agriculture, Fisheries and Food, so that further information can be gathered. Are committee members content that that is sufficient action on the petition at this time?

Members *indicated agreement.*

The Convener: The only other point is that there is an annexe to this agenda item on petitions. There is information from Mr Grant about psychiatric care in the NHS in Aberdeen, which I think might be useful to members, who should bear it in mind when we return to the Millan commission on mental health.

That brings to an end the public business of this morning's committee.

11:45

Meeting continued in private until 12:38.

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