HEALTH AND SPORT COMMITTEE

Wednesday 26 September 2007

Session 3

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HEALTH AND SPORT COMMITTEE
5th Meeting 2007, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

*Joe FitzPatrick (Dundee West) (SNP)
Jamie McGrigor (Highlands and Islands) (Con)
Irene Oldfather (Cunninghame South) (Lab)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Bill Howat (Budget Review Group)
Chris Naldrett (Scottish Government Primary and Community Care Directorate)
Billy Reid (Scottish Government Healthcare Policy and Strategy Directorate)
Jenny Stewart (Budget Review Group)

CLERKS TO THE COMMITTEE

Karen O'Hanlon
Simon Watkins

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Wednesday 26 September 2007

[THE CONVENER *opened the meeting at 11:06*]

Interests

The Convener (Christine Grahame): Good morning and welcome to the fifth meeting in session 3 of the Health and Sport Committee. I ask members and people in the public gallery to switch off their mobile phones—I had forgotten to do so myself. I have received apologies from Michael Matheson, but we are joined by Joe FitzPatrick, the Scottish National Party substitute member. I welcome Professor Sutton, who is our budget adviser and who is here for later proceedings—I say that in case anybody wonders why he is here.

We have three new committee members. Could we get Richard Simpson, please? I think he is outside the room.

Ross Finnie (West of Scotland) (LD): He is just standing out there, by the door.

The Convener: He thinks that five minutes lasts seven minutes, but we will teach him otherwise. In any event, I welcome the two new members who are present. I am pleased that Helen Eadie is now here as a member in her own right, rather than as a substitute for Karen Gillon or Malcolm Chisholm—it is good to see her getting her appropriate role. As this is Rhoda Grant's first committee meeting, I ask her to declare any relevant interests.

Rhoda Grant (Highlands and Islands) (Lab): I am a Unison member, which may have relevance to the committee, as Unison is a major representative of health care workers. I have no other interests to declare.

The Convener: I welcome Dr Richard Simpson and ask him to declare any interests that are relevant to the committee's remit. This may take some time.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Until recently, I was employed as a consultant psychiatrist by Lothian NHS Board. I have now retired from that post, but I will continue to hold a consultancy with the board for a temporary period, which will probably be about six months, for specific work on developing a single shared assessment system for drugs and alcohol users. I declare membership of the Royal College of General Practitioners, fellowship of the Royal College of Psychiatrists, membership of Amicus, which is now part of Unite, membership of the British Medical Association, membership of the Scottish Association for Mental Health and membership of the Scottish Drugs Forum. I am also a member of Strathcarron hospice and a past chair of its management committee. Those are all the interests that are particularly relevant to the committee, although I should say that as well as having been a psychiatrist I was, as Dr McKee was, a general practitioner for many years.

The Convener: You and Dr McKee will be valuable committee members, given your expertise.

Decision on Taking Business in Private

11:09

The Convener: Item 2 is to ask the committee whether it agrees to take item 5 in private to give us an opportunity to consider our approach to budget scrutiny. For the benefit of new members, that is normal practice. Are we agreed?

Members *indicated agreement*.

Subordinate Legislation

National Health Service (Charges for Drugs and Appliances) (Scotland) (No 2) Regulations 2007 (SSI 2007/389)

11:10

The Convener: Item 3 continues consideration from last week of Scottish statutory instrument 2007/389, which is subject to the negative procedure. We decided last week to ask officials to give evidence on charges for wigs under the NHS. I refer members to the copy of correspondence from Shona Robison, the Minister for Public Health. I welcome Chris Naldrett, Shelagh Scott and Billy Reid, from the Scottish Government. I invite Mr Naldrett to say a few brief words before we move on to questions. I hope that I have pronounced your name properly, Mr Naldrett.

Chris Naldrett (Scottish Government Primary and Community Care Directorate): You have indeed. I am assuming that members have read the letter from the minister dated 24 September, so I will keep this brief and reiterate the key points. The statutory instrument makes a couple of technical amendments, which we can go into if the committee wishes. The key change is to regulation 7, which in practice lists all exemptions from prescription charges. To it is added a new exemption category in the shape of medicines that will be prescribed and dispensed for sufferers of tuberculosis. That is being done on public health grounds and in parallel with health administrations in the rest of the United Kingdom. Patients who have TB, or people with suspected TB, require a cocktail of antibiotics to treat their condition. If they are not exempt from charges, there is, given the number of prescriptions that they have to be given, a possibility that they will not be able to take all their medication because of the prescription charge. The provision will remove a financial barrier to patients continuing and finishing their treatment for TB.

The Convener: Thank you. The minister's letter was helpful.

Helen Eadie (Dunfermline East) (Lab): I have no wish to delay the TB aspect of the SI from going through, but I would like to know whether alopecia is regarded as being a chronic condition. There are many hundreds of alopecia sufferers, including young women and children. I had a big meeting in Parliament on the issue.

Chris Naldrett: There is currently no strict definition of "chronic condition", although the Scottish Government is considering its manifesto commitment in that regard. What we can say, which is in the minister's letter, is that the group that is reviewing the matter of supply of wigs has made its recommendations to the minister. Chronic conditions fall outside the medical exemption from prescriptions.

Helen Eadie: You say that the supply of wigs investigation group has now reported to the minister. When can we expect an outcome?

Chris Naldrett: I am not sure. Billy Reid was policy lead on that matter. The report was compiled and presented to the previous Administration at the end of its term of office, but it is just within the past week or so that it has been resubmitted to the current minister. Billy Reid might have a better idea of timetables than I do.

Billy Reid (Scottish Government Healthcare Policy and Strategy Directorate): I do not think I do. The report was presented to the minister on 20 September, so we are waiting for a response.

The Convener: I suggest that we write to the minister, who might give us some idea of when we are likely to have the report.

Helen Eadie: That would be helpful. I would not want the SI to be delayed today. In writing to the minister, I encourage the committee to agree to support the form of words that I have brought with me.

11:15

The Convener: I wonder whether I can first put some questions to the committee and see then whether we can reach a form of words that you might be content with.

As the Subordinate Legislation Committee has raised no issues in relation to the regulations and no motions to annul have been lodged, is the committee agreed that it wishes to make no comment on their main purpose of providing free prescriptions for the treatment of tuberculosis?

Members *indicated agreement*.

The Convener: In light of the working group's review, the comments that we have heard today on the details in the minister's letter about the provision of wigs in the NHS and the fact that we have agreed to write to the minister to find out when she will report to us on the matter, does the committee agree to wait for the review's outcome and then to comment accordingly in our report on the regulations to the Subordinate Legislation Committee?

Helen Eadie: When we write to the minister, can we ask specifically for a copy of the working group's report?

The Convener: I think that it will be in the public domain, but we can certainly ask for a copy.

Dr Simpson: On a technical point, are people who suffer from total alopecia as a result of cancer treatment eligible for free wigs or do they still have to pay prescription charges?

Chris Naldrett: That depends on where the prescription is made. If the prescription is made for dispensing at the hospital, it will be free of charge; however, if a patient is in the community and is not exempt under other exemption criteria, he or she will be liable to the charge.

Dr Simpson: So the provision is provider-focused, rather than patient-focused.

Chris Naldrett: Yes.

Dr Simpson: I suggest that, in writing to the minister, we ask that the review be patient-focused, not provider-focused.

The Convener: We do not think that the review has dealt with that matter, so we can certainly raise it with the minister.

Ian McKee (Lothians) (SNP): The executive note to the regulations states:

"The purpose of this instrument is that NHS prescription charges shall not be levied in respect of drugs prescribed for the treatment of Tuberculosis".

You have said that there is a public health reason for that provision. Does that mean that you will charge for drugs that are given to those who have had contact with people who have tuberculosis or will they, too, be exempt? After all, it is equally in the public health interest that those people take their drugs.

Chris Naldrett: The provision is specific to people who are being treated on the premise that they have TB.

Ian McKee: So people who might have TB will have to pay for their drugs.

Chris Naldrett: Yes, until it becomes a condition that looks as if it is TB.

The Convener: We are backtracking somewhat. So far we have agreed to await the review's outcome, to write to the minister and to ask whether the review has been patient-focused rather than provider-focused. Have I missed anything?

Helen Eadie: We were going to ask for a copy of the report.

The Convener: Indeed. I missed that.

Ian McKee: I am not backtracking. I agree that any treatment that is to be prescribed—

The Convener: All I am saying is that we have already agreed part of our response to the Subordinate Legislation Committee. However, Dr McKee raises an interesting issue from experience that he might wish to pursue with the minister or through a parliamentary question.

Ian McKee: It seems only reasonable for such a public health issue to be covered in public health regulations.

The Convener: Are members content with the other points that we have been discussing?

Members *indicated agreement*.

The Convener: I thank the witnesses for their evidence and thank members, particularly Helen Eadie, for raising certain issues.

Budget Process 2008-09

11:19

The Convener: I welcome Bill Howat, lead reviewer, and Jenny Stewart, from the budget review group. I refer members to paper HS/S3/07/5/02, "Budget process 2008-09", and I invite Mr Howat to talk about the review group's key findings and potential areas of headroom in the health and community care budget.

Bill Howat (Budget Review Group): Good morning and thank you for the opportunity to appear before the committee. I will introduce myself briefly and let Jenny Stewart introduce herself, after which I will make opening remarks.

I retired just under two years ago from being chief executive of Comhairle nan Eilean Siar—Western Isles Council. Since then, I have done consultancy work, which included my work as lead reviewer for the budget review. This is not a declaration of interests, but I alert the committee to my voluntary chairing of Volunteer Development Scotland, which is working with NHS Scotland to develop a volunteering strategy. I do not think that that affects anything that I will say, but I mention it out of courtesy to the committee.

Jenny Stewart (Budget Review Group): I am head of infrastructure and government at KPMG, the professional services firm. At the time of the review I was director of project finance and a member of the UK government services leadership team at Ernst & Young. For the past 14 years, I have been an adviser to the public and private sectors on major financial and performance improvement assignments. As a courtesy to the committee, I mention that in the past two years my clients have included four Scottish health boards, the Department of Health and the Scottish Executive.

Bill Howat: I will comment on the remit and context of our work and give the committee a few bullet points on generic issues that arise from our report, "Choices for a Purpose: Review of Scottish Executive Budgets", which are relevant across all portfolios. Jenny Stewart will talk about the health portfolio.

As members know, we were commissioned by the previous Administration, so we focused on the priorities that were set out in "A Partnership for a Better Scotland"—the partnership agreement. It is clear that we are in a new political environment. We were one of several work streams for the spending review and we all worked under the assumption that the settlement would be very tight. That is a main message of the report. Our main aim was to identify areas in which resources could be used more effectively to achieve priorities and aims—our shorthand for that was "headroom". I emphasise that we were not trying to identify waste; rather, we were focusing on better use of available resources.

I emphasise that in order to meet the timescale, the group considered available evidence. That point came up when we gave evidence to the Justice Committee last week. We did not commission our own research—we were not like a royal commission. The group had a big discussion about whether we should do the work, because we acknowledged that we would simply be reviewing available evidence. We were challenged to be radical and provocative—I think that in many instances we were—and we were asked to apply our views and judgments. Therefore, we were not producing an evidence-based report, but were reviewing the available evidence, on the basis that is set out in the report. To a large degree, we applied our experience and exercised our judgment in making recommendations, albeit that they reflect a good deal of what the stakeholders whom we interviewed said to us. The review was largely complete by May 2006. Some of our recommendations have therefore been overtaken and no doubt others will be overtaken in short order. However, most of our recommendations remain relevant, especially those on generic issues.

The key generic issues are set out in paragraphs 1.5 to 1.12 of the executive summary, for anyone who wants to see them in shorthand. We identified a need throughout the Scottish Executive for clear outcomes-based priority targets at strategic or political level. We especially recommended the development of a best-value culture, which includes a robust and rigorous challenge function across not just new spending but all spending. We said that the Scottish Executive needs to focus more on strategic issues, outcomes and impacts and less on spending up to budget and micromanaging delivery of specific projects. In short, we recommended a much more holistic approach.

For example, the Health and Sport Committee will want to consider other portfolios. The committee has an interest in sport, and the education and justice portfolios are relevant to health spending. We emphasised the need for much more joined-up government. In doing that, we recognised that every public pound has its champion and that, therefore, there is a big debate to be had about where money is spent. We characterised that as the apples versus pears debate. I am sure that you come across that regularly in your work.

Having made those general points, I hand over to Jenny Stewart, who will make some specific points on the health portfolio. After that, we will be happy to answer questions.

Jenny Stewart: All Bill Howat's points on the generic issues are relevant to health, including his points on the need to identify clear outcomes and the need for better performance management and financial management.

We focused our efforts on encouraging the Scottish Executive to develop a much more sophisticated budget-setting process based on better cost information, on the ability to allocate resources to the areas that are most likely to deliver health gain and, therefore, on the ability to reallocate resources, where necessary, to reflect changing priorities. It is clear that priorities have changed in the past 18 months.

We also spent quite a lot of time trying to challenge the view of locked-in spend. There is a general perception that the NHS is a supertanker that is difficult to turn around. It is true that there are huge cost pressures in changing the health service, but we did not find much evidence of people challenging that and saying, "Yes, there are different ways of doing things. We can turn this tanker around slightly more quickly than we have in the past."

In considering the health budget for the forthcoming period, the other aspects that I highlight to the committee are allocation of capital, use of the NHS estate as a whole, and how the NHS disposes of surplus assets.

Finally, we were asked to examine the health budget at level 3, which ranges from a line that says, "Here is £6 billion for the NHS" to other lines of a mere few thousand pounds. There is an issue about scrutiny of particular levels of expenditure.

The Convener: Thank you both very much.

Ian McKee: I believe that you are looking for headroom, or savings, of £50 million from the pharmaceutical bill of the national health service. We know from evidence on the new general practitioner contract that GPs have exceeded their targets by quite a large amount, but many of those targets involve new pharmaceutical expenditure such as expenditure on statins for people who have raised cholesterol, tablets for people who have high blood pressure and treatment for people with diabetes. We did not know about those people before, but because of GPs' efficiency in reaching and exceeding their targets, they have been discovered, which has led to new pharmaceutical costs. In addition, new medications come along and illnesses that were previously dealt with by nursing treatment are now dealt with by pharmaceutical treatment. How will you reduce pharmaceutical spend, given that all the evidence suggests that it is likely, for good reasons, to increase?

Jenny Stewart: As Bill Howat explained, our work was based on interviews with a range of people throughout the then Health Department and the NHS. We heard that there was scope for a reduction in the pharmacy bill, particularly in relation to hospital prescribing and people who bring their own medicines into hospital. The figure that we cite came from talking to people. In general, we thought that it represented a reasonable view of the expenditure that could be driven out. It did not involve switching from branded drugs to generics—enough has been done on that front—but focused instead on other options.

After our report was published, the audit body in England—I think—came out with a similar ramped-up figure for England. It mentioned a £500 million reduction in the pharmacy bill in England. On the basis of a 10 per cent reduction, £50 million seems to be broadly in line with that.

11:30

Ian McKee: That seems extraordinary. I would have thought that you could quantify the extra statins, high blood pressure tablets, diabetes treatments and new medication fairly easily. If you take that increased amount out of the picture, the overall reduction is much bigger. Getting that just by talking to people sounds a little vague, if you do not mind my saying so.

Jenny Stewart: That is a fair challenge. As Bill Howat says, we are conscious of the limitations of the report. It was not the most detailed exercise, and I would have loved to spend the subsequent year delving into more detail. As for where the savings were to come from, those were the views that were expressed to us.

Ian McKee: It is a lot of guesswork.

Jenny Stewart: It is an expression of the views we received from the Health Department and NHS managers.

Bill Howat: I do not want to underplay our recommendations. You will find at the back of the report a fairly detailed pro-forma that every budget holder had to give us. Usually, reams of evidence came attached to it—in some cases, substantial reports were submitted. I take your point, Mr McKee, and we did talk to people, but we also analysed a good deal of underlying data as best we could in the timescale that was available. Without wishing to underplay the recommendations, we recognise the deficiencies in the timescale and remit that we were given.

I will make a further general point. You have given an interesting example of what I would call connectiveness. Various schemes were introduced to encourage GPs to do certain things, but did anyone work out the potential consequences elsewhere? One of the big issues

in our report is linking things through, for example from health to justice. If you read carefully what we have to say about justice and make the link to the drug problem in prisons, for example, you might ask whether people are making those connections. I am not saying that they are not, but they are not always being made. The situation could certainly be improved in that respect.

The Convener: That is a fair point.

Ross Finnie: Time has moved on, so I will focus my remarks on your experience of conducting the review at the time you did and on how you might guide the committee on the task of budget scrutiny upon which we are about to embark. I am encouraged—but also slightly nervous—about Jenny Stewart's remarks and the contents of paragraphs 6.5.7 to 6.5.14 of your report, which are all about outcomes.

Given your experience, can you give the committee some helpful comment on the dilemma we have, which is that we should indeed not try to micromanage, but we need to examine the budget at the right level—which is a difficult choice in itself? We are concerned about the total amount that is spent and the overall impact and effect on the Scottish budget.

The committee must also be concerned about the outcomes for patients. I appreciate that measurements concerning health sometimes need to be long term. There is also the accompanying financial measurement, to which you allude strongly in your report. If the Health and Sport Committee were to select just two or three of the Government's key priorities in health delivery for the individual, in which areas do you think we might encounter difficulties, or where do you suggest we concentrate? The committee has a big difficulty in its ability to conduct its review effectively.

Bill Howat: I will make some general remarks before I pass over to Jenny Stewart, who was closely involved in the health portfolio—I am sure that she will have views on the points that you make. I sympathise entirely with your position, and you have summed up the situation accurately. Such problems are faced by other committees of the Parliament across the board.

We have mentioned the fact that we were dealing with level 3 budgets. For this committee, that means £6 billion going into one budget line and getting distributed through the Arbuthnott formula. That illustrates the problem that you face. What is the appropriate level of scrutiny to give to that budget? You should not lose sight of the fact that you are here to scrutinise, so you should be happy to dig, to delve and to ask awkward questions about costs and other estimates that may be put in front of you. I am sure that you do not need me to tell you to do that.

I know from other work that I have done across the Scottish Executive that evidence of the development of what are loosely called performance management frameworks is emerging. In your question, you set out how the committee should do that work: by identifying three, four or more broad outcomes that the Government should seek to achieve and constructing meaningful indicators of those outcomes. I know that that work is under way in other parts of the Government, so I am sure that it is being done in the health directorates. I bow to Jenny Stewart and the committee on what the outcomes might be, as I did not look at the health portfolio.

Jenny Stewart: I echo completely what Bill Howat has said. The committee will want to challenge and review the outcomes that the health directorates set for the NHS. It should ask what performance management framework has been put in place to allocate those outcomes and what financial information lies beneath the framework. The costing information is poor. Like Bill Howat, I sympathise with the committee regarding its scrutiny role, as we encountered the same problem in the budget review. The financial information that is available is of limited quality, so the committee will have difficulty assessing it.

Mr Finnie asked us to identify three areas on which the committee could spend a great deal of time. The three key pressures are staff costs and contracts, the drugs bill and capital spending. Those are the areas that absorb the biggest share of health service expenditure and to which most scrutiny should be allocated.

Ross Finnie: Both of you have alluded to difficulties of which all members are aware. I am slightly depressed by the fact that eight years ago members of the Health and Community Care Committee were probably making the same point. The convener has emphasised it repeatedly, so it is a bit of a disappointment, to say the least, that the matter has not been addressed.

Bill Howat raised the issue of our scrutinising costs. It is difficult for us to do that if health costs are expressed under block issues or are not adequately provided, especially if we are pursuing or trying to get our hands on a particular outcome. Can either of you add to what has been said on that issue? Jenny Stewart may want to address the point. I notice that Bill Howat has a swift pair of hands. If he can pass that swiftly, he should make himself available for Scotland for Saturday's game, as he may be required. That was a splendid piece of footwork and handwork—a brilliant way of saying, "I'm in charge, but here's my assistant, who did the work." Could the witnesses guide us on the issue, which they raised but in which there is an inherent contradiction?

Bill Howat: I accept the point that the member makes. One of our earliest comments in the full report concerns the difficulty we had dealing with the Scottish Executive's classification of public expenditure across the board. We were asked to examine certain types of classification within the framework that we were given, but we found it impossible to do so. I am conscious of Mr Finnie's accountancy background. In asking the committee to dig into costs, I encourage it to question not simply whether the figures are valid but the method by which they are prepared. The classification of expenditure is an issue worth considering, although I accept that it has been raised in the past. In our report, we echo everything that Audit Scotland has said on the matter over the past five or six years.

I am not being particularly helpful to the member, but I am sure that he did not think that I had a ready answer in my hip pocket. I am also sure that Jenny Stewart would hate to be called my assistant in any sense or at any time. Despite putting on weight, I am still far too light to appear for the Scotland rugby squad.

Jenny Stewart: I certainly would not be able to catch an oddly shaped ball.

The Convener: I warn you, Miss Stewart, that the committee has already featured in various diaries and I can see us heading that way again.

Ross Finnie: I think I will take that as an accounting term.

Jenny Stewart: Absolutely. I have forgotten the question.

The cost pressures and where the committee might direct its resources is a generic point. Costing information is so weak that it would be good if the committee can cajole, encourage or require the Scottish Executive—and thereby the health service—to provide better data, to focus more on outcomes and to manage accordingly. Our report talks about the direction of travel; we have to push the NHS supertanker in that direction.

We are entering a tighter spending environment. Because the cost and other pressures to which we have alluded will bite, it is imperative that all who are involved in any way should be able to see the very specific health outcome that we want for the nation, which is an improvement in the nation's health, so we need to ask how we should allocate that massive £10 billion spend most effectively and what health outcomes we will get for each public pound. If money is more limited in future, we can reallocate resources in a way that will have the least impact on health outcomes. We need to move in that direction.

Mary Scanlon (Highlands and Islands) (Con): Convener, I hope you do not mind but I have five questions arising from the Howat report. I hope that they will be brief.

On the consultant distinction award, a consultant can be paid up to £24,000 on top of their "substantial" increase. That amounts to £19 million, and it is highlighted under the headroom heading. Is it possible for the new Government or the committee to recommend that this be changed, or does it come under the UK settlement?

I also noted what was said about Buggins's turn.

Secondly, I was looking for figures for drug detox and rehab, given that my party manifesto talked about allocating £100 million to that. I was quite surprised to read in paragraph 6.5.169 of the report:

"Drug Misuse funding has been transferred to the Justice Department for 2006-07."

I do not know whether that means drug misuse or detox and rehab. Can you clarify that? That is all I could find about joined-up working on detox and rehab in the report.

My third point—

The Convener: Are the witnesses quite happy to answer five questions all at once?

Jenny Stewart: Yes.

Mary Scanlon: I wanted to do it all at once rather than have you keep coming back to me convener.

My third point is about mental health. I note that the report says that there is no accurate information about auditing, monitoring or outcomes. Can you advise us on that? The committee has a commitment to mental health in the general population and the elderly, and we need to know how we can allocate that commitment so that we can increase health and well-being.

Fourthly, it is a known fact that 90 per cent of NHS contact is with general practitioners, and that that is for 6 per cent of the pay, which is a wee bit iniquitous. Will you comment on that? There is supposed to be a move from acute to primary care.

I raised my final point during the pre-meeting briefing. I am an MSP for the Highlands and Islands. I noticed that our out-of-hours service costs five to six times more per head of population than it does in Glasgow, and I received a written answer today from John Swinney, the Cabinet Secretary for Finance and Sustainable Growth, in which he confirmed that

"There are no measurements of deprivation specific to rural areas and islands where the population is spatially dispersed."

When no measurement of deprivation in rural areas is made, how can I and my colleague Rhoda Grant be assured, as Highlands MSPs, that NHS Highland, NHS Western Isles, NHS Orkney and NHS Shetland are getting a fair share?

11:45

The Convener: Well done, Mary.

Mary Scanlon: Thank you.

Jenny Stewart: I will take it from the top, which was the question about the consultant distinction award. There was quite a bit of debate about that among our team members who look specifically at the health side of things. You are absolutely right about the figure: it is just short of £20 million. Payments are discretionary, however: it is entirely up to the Scottish ministers to decide whether to continue the scheme.

Where resources are scarce, and taking account of retention rates and so on, we feel that it is absolutely right for people to be paid according to that measure, but we also feel that making a blanket award—which is how it happens at the moment—is in effect an add-on to pay. If ministers are looking for headroom, the scheme could be scrapped or, if health boards want to retain a particular consultant for the health service as a whole, they could be allowed to make awards from their own budgets.

The second question was about drug detox and rehab. As the budget line Mary Scanlon mentioned relates to prisons, it has gone to the justice department. I suspect that the general position on drug detox and rehab will be subsumed into individual board expenditure. If we want to reach a perspective on that spend out of the massive lump of expenditure that goes out to health boards, we would need to go down to board level, find out how much each board has spent, and reaggregate the figures.

Mary Scanlon: How difficult does that make it for the committee—or indeed for the Parliament—to say, "We are putting in an extra £100 million for drug detox and rehab work"? How do we know that it will go to drug detox and rehab work? If the spend is not even in the Howat report, how can outcomes be measured?

Jenny Stewart: It is difficult. If I may, I will turn to your next three questions; on mental health outcomes, on the balance of pay for GPs, and on issues to do with the Highlands and Islands. All relate to the Arbuthnott formula and how moneys are allocated to health boards.

I am not an expert on the Arbuthnott formula, but I understand that it is predominantly population driven with adjustments for factors such as deprivation. One issue for ministers—and for the committee—is whether the present Arbuthnott formula reflects the priorities of the new Government.

The Convener: I remind Mary Scanlon that we will take evidence on the Arbuthnott formula after the recess.

Jenny Stewart: That will give the committee a better feel for how funds are allocated. We referred to the Arbuthnott formula in the report. If ministers want to ensure that money is allocated to priorities, one way would be to set out some of them in the Arbuthnott formula. Another way would be to reserve certain pots of money to the centre and allocate them individually to boards, as ministers in the previous Executive did. If a pot is allocated at £10 million or £100 million, ministers can see more clearly what they are getting than is the case with the generic £7 billion that goes across to health boards. The committee may wish to look at that balance to see whether priorities are being met.

Bill Howat: A general issue that we raised in the report was the use of initiatives. It is open to any Government to ring fence money and thereby follow it through, but we recommended that that practice should be minimised. Our experience not only in health but across the public sector was that ring fencing is disruptive, often has unseen and unintended consequences and creates a cascade effect. Although it might seem to be a good idea, in that the minister can say that money has been put into a certain initiative and has had a certain impact, it involves taking people off and disrupting mainstream work. We are not saying that ring fencing should not be done—there may be occasions when it is entirely right—but as a general rule we have recommended against it.

Mary Scanlon: I was not recommending ring fencing—I was just trying to understand what the situation was.

Jenny Stewart: I will make a general point regarding Mary Scanlon's figures showing that 90 per cent of contact time is with GPs, who receive 6 per cent of pay. As was mentioned in the previous session, we were trying to caution against provider-based rather than patient-based analysis, and against looking at inputs rather than outputs. I accept that, given that the shift of activity is towards primary care, it is important that the money should follow the activity to that level.

Mary Scanlon: So you are recommending that more resources go into primary care.

Jenny Stewart: At the moment, yes. During the budget review, we saw an interesting map tracking

activity across the NHS at different levels and the number of episodes across all the different areas of care. I asked whether the pound signs could be attached to that. At that stage they could not, although work had begun to allow that to happen. The committee may want to press further the issue of being able to track where the big amounts of money are going in and where we are getting the output.

Bill Howat: I will take off my hat as lead reviewer and put on my old hat as chief executive of Comhairle nan Eilean Siar to respond to Mary Scanlon's comments about the index of deprivation.

First, I do not know what the question was that was answered by Mr Swinney. I am mildly surprised that the answer seems to be in such absolute terms. Secondly, my understanding is that—on the health side—the Arbuthnott formula contains some factoring in for rurality, and that there is a Scottish index of multiple deprivation that is quite widely used and has elements for rurality. During my time in the Western Isles we regularly had debates with the Scottish Executive about those factors. Thirdly, there is an initiative for the Highlands and Islands within what used to be the Enterprise and Lifelong Learning Department—I do not know which group it will be in now—called iomairt aig an oir, which is Gaelic for "initiative at the edge". That has a specific rurality index. Such things exist and can be used if anyone is so inclined.

Ian McKee: Is there not an index of deprivation and rurality?

The Convener: Just a minute.

Mary Scanlon: It is worth putting the answer on record—it was quite substantive and I only read out the first sentence. It was unfair not to go through the whole thing, as there is more to it than that.

The Convener: In fairness to Mr Swinney, perhaps it would be appropriate to read out the entire answer.

Mary Scanlon: My question was:

"To ask the Scottish Executive whether it will outline the measurements of deprivation used in rural areas and islands where the population is spatially dispersed."

The answer was:

"There are no measurements of deprivation specific to rural areas and islands where the population is spatially dispersed. In terms of resource allocation, different funding streams consider deprivation measures in the context of the basis on which the funding is made available e.g. to fund health boards through the Arbuthnott formula, to fund local authorities through grant aided expenditure and to fund area regeneration through the Community Regeneration Fund. Each of those key blocks of funding take account of deprivation as appropriate.

Additional measures include household income and poverty. Information on the percentage of rural population that is classified as living in relative poverty was published on the Scottish Government website at 9.30 am on Friday 21 September."—[*Official Report*, *Written Answers*, 25 September 2007; S3W-4309]

That information was published just a few days before this question was answered.

Ross Finnie: There is a technical issue, as "index of deprivation" is a technical term that requires proper definition. I am not here necessarily to support the minister, but I think that we should be fair. Although the first sentence of the answer seems to indicate that there is no index, because that is a whole cohort of measurements that are then bundled, it is not fair to suggest that no work has been done. In the past eight years, we discovered that the Carstairs index, which is a subset, was being used for rural areas. Under that index, people who own a car cannot by definition be deprived, which in a rural area is obviously absurd. That was adjusted in the work that was done in the past eight years.

The Convener: I knew that there was value in having former ministers on the committee.

Helen Eadie: I welcome the thinking that has been done about taking into account all the service departments throughout government. My thoughts turn to situations that I have experienced in which local government decisions impacted heavily on health board decisions and created real pressures. An example of that is bedblocking.

We are told that there are pressures on the budgets for drugs. I have read some Audit Scotland reports on the matter, which say that, as patents run out, generic drugs will be possible. However, that is all historical information, whereas I am troubled about the new generation of drugs and looking to the future. The point about interaction between services and departments raises another question, about the interaction between services in Scotland and UK services, such as social security benefits and pensions. Sufferers of rheumatoid arthritis may be helped by some of the new biologics, but giving them such drugs is a big pressure on the health service. However, in socioeconomic terms, that releases pressure because it enables people to get back to work. It is important to look at the bigger socioeconomic picture, because that gives dignity back to patients.

Jenny Stewart emphasised the need to consider quality outcomes for patients. The interaction is not only here in Scotland. My concern is about how we ensure that people in the NHS can access the new generation of drugs that are coming through, given the hefty price tags. We should consider not only how to release funding and make savings but how to release funding and

make efficiency savings so that we can spend and make health improvements for patients.

Bill Howat: That is one reason why our report is called "Choices for a Purpose". We tried to find improved ways of using resources to achieve better outcomes. I remember one amusing discussion during which one of my private sector colleagues—not Jenny Stewart—asked why we were doing the review and suggested that we just stop spending. We had a bit of difficulty explaining the nature of public expenditure and the pressures that exist. I support Helen Eadie's general point, although I am not sure that our report can give more guidance than we have already given on the specific issue that she raises.

Helen Eadie: I asked about the health board and local government aspect.

Jenny Stewart: To be clear, we did not examine local government expenditure, so our remit did not allow us to consider the social work aspect of the health and social work interlinking. That was a little frustrating for the health group, because we would have liked to consider the issue. Tie-ups definitely exist and the point is important.

Helen Eadie's point about drugs takes us back to some of the more general points in the report about pre-expenditure assessment. With new initiatives or, in this case, new drugs, we would expect an analysis of cost and benefit. Helen Eadie talked about capturing the wider economic benefit of providing new drugs. With good policy and economic analysis, that benefit should be considered before decisions are made about such drugs.

The Convener: I was just reminded of an issue. I think that it is appropriate to say—no doubt the committee will let me know if it is not—that the various subject committees are aiming to approach the budget scrutiny in a co-ordinated fashion, so that we can try to make sense of the interaction and cross-funding to which Jenny Stewart referred. To return to Mary Scanlon's point about drugs and rehabilitation, the funding for that issue is in the justice, social work and health budgets. The committees have not come to an arrangement about that yet, but we are endeavouring to proceed in that way. While we are at it, such an approach would help ministers, as the issue is a problem for them as well as for committees.

12:00

Jenny Stewart: I give the Scottish Executive credit where it is due. There was a £30 million fund specifically for initiatives to reduce bedblocking. I gave the initiative credit in the report for demonstrating value for money and meeting its policy objectives. It was one area where we were particularly pleased.

Helen Eadie: I am disturbed to hear that. My next question was going to be about that, because I have evidence that there is a lot of bedblocking in Fife, but I will let that hang for a moment.

The Convener: That is perhaps a matter for parliamentary questions.

Dr Simpson: I realise that we are under a little bit of time pressure, so I will try to be brief. It is disappointing that all the work on tariffs and costs that was done under GP fundholding seems to have been lost since 1997. I am glad that we got rid of GP fundholding because it had lots of problems, but it did focus on costs. The effort that was made in that direction seems simply to have evaporated completely. When you considered the historical situation, did you look at that aspect in detail?

You suggest that a saving will be made on information technology, whereas, as I understand it, Wanless states that 3 to 4 per cent of NHS expenditure should be allocated to it. The budget allocates 0.65 per cent to it, and we spent 0.45 per cent on it in the past four years. We spent £20 million under the budget on IT. Instead of spending £300 million to £400 million, we are spending just over a tenth of that. That is why IT in the health service is appalling. How did you reach your conclusions? I apologise that I have not had time to read the section on this in the full report.

Jenny Stewart: The budget review group did not look in detail at tariffs and costing, but I know from my previous roles that costing has fallen away since 1999, so the information is much weaker and different from the position under GP fundholding.

The IT budget is an interesting question. It is true that, in accordance with the Wanless report, we should in theory spend more pro rata on IT in Scotland. We came to the headroom figure from seeing that £100 million had been allocated for IT in the budget for that year, with no realistic prospect of its being spent. We saw that £40 million was simply not being spent. There is a vague notion of, "Yes, we will spend £100 million," but we did not see a detailed spending programme. Our message to the NHS, therefore, was that it had to look at Wanless and prepare a full budget for what it needed, and that it should have a properly budgeted, long-term plan for IT.

We also pointed out that, of the investment that had been made in IT systems, we had picked up anecdotal evidence—I say no more than that—that existing systems were not being used as effectively as possible. If IT were used to its full functionality, staff could be freed up for front-end service delivery much more than has been the case. We were asking the NHS to get Wanless right but also to think much more about the human

consequences of what it was doing and to put time and effort into training people in the NHS to use what is already there, so that we get maximum benefits out of it.

Dr Simpson: This links well with the Audit Scotland report of November 2006, which I know the committee looked at briefly in a single session. I may want to return to it.

Ian McKee: Jenny Stewart said that we should make better use of health spending to achieve broader health gain. The general background to the Howat report is about aims not sitting in silos but moving across the whole realm of government and about a broader health gain being obtained from a multitude of departments, of which health is only one. I was going to ask how you felt that we should handle that, but the comments made by the convener and Helen Eadie have probably answered that for me, unless you have anything else to add.

Jenny Stewart: I wanted to make a point about the generic issue. Alcohol and drugs are key to a lot of spending on health, prisons and social work services, so in considering cross-cutting themes, much more effort could be directed at policies on alcohol and drugs. We have had great success with the smoking ban, and a similar co-ordinated approach to alcohol and drugs would make the biggest single difference to the health service, the prison service and our social work departments.

Bill Howat: Let me elaborate on the evidence that we found, particularly on justice. I recommend that you read that chapter of our report; indeed, you could even invite some people from the Crown Office and Procurator Fiscal Service and possibly even the Scottish Prison Service to the committee. They have amazing data that tell us a sad tale but also reveal that a very small number of people are costing a huge amount of public expenditure—and the problem is linked to drugs and alcohol.

I thank Ian McKee for raising the generic issue of looking across themes, which is covered in the report. Specifically, we had a number of discussions with the analytical services department about what we loosely called the apples versus pears debate. Is it better to spend £1 of public money on prevention or on treating the symptoms? We might get an instant hit by curing somebody today, but if we spend the £1 on prevention, we might stop 20 people catching the problem years down the line. Should we spend the money on sport to keep people healthy? The committee will be familiar with that debate.

The chapter on this issue in the report shows that we were advised that nobody in the world has cracked it. Every single Government is looking at it to a greater or lesser degree, and here is a chance for the Scottish Parliament to be at the cutting edge—as ever.

The Convener: We had a debate on the issue fairly recently and, across the parties, we agreed that it is a tough one. If there was a road map, we would all be following it. From my experience of convening the Justice 1 Committee, I know that there is nothing that you are telling us that most of us have not heard. There is an opportunity for the committees, especially as the Parliament has now matured—I am not referring to our dates of birth—to go down that road. We may well discuss that when we consider our work programme.

Rhoda Grant is the last questioner, asking her first question on the committee.

Rhoda Grant: My question is quite short, but I fear that the answer might not be. When you referred to better costing information, alarm bells began to ring about how on earth that can be provided without creating a huge new bureaucracy in the health service and rearranging how the budgets are done. Is there a simple answer to that?

Secondly, you talked about having fewer initiatives and more mainstreaming. In a way, initiatives are used because costing information is difficult. We can put forward an initiative, plan it and cost it, and we can see the outcome. We can keep the costing ring fenced and see whether the initiative provides a cost benefit, which we cannot do if it is a mainstream service. To unpick that, do you need to unpick the first point? Is there a simple answer to that?

Bill Howat: No.

The Convener: We were promised a long answer, but that was the shortest so far.

Jenny Stewart: There is a danger in costing information. As a consultant, I have done activity-based costing, and I would certainly not recommend sending in armies of people to do heaps of that. There would be a lot of effort for a limited outcome. However, we need to get a handle on the key cost drivers and how they affect policy. There are some good examples of specific initiatives where we can see the cost going in and what comes out. Those examples are relatively few and far between, but if we can take that approach and apply it throughout the NHS, there are individual lessons that can be shared more widely.

There are issues around the totality of the budget and how the health boards then deal with the issues, cost up and allocate their resources. If they can make a shift from inputs to outputs and allocating cost on that basis, that might help.

That is not a simple answer, but it indicates the direction of travel in which we need to go.

Bill Howat: Can I give a slightly longer answer?

The Convener: You do not have to.

Bill Howat: I know, but this is a difficult issue. The main point that I would take from what Jenny Stewart said and what we saw as a group is that we are not going to crack the problem overnight. What we need is a journey of travel—call it what you want, we have to make progress. It links partly to the use of IT and training and retraining. Above all, it will be largely determined by the strategic views set by the committee, the Parliament and the Scottish Government.

The way forward is to move to more performance management frameworks, in which people can address high-level objectives and know that those are being driven down through the rest of the hierarchy to the lower levels of information. As a committee, you need to be clear that it is up to you to drive that forward at the strategic level and be satisfied that it is being driven down through the rest of the systems.

Let me give just one illustration from the report. In the section on the Crown Office and Procurator Fiscal Service, we highlighted the fact that, in the past four years, it has made major changes in how the High Court works—the Bonomy reforms—which have been translated into summary justice. The COPFS has some great statistics. It can tell you how much money and police officer time will be saved and so on. However, we could not find anybody who had worked through the implications for other portfolios. There will probably be a bigger burden on social workers and the probation service, and the police time that is saved in court might have to be used to supervise people under orders. However, the programme is a great start, and we said in our report that it shows the kind of thinking that needs to be driven through the whole process across all the portfolios.

The Convener: That is extremely interesting. I thank you both for your evidence to the committee. That ends today's business in public. I will give members a short break before we move on to other business.

12:12

Meeting suspended until 12:17 and thereafter continued in private until 12:50.

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