HEALTH AND SPORT COMMITTEE

Wednesday 31 October 2007

Session 3

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HEALTH AND SPORT COMMITTEE
7th 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:

Richard Copland (NHS Scotland Resource Allocation Committee)
Dr Karen Facey (NHS Scotland Resource Allocation Committee)

CLERKS TO THE COMMITTEE

Karen O'Hanlon
Simon Watkins

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 31 October 2007

[THE CONVENER *opened the meeting at 10:02*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning. I welcome everyone to the Health and Sport Committee's seventh meeting in session 3. I have apologies from Ian McKee; Joe FitzPatrick joins us as his substitute.

Agenda item 1 is to ask the committee to agree to take in private item 6, which is a discussion about Lord Sutherland's independent funding review of free personal care. Is that agreed?

Members *indicated agreement*.

Subordinate Legislation

Natural Mineral Water, Spring Water and Bottled Drinking Water (Scotland) Regulations 2007 (SSI 2007/435)

Community Care (Direct Payments) (Scotland) Amendment Regulations 2007 (SSI 2007/458)

10:02

The Convener: Under item 2 we have two negative statutory instruments to consider. The Subordinate Legislation Committee sought clarification from the Scottish Government on a minor technical matter in relation to SSI 2007/435 and was satisfied with the response.

No comments have been received from members and no motions to annul have been lodged. Does the committee agree that it does not wish to make any recommendations on SSI 2007/435 or SSI 2007/458?

Members *indicated agreement*.

"Delivering Fair Shares for Health in Scotland"

10:03

The Convener: For item 3, I welcome Dr Karen Facey, the chair of the NHS Scotland resource allocation committee. Subject to M8 difficulties, we hope later to welcome Richard Copland, a member of that committee. I remind members—I should have done so earlier—to switch off mobile phones.

The resource allocation committee was established in 2005 to improve and refine the Arbuthnott formula by taking into account new data, matters that the formula did not cover and unmet need. I would be pleased if Dr Facey gave a brief introduction.

Dr Karen Facey (NHS Scotland Resource Allocation Committee): Thank you for the opportunity to speak to our report "Delivering Fair Shares for Health in Scotland". As members know, our committee was given a clear remit, which is outlined on page 10 of our report. We sought to create improved resource allocation methods that were objective and evidence based, in order to provide fair shares for the 14 territorial health boards in Scotland.

The bulk of health expenditure—about 70 per cent of the budget—is on hospital and community health services and on general practitioner prescribing. The formula for that is the Arbuthnott formula, which has been in place for about seven years. Our aim was to improve that formula. If the committee will allow me, I will explain a little about the formula, which is central to the work that we have done.

The Arbuthnott formula is complex. It uses something called a weighted capitation formula, which is easy for economists to understand. Basically, we try to estimate the population of a health board area and then make adjustments, as health board areas have different needs and populations. Health boards also face different costs—for example, we know that it costs more to deliver services in remote and rural areas. The Arbuthnott formula was established on that basis. In figure 1.2, which is on page 11 of the report, members can see the set-up of population adjusted for needs and supply.

Our work did not change that structure. Instead, it sought to improve it, as there have been a number of substantial developments since the Arbuthnott formula was introduced. There have clearly been changes in how health services are delivered and there have been exciting new developments in relation to evidence, particularly

Scottish neighbourhood statistics. We now collect data locally in a different way, and we should use that evidence in the resource allocation formula.

The process is complex. The NHS Scotland resource allocation committee, which I chaired, was publicly appointed. We felt that our role was really a research/governance role and that we had to identify what needed to be done to improve the formula by talking to health boards about their experience of the current formula, identifying important new evidence and then seeking to employ the best international researchers to do the appropriate work for Scotland. We commissioned high-quality researchers to do that work. We then consulted health boards, from which we received very helpful feedback. Following that, we developed our ideas further. The report's final recommendations mainly relate to how we would like to improve the allocation formula for hospital and community health services, although other areas of the budget are also covered.

Chapter 3 of the report includes our proposals for improving the population estimates by using rebased population projections, which sounds quite technical. Such an approach is used in the grant-aided expenditure formula for local authorities. Basically, it is a more sensitive approach that follows population changes more clearly.

Chapter 4 looks at improving how needs according to age and sex are considered in the formula. We proposed making the formula much more sensitive so that the extra costs that are associated with treating the older population and the very young are picked up, and we carried out major work that looked at additional health care needs over and above those related to age and sex. That is probably the most complex part of the formula. We recommended the creation of three health indices associated with needs related to morbidity and life circumstances. I am sure that we can go into that matter in more detail when members ask questions.

The other part of the formula relates to the excess costs of supplying services in some of our remote and rural areas. We did our most major piece of work on that. The Arbuthnott formula used quite a simple proxy to consider hospital excess costs, which was based on road kilometres per 1,000 people. We considered a much more sophisticated model, which created quite major changes in the formula. We also considered how community services are delivered and, in all our work, we considered islands issues in particular. Boards told us clearly that island populations have different issues to face and extra costs. That was a central part of how the work on excess costs was undertaken.

Those are the main recommendations that were made. We have created a new formula that we think is a great improvement on the previous formula and have made recommendations on other funding areas, particularly on funding for family health services—that is, community pharmacy, dental and ophthalmic services.

We have created formulae that will allow resources to be allocated on the basis of need, not on the basis of demand, as happens currently. Those formulae are not quite ready yet—we need more experience of the new contracts. However, the formulae will be a helpful tool for the future. We have also looked at health improvement and capital allocation, about which we made recommendations.

During our work, we identified some problems with evidence and data that we tried to highlight in the report. There are particular issues with the paucity of data for community health services, which will be a major area in the future as we look at shifting the balance of care. That situation must be improved. We were able to use very few data for ethnicity on a national basis, and that situation should also be improved. There are other data problems around GP prescribing and the community health index, or CHI.

We tried to show that the formula is robust enough to accommodate future changes. We do not think that a review should be done only every seven years. The NRAC review was quite a big bang and we looked at a lot of issues. We propose the setting up of a standing committee to review resource allocation on an on-going basis, to look at how services are changing and to use new evidence as it emerges.

On behalf of the NRAC, I am happy to stop there and take any questions.

Rhoda Grant (Highlands and Islands) (Lab): You said that you looked at more sophisticated models of funding for remote and rural areas. One of the obvious points to come out of the report is that the Arbuthnott formula increases for rural areas have been wiped out by the new modelling and that rural areas are suffering. I am interested to know what those more sophisticated new models are. Do they take into account the GP out-of-hours costings that show the hugely different costs of delivering services in remote and rural areas? That is a justifiable and focused example of additional costs.

The Convener: Before Dr Facey answers, does anyone else have questions about costs in remote and rural areas? I invite Mary Scanlon to put her question.

Mary Scanlon (Highlands and Islands) (Con): I wanted to ask a couple of general questions as well.

The Convener: Ask your rural question first, and I will come back to you after that—you are next anyway.

Mary Scanlon: My question is on the back of Rhoda Grant's question. NHS Highland benefited from the Arbuthnott formula by £16 million a year. A complete reversal is now proposed, and NHS Highland will lose out by £21.2 million a year, which is a significant change. Across the board, it seems that urban areas will benefit and that rural areas will lose out.

Dr Facey: The Arbuthnott formula took a very crude approach to assessing the excess costs associated with hospitals—it simply considered the road kilometres per 1,000 of population. We have shown that that is not a good proxy for excess supply costs. We took a measure that looked at the eight Scottish Executive urban-rural categories, which divide into primary cities, towns, small towns and so on. We recognised that islands were an issue, so we added two extra categories. We then looked at every data zone, or small unit of about 500 to 1,000 people, and at how and where people accessed services, and we compared the local cost of services with the national cost. We did a very complex bottom-up model that looked at the costs faced in a small community. The change is partly because hospital costs have not increased above the average in the Highlands, for example.

10:15

To answer the question about out-of-hours services, I understand that the money for those services goes straight into the unified budget for hospital and community health services, so it would be picked up however health boards have recorded the cost. For example, in Forth Valley NHS Board, we have changed the way in which we align those costs. We used to align them within the primary care budget, but we now align them within hospital services.

The resource allocation committee is in some difficulty with out-of-hours services, because health boards record their costs in different ways. We did not consider out-of-hours services as a specific care programme or element—they were simply incorporated into other hospital costs—but that could be done in future.

The Convener: Does Mary Scanlon think that her question was answered in that reply?

Mary Scanlon: No, I do not think that it was. According to the table on page 69 of the report, apart from the three island health boards—Shetland NHS Board, Orkney NHS Board and Western Isles NHS Board—Highland NHS Board has the highest excess cost indices in Scotland for travel-based community services, clinic-based community services and community services overall: they are 18 per cent, 38 per cent and 25 per cent respectively above the national average.

Dr Facey mentioned that the resource allocation committee had consulted health boards. She said that her committee's model was more sophisticated than the previous one—although many people in the Highlands and Islands may disagree. Professional review was a feature of the Arbuthnott review. The Arbutnott committee's work was put before a technical expert group for peer review consideration of its effect on individual health boards. Was a process of similar professional rigour undertaken before Dr Facey's committee came to its conclusions? Was her committee aware of the significant effect that its decisions would have on Highland NHS Board and Borders NHS Board before the report was published?

Dr Facey: We had a number of levels of review. We had public consultation for three months, particularly on the hospital model because it was so new. We found that it was too complex for many people to comment on rigorously, so we put it to resource allocation experts in the other countries of the United Kingdom. We also had an academic expert in resource allocation perform a formal peer review, which appears on our website.

In relation to those issues, we made all our decisions completely blind. We made decisions on all the excess costs on the basis of regions. We examined what happened in island communities, primary cities and remote and rural towns. Then we aggregated the information up to health board level. Only at the end, when we unblinded, did we see the final result.

Mary Scanlon: It is a huge change for Highland NHS Board. Did you consider the magnitude of the changes? Did you take into account the fact that your assessments were based mainly on hospital-based services? You have already said that the data for community-based services are poor. Do you acknowledge that there is a disparity and an anomaly for a remote rural area such as the Highlands? You have not taken into account the massive distances that people have to travel in counties such as Sutherland. Do you accept that it is a very bad settlement for Highland NHS Board?

Dr Facey: I accept that there is a large change for Highland NHS Board, but the formula is much more evidence based than the previous one. We have taken account of every area, including Sutherland. We work on populations of 500 to 1,000 people and consider where those communities access hospitals. I am sure that the researchers would be happy to open up their modelling to show how they did that in Highland NHS Board, if it would be helpful to test the model more rigorously.

Mary Scanlon: Do you conclude that NHS Highland's funding has been more generous than it ought to have been? Under Arbuthnott, the board has been one of the main gainers. Are you saying that that situation would be corrected by your more sophisticated model, whereby NHS Highland would lose out by £21 million?

Dr Facey: That is an interpretation, yes.

Rhoda Grant: I heard what you said about hospital services. However, although consultants in remote and rural areas often go out to people pre-hospital admission, and clinics are run in various areas, the unit cost of consultant time per patient does not appear to be reflected in your approach. If travelling time is included, hospital costs as a whole go up, because a consultant in a rural area sees perhaps half the patients that a consultant in a busy urban area would see.

The reason I asked whether you had taken account of out-of-hours costings was to ascertain whether you had used a modelling framework to look at costings that is robust and can take costs almost from a standing start and demonstrate the different circumstances and costs of service delivery in remote and rural communities. It seems that the current approach has been turned on its head, given the impact on not only NHS Highland but other rural areas, such as NHS Western Isles. On the specific needs of island communities and developing a formula that would help them, NHS Western Isles is another big loser in your formula, in terms of the board's percentage share.

I am uneasy about the information on which the calculations are based. How can your formula suggest that it is more cost effective to deliver services in remote and rural areas? We are trying to get oncology and dialysis services into communities. In this day and age, it is unacceptable that a person should have a six-hour round trip three times a week to access dialysis services. If we are to provide services in the community there must be specialists in rural areas, so the unit cost per head will be higher.

Dr Facey: The costs are provided by health boards, whose returns are based on how they cost their activity, so if a board has to pay a consultant to travel, that should be included in its costs. We have considered boards' actual costs, compared with the national average. We have all that information.

You make a good point about community services. We are trying to move services into the community. We have a good model for considering community travel-based services, but we have not updated the element for community clinic-based services. We were unable to progress work on that, because it relates to the general medical services contract work that is still under way in Scotland. However, we take cost data, which come from the health boards.

Rhoda Grant: Are you confident that the data are robust?

Dr Facey: There could undoubtedly be improvements. Indeed, we recommend improvements. We also have concerns that the data are variable among health boards. However, it is the health boards' responsibility to improve the data, which we have no alternative but to use. The data are used in the current formula, but we are trying to use them in a better way.

Ross Finnie (West of Scotland) (LD): The report is technical and quite difficult for members of the committee, so we are grateful that you are here to explain it. When one considers the weightings in each chapter, even if one does not wholly understand the statistical methodology that was used, one gains a clear impression that a great deal of rigour was applied at each stage to testing whether the methodology was appropriate to enable you to arrive at a formula that could be applied to any given level of expenditure. However, with all due respect, the formula does not amount to much if you apply it to a level of expenditure in which you do not have confidence as to how that expenditure is recorded.

Although we accept in the final analysis that the data are entirely the responsibility of the health boards, I am slightly surprised that, although you make a general criticism, you are not concerned, given the huge investment in professionalism in arriving at the formula. You did not, even on a statistical basis, pick certain elements of the data as a check on whether the reality of what a health board was spending was clear in order to use in the formula that you devised.

Can you develop that point? I understand what you are saying—you are not responsible for those figures—but then you are not necessarily responsible for all the other figures. If my reading of the report is right, you tested the methodology rigorously.

Dr Facey: We have to be careful. We always try not to look at health board figures because we do not want to create perverse incentives. Instead, we try to examine national figures and adjust for needs and costs of supply.

We tested issues on a year-by-year basis. In addition to the peer review that I discussed earlier, we looked at the stability of age-sex cost weights, for example, over two separate two-year periods. We looked at the indices that we had created for need in relation to two sets of independent costing data, and we showed stability in that information.

However, we have no remit over the cost data, which have been used for many years in Scotland

for a variety of processes. We recommend that they should be improved, and we have worked with directors of finance to explain to them exactly how the data are used so that they understand the importance of correct returns. However, the data are really outwith our remit. For example, we struggled long and hard over maternity services because we identified huge variation in costs that we could not explain. We try to explain away variations in cost, but we could not explain that variation due to elements of need or excess costs, and in the end we introduced a rural factor.

The issue is partly about how health boards deliver their services. They do that in different ways, and we do not have a remit to have an impact on that. A resource allocation formula has to sit alongside policy developments and initiatives.

Ross Finnie: I want to test you quickly on a further aspect. The committee has considered the issue of allocating fair and reasonable costs to the patient, so, likewise, we are perhaps not so concerned about the health board. That leads to a conclusion that your focus is therefore on the patient getting a fair allocation of resource, but the patient is not responsible for inefficiencies in the health board—that is a matter on which the Government, committees and others can make separate recommendations.

I suppose my concern is that, if one ignores how the costs are built up, inefficiencies that might be the subject of a different report are nevertheless built into the system because, irrespective of how the service is delivered, you come up with a theoretical allocation of cost. That could mean that individual patients in individual health boards are punished unless somebody has identified that the difference between the allocation according to your formula and the actual cost built up by the health board contains an element of inefficiency. I appreciate that that is not your remit, but it seems to give rise to a potential difference.

10:30

Dr Facey: One of our clear recommendations in the report is that the formula should be used more extensively by health boards for planning and by the health directorates for performance management. For health boards, separate lines look at how much is allocated for maternity, acute services and care of the elderly, but those are all added up and given to the board as a lump sum. Health boards use it as they will, but their use of the money varies because they have different needs. The formula could be used in a stronger way to look at how money is being used in a health board and as a basis for discussing whether, based on our modelling, that is the best and most efficient way to use those resources.

Ross Finnie: That is a very helpful suggestion.

Dr Facey: It is a clear recommendation in the report.

The Convener: I cannot remember which recommendation that is. Can you tell us which one it is?

Dr Facey: It is in chapter 10. I will find it in a minute—the problem is that there are too many recommendations.

The Convener: It is recommendation 10.3.

Dr Facey: Yes—on page 111.

Joe FitzPatrick (Dundee West) (SNP): The recommendations in the executive summary acknowledge that the formula needs to compensate for the underuse of health services in more deprived areas. One might think that if services are underused there should be savings, but I assume that you mean encouraging deprived populations to take up services. I have seen that happen in Dundee, where an on-going project encourages people in deprived areas to take up tests—such as blood pressure tests—for circulatory diseases. That appears to be working well and identifying people who need treatment.

The report identifies a problem, states that money is required to deal with the problem and says that that should be part of the formula. Given that the report identifies a higher health need in areas of high ethnic minority populations, why do the recommendations not state that that should be part of the formula and that there should be extra money for areas with high ethnic minority populations?

Dr Facey: The researchers found that there was a levelling off in the use of services in areas with high ethnic minority populations, but that there was not an increase in disease prevalence, so it was not clear that the ethnic minorities experience increased disease, which is what we see in the 25 per cent most deprived areas. In those areas there is a great increase in the need for coronary heart disease services—cardiac services, for example.

When we considered how we had identified factors of need we found that those in ethnic minority populations had those factors of need, so it was already taken into account. We examined the matter in some detail. However, we had to include the caveat that the analysis was based on 2001 ethnicity data. We could not see clear patterns that would make us suggest that there was unmet need based on ethnicity, but we strongly suggest that better data is required on ethnicity recording, because the research was based on the 2001 census data and we know that there have been major changes since then.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): The report indicates that the Tribal Secta research was inconclusive. That slightly surprises me because, as the report states, although the overall number of people from ethnic minorities in Scotland is small, at 2 per cent of the population, they are concentrated in one or two specific areas. Although those areas may also reflect deprivation—your answer suggests that you felt that the issues were covered, as far as they could be, by deprivation—I suggest that considerable research shows that those in ethnic groups have higher rates of disease in certain specific categories, for example diabetes and cardiovascular disease. I am slightly surprised that you were unable to make an inference on that. I accept that you do not recommend an adjustment to the formula because the numbers are too small, but you suggest additional data collection in paragraphs 9.3 and 10.4, and you also suggest that health boards focus specifically on the matter.

In my experience as a doctor, groups from ethnic minority communities do not access services adequately. Outreach services are required, which are more expensive. In areas with high concentrations of ethnic minorities or indeed asylum seekers—they tend to be concentrated in Glasgow and Fife, as I understand it—there is perhaps a need for some top-slicing until we get the formula adjusted.

Dr Facey: We were slightly surprised by the results on ethnicity. The resource allocation committee spent two and a half years talking about issues related to ethnicity. A particular part of our remit was that we should look at the data related to ethnicity, and we tried hard to get good data. We had close contact with the national resource centre for ethnic minority health and we were fully aware of Raj Bhopal's work on increased need in relation to circulatory disease in ethnic minority populations. We decided to consider more extensive research than was required of us.

Most resource allocation formulae look at unmet need or underuse of services only for deprivation, but we extended that to include ethnicity and rurality. We did detailed analyses, which are reported in technical addendum D. However, we could not find relationships between the underuse of services and the prevalence of disease, despite our attempts to do that.

We are still working with NHS Health Scotland because we are concerned about issues in relation to translation costs. We have been helping with the surveys that it is undertaking to identify whether there are excess costs. That is an example of an issue of costs and needs. We will keep a watching eye on the matter in the coming years, and we certainly want to encourage better data.

Dr Simpson: You recommend that we should not review the formula only every seven years. I am disappointed that, during my four years away from the Parliament, there was not an earlier review of the Arbuthnott report, which was complex but valuable.

Before I ask my other questions, convener, I should declare that I have been working for NHS Lothian and that one of my close relatives works with ISD Scotland on the continuous morbidity recording—or CMR—project at the University of Aberdeen. I do not know whether the project is still called that, but it is a data collection system. My other questions are on data collection.

The Convener: Before you proceed, we can at last welcome Richard Copland. I ask him to join us at the table. He has had a journey involving trains, boats and planes to get to us. Welcome to the committee.

Richard Copland (NHS Scotland Resource Allocation Committee): I apologise for my late arrival.

The Convener: The causes of it have been well publicised on the radio.

Dr Simpson: One of the biggest disappointments is that, when we discussed the Arbuthnott report back in 2000, the data from primary care were regarded as poor and we requested that they be strengthened. We thought that that was important, particularly if there was to be a shift from acute and secondary services to primary services. It is disappointing that we are sitting here seven years later with data that are no better.

It would be too strong to talk of an imminent collapse, but the number of general practitioners who use the general practice administration system for Scotland—or GPASS—has reduced and many now use using other data collection systems, so the ability to collect data might be eroded further rather than improved. I am slightly surprised that you did not make tougher recommendations in that regard.

Similarly, one of the major problems with data collection is that we do not collect data for the full patient care pathway. We collect data in primary care and data in secondary care. We also collect some data in social care—in care homes and so on—which are important as well. However, the data are not adequately linked. In a small country such as Scotland, it should be possible to have a world-class data collection system that links all the care pathways. Will you comment on that?

What comparisons or benchmarks do you use to test whether the hospital costs data, on which the majority of funding is based, are robust? I suspect that they have deteriorated massively since 1996,

when there was a contracting system in place. Have you used benchmarks against the private sector? Have you used benchmarks against the English commissioning system to determine whether hospital costs are in fact appropriate and whether we are distributing our money on the basis of what costs there should be, rather than the ineffective costs that are in fact being presented to us by health boards?

Dr Facey: Thank you for those helpful questions. This is an apposite moment for Richard Copland to contribute, as he is the ex-head of ISD Scotland.

Richard Copland: I will start off with the question about information from primary care and the community. Our committee is disappointed that community information, in particular, has not improved. I am not here to make apologies for that, however.

There are one or two significant hopes for the future. In fact, they are more than hopes. A data set is emerging that it will be possible to use far more widely, thanks to the new GMS contract for GP practices. That development was probably a year or so too late for the NRAC committee. It takes two or three years for such data sets to become stable and comparable as they settle down. Those data sets split up the patients who go to general practices into a number of health registers or disease registers, which relate to GP practices' remuneration. To explain that in crude terms, there will be a protocol for what good treatment is for diabetes, for example. That would include taking blood pressure regularly, checking patients' feet, conducting eye tests and whatever might be considered to be the best protocol. Those data are now collated by GPs, because it is part of their remuneration. There is a rich data set there, which will help us into the future.

That leaves the issue of the community. Not just in Scotland and the UK, but in many parts of the globe, health organisations struggle to collect data in the community. I do not put that forward as an excuse, however. The situation is becoming even more difficult—the landscape is changing even more. The way in which we deliver community services is changing: some are delivered around the general practice; others are delivered in co-operation with, and in joint teams with, social services departments.

The recommendation on that is very important, and it must cover every way in which we deal with community services. It should be acted upon quickly. It is not particularly easy to collect information about community services. It is always slightly easier to collect information when bounded by four walls, such as in a hospital or a GP practice. When it is a matter of clinical staff working with patients in or near their own homes, it proves slightly more challenging, despite the improvements of technology in that area.

The Convener: When you were speaking about primary health care data, which recommendation were you speaking about? I am trying to nail the various recommendations down. It should be around p115, I believe, in paragraph 10.

Dr Facey: You are referring, I think, to the recommendation on community data.

The Convener: Community health services.

Dr Facey: Yes.

The Convener: Which recommendation is that? I am trying to pin it down.

Dr Facey: It is recommendation 10.9 on page 116.

The Convener: Thank you.

10:45

Richard Copland: Dr Simpson asked whether hospital costs data have changed since 1996. In 1996 we had the market, so the costs were part of the currency for the movement of funds that followed a patient around the system. The costs were used on a granular basis day by day. We have moved away from the market, and one might feel that the quality of data is lower than it once was.

In the past three or four years, England has adopted a system of payment by results. A tariff is set for procedures and treatments, and various organisations, the independent sector and NHS hospitals are paid via the tariff.

There is a judgment call. We have moved away from the market and the quality of data might have changed slightly, but having a market, and having payment by results, can raise the risk of perverse incentives arising in the use of data. I will give an example of the use of payment by results—and I apologise if I am getting a bit technical or if I am teaching my grandmother to suck eggs. Patients' diagnoses and treatments are put into things called health resource groups. The treatments are collected into aggregates of similar treatments with similar costs. What determines a patient's health resource group is the precise diagnosis and the precise procedure that the patient will receive. Clinical coding therefore becomes a hugely important factor. Some evidence is emerging in England of people perhaps being keen that procedures and diagnoses be coded as being more complex. There are therefore pluses and minuses.

On the question of the blue book and the costs, it has been recognised in Scotland over the past three, four or five years that work has to be done

to maintain the quality. The health department, ISD Scotland and health board directors of finance certainly have a programme of work to ensure that things improve. The cost book is a national publication and—like every other comprehensive set of data that is collected routinely and in which there may be elements of interpretation related to the allocation of some costs—it has to conform to certain standards.

I do not mean this to sound negative, but there are few alternatives—in fact, there are no alternatives—for dealing with the costs. The cost book is the way in which NHS finances are collected.

The Convener: Rhoda Grant wants to ask a question and, if nobody has any other questions, I think—

Ross Finnie: I have a supplementary.

The Convener: See, when I say that—

Ross Finnie: I know, you should never offer.

I want to follow up on Richard Simpson's question on data and data collection. I thought that, in your answer, you were kind to the boards by almost providing a plea in mitigation that reverse or perverse incentives would develop if data began to be collected in a refined way and a market principle was then applied. However, the fact that nobody who is currently in charge of a health board is showing any desire to reintroduce a market principle does not exonerate health boards from failing to improve systematically and regularly the quality of the data that are provided. Given the fact that, as Dr Facey earlier pointed out, the recommendation in paragraph 10.3 is crisp and short in its criticism of that, I am surprised at both the nature of your answer and the fact that the recommendation is not harder. It is fundamental to the working of the formula that there are data. You apply the formula to the data, and if the data are wrong, all the work that you have done is undone.

Richard Copland: I apologise if it sounded as though I was exonerating anybody. I was trying to make the point that, down in England, where the market has continued, one might see a higher risk of perverse incentives.

My second point was that the NHS, the health department and ISD have recognised the need for further scrutiny of the timeliness, completeness and quality of the cost data. That programme of work has started.

Dr Facey: When we put the matter out to consultation with health boards in the summer of 2006, there was surprise even among directors of finance at what the cost data were being used for. We have had a specific programme of education, as the Arbuthnott formula is quite complex and hard to get into. Our new formula is also complex, but we have tried to be more transparent and make clear what the evidence is used for. Boards are becoming increasingly aware of the importance of providing accurate cost data, but the more that we can do to encourage that, the better.

Rhoda Grant: What do you think that the overall impact of the new formula will be? When the Arbuthnott formula informed health spending, NHS Greater Glasgow and Clyde received about £40 million above its Arbuthnott formula share, while other health boards received slightly less. The new formula will mean that, in real terms, NHS Greater Glasgow and Clyde will face a cut in spending. Do you foresee the new formula being implemented strictly, or do you foresee it only loosely informing spending decisions?

Dr Facey: The new formula provides a larger share to NHS Greater Glasgow and Clyde. It provides a 24.77 per cent share, which is greater than the 24.64 per cent share under the Arbuthnott formula. Unfortunately, we cannot address the issue of implementation. Our committee was told clearly that we could say nothing about implementation; the question needs to be addressed to the health department.

The Convener: That is rightly a matter for ministers. Do you still have a question, Mary, or have you been gazumped?

Mary Scanlon: That takes care of half of my question, which was about the period of implementation. However, I ask for further clarification. Is the report simply a recommendation to the cabinet secretary? Can the cabinet secretary make changes or adjustments, as she sees fit, in the allocations to various health boards?

Dr Facey: Yes. We were asked simply to report to the cabinet secretary. It is up to her what she does with the report from here although, after two and a half years of work, we hope that she will take on board our objective, evidence-based advice.

The Convener: I assume that she is listening even as you speak. Thank you for your evidence. I thank especially Mr Copland for his heroic efforts—I hope that they were not in vain.

I will suspend the meeting for three or four minutes. Before anybody moves, I ask members to consider during the suspension whether the committee should submit a formal response by letter regarding points that have arisen on which there has been clarity and on which we might be able to come to a view. I ask members to chew over that as I suspend the meeting for five minutes.

10:55

Meeting suspended.

11:01

On resuming—

The Convener: After that interesting presentation, I am minded to ask the committee whether it wishes to write to the Cabinet Secretary for Health and Wellbeing on the key issues that have been raised. I propose that we discuss those key issues briefly now and, if members are content, we will circulate a draft before sending our letter to the cabinet secretary. Are members happy to discuss the key points?

Members *indicated agreement*.

Mary Scanlon: I am concerned that any significant changes in funding—by which I mean reductions; after all, it is always easy to spend any increase in funding—should be implemented over a period of time to ensure less turbulence and uncertainty in the provision of NHS treatment.

The Convener: How do other members feel about that? Obviously, we all have to agree to the letter.

Dr Simpson: The same situation arose with Arbuthnott, which led to significant gains for Highland, for example, and losses for other health boards; it was phased in over a period of time. As we all know, there will be significant restraints on expenditure in the period 2008-11, so it would be reasonable to ask for any changes not to be introduced very quickly.

The Convener: You are suggesting that we refer back to previous practice and, in particular, the way in which Arbuthnott was introduced.

We definitely want to say something about data, so it would be helpful if someone could come up with one or two lines on that. I believe that Richard Simpson is very informed on the matter.

Dr Simpson: We should say, perhaps in our opening sentence, that we very much welcome the report and its focus on data and that we constantly need to improve the quality of data collection. However, we should also express our disappointment that comments that were made by the Health and Community Care Committee in 2000 about data collection in the community sector were not followed through in the way that members had expected and suggest that, as a result, that issue should form the focus on this occasion. Indeed, convener, you have already referred to section 10.4, which contains important points about data collection.

In one of my questions, I alluded to the need for data to be collected from the community and hospital sectors. If we genuinely wish to transfer resources between primary care and the community, we need data to understand the clinical pathway and any associated costs. That aspect needs to be strengthened.

I think that Richard Copland suggested that that may in fact be happening, and I hope that we would therefore be pushing against an open door. Caldecott and others have raised problems with data sharing between secondary and primary care. That may sound bizarre, but confidentiality issues are involved—including the issue of patient identifiers—and are blocking the collection of effective data. In our letter, we should encourage the minister to try to resolve some of those blocks.

The Convener: The issue is not only the quality of the data, but the lack of uniformity in the way in which it is presented. Boards are presenting their data in different ways. Does that tie in with recommendation 10.3? It says that

"NRAC recommends that Health Boards and SEHD use the revised formula for planning and performance management purposes".

Is that what that means?

Dr Simpson: That is a slightly different point.

Ross Finnie: Yes, it is. You are right about that, convener, but we must also take account of another matter.

I am fascinated by recommendation 10.3. It runs to only two lines, but what it says is pretty fundamental. If—and it is a big if—we accept the methodology, and that the basis for arriving at the build-up of costs was fair and reasonable, and that a lot of time was spent on arriving at the formula, it would be extraordinary for the health boards, which were consulted on the matter, not then to buy into the process. I cannot see any other way in which comparisons can be made.

If the formula is broadly accepted but the health boards build up their budgets without any relationship to it, how can they measure performance or reach the position at which an allocation of Government resource bears some relationship to the way in which they build up their costs? How can they measure whether they are working efficiently or inefficiently if they do not do that in accordance with an independently arrived at formula for expenditure?

With better data, recommendation 10.3 would become critical to how we see the connection between the allocation of Government funding to health boards and Government's ability to ask health boards to demonstrate the connection between funding and performance. More important, it would allow us to see whether patients are getting the money that Government intended they should get, by way of the formula. Your two points are connected but different, convener.

The Convener: Yes. We welcome the review of the formula. If we accept that the way in which it is applied is robust and appropriate, it is still only as

good as the data on which it was based in the first instance and against which it will continue to be applied in the rolling programme of review. That is what I am getting at.

This is a kind of wake-up call—I hate using such phrases; I must think of something else to say—to the health boards to get more robust data and a uniform method, in so far as that is possible, of data gathering across all service delivery areas. At the moment we have a formula, but its application may not reflect what is happening on the ground.

Michael Matheson (Falkirk West) (SNP): Richard Simpson said that, back in 2000, our predecessor committee made recommendations on the back of Arbuthnott. Was a committee report produced at the time?

Dr Simpson: I cannot remember exactly, but I think that we dealt with the matter in a similar way to that which we are discussing today, which was by sending a letter to the minister.

Michael Matheson: In our letter to the minister, it may be useful for us to refer to some of the points that were made at the time. We should say that the discussion on the matter goes back to 2000.

Dr Simpson: Certainly, the GMS data were regarded as not strong enough. When Professor Watt gave evidence, I think he said that they were not adequate in reflecting deprivation.

The Convener: I ask members to speak through the chair. We are in public session.

Dr Simpson: I apologise, convener.

The Convener: The clerks are prepared to dig out the letter that was sent in 2000. We can then refer to it in our letter to the minister. I will ask the clerks to e-mail a copy of the letter from our predecessor committee to Richard Simpson, along with a draft of our letter.

We have probably rehearsed sufficiently our comments on the data, but perhaps we should raise the matter of ethnicity, for which the data are out of date: Scotland has a changing population profile and the data are based on the 2001 census. Do members want to draw attention to that?

Dr Simpson: Yes. That relates to recommendations 10.6 and 10.7 on ethnicity and asylum seeker data.

The Convener: We can keep it neat.

Rhoda Grant: Can we mention rural issues and highlight the GP out-of-hours costings, for which there is quite a robust model, and contrast that with the weighting that is given to remote and rural places? That could feed back into the dataset that is being used. We could attach a health warning to it, if you will pardon the pun.

The Convener: Mary Scanlon picked up that point. Where there are fairly substantial reductions in mainly rural areas—and if the cabinet secretary were to decide to follow the recommendations to the letter—they would be made in a phased manner. I think that Mr Copland referred, quite rightly, to the data that have been collected on the new GP contract as a model. I do not know whether I have remembered that correctly; perhaps we could check in the *Official Report*.

Dr Simpson: Perhaps the point that was made by Mary Scanlon and Rhoda Grant needs to be included in the letter. We could say that if there is a determination to shift resources from the acute sector to the community sector, that will have greater implications for delivery in rural areas. At the moment, because the majority of health board distribution costs in the revised formula, as in Arbuthnott, are based on acute services—which are not radically different between Highland and other areas—there will have to be a significant revision when the shift in resources occurs. To use Rhoda Grant's example, if someone decides to increase their home dialysis significantly, costs might well go up; such a change might be highly appropriate in a rural area, so that needs to be reflected in the distribution.

Even if we are giving the minister a health warning, as Rhoda Grant said, we should say something.

Mary Scanlon: All our discussion about improving the data could be a wake-up call for many health boards, so I would like to ensure that recommendation 10.12 is covered in the letter. Rather than there being a big bang every seven years, finances and financial allocations should be adjusted every year. As the data improve, the financial situation would be reflected more accurately.

The Convener: You have pre-empted me, Mary, and I had put a star next to the words "standing committee". That is one of the final points to make. I think that the committee welcomes the recommendation that a standing committee should review the allocation.

Dr Simpson: Recommendation 10.13 is linked to that, because it recommends that the standing committee should supervise the data collection development programme at ISD. That is very important.

The Convener: We have got the key points for the letter to the minister. We will send members a draft version for consideration, along with the letter from our predecessor committee so that a comparison can be made. Once we are all agreed, we will send the letter to the minister.

Public Health etc (Scotland) Bill

11:13

The Convener: Agenda item 4 concerns the Public Health etc (Scotland), which was introduced last Thursday. At our meeting on 19 September, we agreed to issue an open call for evidence after the bill's introduction; the clerks did that on Monday. We also agreed in principle to appoint an adviser; to set in motion the approval and appointment process, we need to formally agree a remit and person specification for that post.

I refer members to paper HS/S3/07/7/05 and the issues that are raised therein. Do members have any comments on the adviser specification?

Ross Finnie: It seems reasonable.

The Convener: There can be no greater praise from Mr Finnie than that.

Rhoda Grant: How do we go about recruiting the right person? Given the hours that are required, we cannot advertise the post as if it is a job. How do we find the right people?

The Convener: A list of likely candidates is usually provided, which we discuss in private, for obvious reasons. The committee sees the candidates' CVs and decides who is the most appropriate. In advance of that, the clerks determine whether the parties would be available to do the work. There is no point in choosing someone who will not be available.

11:15

Rhoda Grant: But how do we attract people to come in and give us their CVs?

The Convener: The clerking team does some research and comes up with a list of names; it is up to us whether we like the names. There is nothing to prevent members of the committee from coming up with the name of an expert. If they do so, that name will be put to the committee for discussion and approval.

Rhoda Grant: I was asking about the advertising of the position and how we go about attracting people.

Simon Watkins (Clerk): Most people who want to work with the Parliament have already signed up to a database. That is primarily what is used to contact people.

Rhoda Grant: That is all I needed to know.

The Convener: Are members content with the specification?

Members *indicated agreement.*

The Convener: Are members content for decisions about the payment of witnesses' expenses to be delegated to me, as convener, as is the normal practice?

Members *indicated agreement.*

The Convener: Are members content to consider in private evidence that is taken in public at stage 1 at the same meeting as that evidence is taken, and also to consider in private the drafts of our report to Parliament at stage 1?

Members *indicated agreement.*

Sportscotland Review

11:16

The Convener: The next item concerns our review of sportscotland. In your committee papers you have copies of correspondence from Stewart Maxwell, the Minister for Communities and Sport, inviting the committee's views, by 2 November, on the delivery of sport in Scotland, as part of the Scottish Government's review of sportscotland. Do members have any views? I imagine that the expression of those views will be as short as the timescale that we have.

Rhoda Grant: I am disappointed because, when we were planning our budget scrutiny, we put aside a session to deal with the sportscotland budget and the review and to meet representatives of sportscotland. Could we express our concern to the minister and ask for an extension in the timescale? Sportscotland is our premier sporting body and it seems ludicrous that the committee should not be able to submit a report on it as part of the process.

The Convener: We intend to have the Minister for Communities and Sport before us on 5 December and can ask him questions on the matter at that point. That would be part of the process. I do not know about the extension to the 2 November deadline.

Michael Matheson: For the committee to be able to give an informed opinion as part of a review of sportscotland, we would have to undertake an inquiry into the issue and consider it in detail, particularly given that the remit of the review is to consider sportscotland's current functions and possible organisational changes. We would have to give due consideration to what those possible organisational changes would be, including consideration of alternative models.

Mary Scanlon: I am inclined to agree with Michael Matheson.

Although my party is in favour of decluttering the landscape—to use the normal jargon, we want fewer quangos—there is no certainty about what the minister has in mind as a replacement for sportscotland. There is a huge amount of uncertainty. I appreciate that the proposal was one of the main planks in the Scottish National Party manifesto. However, the civil service is considering the question of who could possibly undertake the work of sportscotland. The civil service has a responsibility to find a replacement.

Having read the *Official Report* of the minister's last appearance before the committee, which was on 19 September, I do not think that enough information is available. We all agree that the work that sportscotland does has to be continued. However, I cannot sit here and recommend that another organisation should take on that work, because I have no idea which one should. I agree that five days is simply not enough time to consider something this important. I am also aware that the civil service is reviewing sportscotland and that Audit Scotland is considering sportscotland's structure. Those two massive, in-depth reviews or studies are on-going, yet we are expected to respond within five days with no information. I find that unsatisfactory.

The Convener: I do not know whether we were expected to respond; we just received an invitation to do so.

Joe FitzPatrick: This might be novel, but the Scottish Government is asking for comments before it makes a decision. As a result, the committee will not have the figures. I know that under previous Governments, consultations were held when the decision had already been made. The minister is asking for our general view. He will come back to us to say what the Government intends to do with sportscotland, at which point the committee will be able to feed in its views directly. However, at the moment, the Government is simply asking for input as part of its review.

The Convener: Although the letter is dated 19 October, it was not received until 24 October.

Ross Finnie: I agree with Michael Matheson. What has happened is unfortunate. I was not present when the matter was discussed but, like Mary Scanlon, I have read the *Official Report* of that meeting. As I understand it, the civil service is not carrying out the review but has been instructed to consult all the major sporting organisations to get their views on it, after which the Government will reach a view.

It is unfortunate that when Stewart Maxwell, the minister, was here, Karen Gillon asked him a question that she perhaps did not phrase cleverly enough, because he misunderstood her to suggest that civil servants should discuss the review with us, which would be inappropriate. Karen Gillon sought to clarify that at the end of the meeting. However, the minister did not take the opportunity to tell us that the committee would be one of the bodies from which he would seek a view. He might have decided that the committee ought to be consulted and that he wanted its views, but that does not sit well with his giving it only 10 days to do so. That is a matter of principle.

I am at a loss to know how we can respond adequately to the request for us to submit views. As Michael Matheson said, we are just not in a position to do so. I welcome the minister's clarification that he thinks that the committee's views are important. However, if he thinks that

they are that important, he simply has to give us more time to consider properly what our response might be.

Helen Eadie (Dunfermline East) (Lab): I was present on the day that the minister was here. My recollection is that he said that the Government was going to replace sportscotland with a different structure and farm out its functions to three regional organisations. I do not know whether that was set in tablets of stone. However, sportscotland was established by royal charter—I wonder whether it is straightforward to remove the royal charter.

The minister said that he would consult all sports stakeholders. He should also consult all the grant-giving organisations, because I understand that sportscotland disburses lottery funds and a range of other funds on behalf of those organisations. It is the responsibility of lottery funders and those who disburse the funds to monitor, assess, evaluate and review that regularly. How does the minister propose to undertake all that work?

It is entirely inappropriate for the minister to ask us to take a view when there is a dearth of information on what he will put in sportscotland's place. I certainly agree with the proposal that we have an inquiry. The minister should not come to a view until we have had that inquiry.

Michael Matheson: I did not say that there should be an inquiry; I said that I think that we would have to have an inquiry.

The Convener: No matter who is in government, a committee cannot tell a minister not to come to a view until it has had an inquiry. We are powerful, Helen, but unfortunately not that powerful.

Dr Simpson: Could I just add something?

The Convener: I wanted to draw the session to a close. Although there is more to say, the general feeling appears to be that we do not have time to respond.

Dr Simpson: I want to make one further point. With the Commonwealth games coming up in 2010, the Olympics in 2012 and the Commonwealth games again in 2014, I wonder whether now is the moment to rush into significant and major changes. Networks are destroyed when that happens. We know what happened to the health service. It took two years to recover from change. It is unacceptable to give us five days' notice to discuss something that may have a fundamental effect on Scotland's ability to perform in those events.

The Convener: Whether the timing is right is a political decision—it is really for ministers to deal with.

Dr Simpson: It is unacceptable to give the committee five days to comment on something that may have a significant effect.

The Convener: We are looking at processes here. We have been invited to comment, but it is impossible for us to take any view in the given period. Would it be appropriate to say that, even if we had enough time, we would need to have the minister's proposals in front of us? The proposals will be out at the end of December, at which stage the committee will consider them, take evidence if required and make its views known. We are looking at a sequence of events. You are right—what could we comment on? We cannot comment on anything at the moment.

Helen Eadie: The committee should write to the minister, strenuously expressing its concern about the impossible position in which it has been placed. I do not know whether the dates were in the minister's control, but we have been asked for a response by 2 November to a letter dated 19 October that we received only on 24 October. That adds insult to injury.

The Convener: I would not put it in quite such dramatic terms. You are right that the committee should indicate its position on the date of the letter, which was not in the clerks' hands until 24 October and could not therefore be presented to the committee until today. I am not making an excuse—the delay in the letter reaching our hands is certainly not appropriate—but even if we had received it sooner, we would still not be in a position to respond. The committee's view is that we have been invited to respond but we cannot do so in the timescale or without the information. Once the information is published, we fully intend to have a rigorous analysis of the proposals. I would be surprised if that does not involve evidence taking. The message will get to the minister that it is pretty pointless writing to us at the moment and that there are lessons to be learned by the ministerial team.

Mary Scanlon: The minister's letter, which was written a month after he was here in committee, says that the remit for the review is

"To examine whether sportscotland's current functions continue to be necessary and, if so, which organisational arrangements are most effective in delivering them."

It is important that people know what we were being asked. When Karen Gillon asked the minister who would coordinate and take over the work of sportscotland, the minister replied:

"I am not talking about the minutiae of day-to-day direction or the micromanaging of sport."—[*Official Report*, *Health and Sport Committee*, 19 September 2007; c 63.]

That substantiates the point that we have very little information and supports the committee's decision.

11:30

Rhoda Grant: I want to amend what we put in the letter. We should strongly ask that no decision comes to the committee already set in stone. If we are going to take evidence on proposals, they should only be proposals. The committee scrutinises the Government, and if the minister will not take views from the committee, he is avoiding any scrutiny of his proposals. That is a slight to the committee and to Parliament.

The Convener: Bear with me a minute. The outcome of the review—

Helen Eadie: I object—you cut across me and now you are cutting across Rhoda Grant as well. You should let her finish her point first. You cut across me too before I had finished my point. I object to that.

The Convener: Bear with me—I think that I have used a fairly light touch. The point that I am making is just for clarification. The outcome of the review will be published in December. In our letter, we will say that we wish to consider that outcome. At that stage, the committee will take evidence and make its response. That seems to be appropriate. The minister and his team will gather evidence, he will publish the outcome of the review, and we can then have our bite at it and say whether we agree or disagree with it.

Rhoda Grant: It must be clear from our letter that we need to be in a position to influence the final outcome. There is no point in our considering something that is set in stone, and saying that we agree or not. As the committee that deals with sport in Scotland, we need to be able to influence the decision.

The Convener: I hope that committees always influence ministerial decisions, when there is something that is appropriate and sharp to say to ministers. I hope that ministers listened, for instance, to our previous debate in which we talked about the quality of data. However, you and I know that even if the entire committee came out with a particular view, the decision would still be a ministerial one, or a decision for Parliament. That is just the way the game is. If the committee takes a strong view on certain issues, I would certainly expect ministers to pay due regard to it, as I would expect them to do with anything that we do.

Our problem is that the process that has been put before us has been unfortunate, and it has caused a storm where a storm need not have been caused. We are left with a situation in which—although members can respond individually—the committee cannot possibly respond within the given timescale. That will be drawn to the minister's attention. No letter will go out without members of the committee seeing it. We will draft a response; not everybody will get everything that they want, but we will try to agree on a suitable response that puts to the minister the issues that members have quite rightly raised.

I apologise if you feel that I have cut across members. We know pretty much where we are now—let us get the letter formulated and sent to the minister, and then we can tackle the issue in an inquiry or otherwise at the end of the year. Are members content now?

Ross Finnie: The minister has indicated that he is interested in our views; although we are unable to deliver them today, that should mean that he will still be interested in our views in the future

The Convener: The minister will know from our discussion that this was not the best way to do things. We now move on to item 6, which will be discussed in private.

11:33

Meeting continued in private until 11:52.

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