HEALTH AND SPORT COMMITTEE

Wednesday 5 March 2008

Session 3

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HEALTH AND SPORT COMMITTEE
7th Meeting 2008, 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:

Dr Jonathan Pryce (Scottish Government Primary and Community Care Directorate)
David Smith (Scottish Government Legal Directorate)
Deirdre Watt (Scottish Government Primary and Community Care Directorate)

CLERK TO THE COMMITTEE

Tracey White

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Emma Berry

LOCATION

Committee Room 5

Scottish Parliament

Health and Sport Committee

Wednesday 5 March 2008

[THE DEPUTY CONVENER *opened the meeting at 10:48*]

Subordinate Legislation

National Health Service (Charges for Drugs and Appliances) (Scotland) Regulations 2008 (SSI 2008/27)

The Deputy Convener (Ross Finnie): I welcome everyone to the seventh meeting of the Health and Sport Committee in 2008. Apologies have been received from the convener, who is temporarily dealing with another matter of some importance. I remind all persons present please to switch off their mobile phones.

Item 1 is subordinate legislation. We have before us a negative instrument for our consideration. The instrument gives effect to the phased abolition of NHS prescription charges in accordance with the Government's policy, which is to abolish prescription charges completely by April 2011. Members should note that, in the committee papers, there is a typographical error in the abridged report of the Subordinate Legislation Committee. The correct date is April 2011, not April 2001. I always thought that choosing 1 April as a date had its potential difficulties.

Following consideration of the instrument by the Subordinate Legislation Committee, our attention is drawn to several points that are outlined in that paper. To assist us for this item, we are joined by Dr Jonathan Pryce, the head of the Scottish Government's primary care division; Deirdre Watt, the team leader of the community pharmacy and primary care infrastructure branch; Catriona Hayes, a statistician in the health analytical services division; and David Smith, a solicitor in the health and community care division. I welcome the officials.

Do members have any comments or questions?

Helen Eadie (Dunfermline East) (Lab): I have two questions. The first relates to the annex to the abridged report of the Subordinate Legislation Committee. It raises a point about regulations 8(11), 10(4) and 11(5). The Subordinate Legislation Committee sought an explanation from the Scottish Government and received a response with which it was partially satisfied. I wonder whether you can expand a bit on that? There was only partial satisfaction with the Government's response. Would you like to say a bit more about that?

David Smith (Scottish Government Legal Directorate): As the paper states, the Subordinate Legislation Committee

"agrees with the Government's response that these provisions do not amount to unauthorised sub-delegation but does not agree with the Government's analysis of where the power to make these provisions is derived from."

However, that committee did not explain whether it considers that there are alternative powers on the basis of which it reached its conclusion that there is no unauthorised sub-delegation. Our position is set out in our response to the Subordinate Legislation Committee's letter and relies on two provisions in sections 69 and 105(7) of the National Health Service (Scotland) Act 1978. Section 105(7) includes a power to make supplemental, incidental and consequential provisions. That is the provision that has been relied on to make the regulations about refunds.

The main point is that the Subordinate Legislation Committee agrees that there are no unauthorised sub-delegations. As far as I am aware, that committee has no concerns about the power to make the provisions; it has simply questioned whether the powers that we have cited are the correct ones. The position is set out in our response to the Subordinate Legislation Committee.

Helen Eadie: The other issue is whether there could ever be a challenge on those grounds. What is the likelihood of that? Is it your experience that it would be unlikely for there to be a challenge arising from the issue of where the powers are derived from?

David Smith: These particular powers, or variations of them, have been in previous versions of the regulations, including the consolidated versions of 2007 and 2001, going back to 1989. There has been no challenge to those provisions so I would not expect there to be a challenge, but one can never tell.

Helen Eadie: That is fine. That answers my first question. My second question relates to—

The Convener (Christine Grahame): I notice that you did not pause between your questions, Helen. That was very cute. On you go.

Helen Eadie: My second question relates to the provisions on page 7 of the regulations regarding appliances, fabric supports and wigs. As people may be aware, I congratulated the cabinet secretary in the chamber two weeks ago on the move to reduce significantly the charge for wigs from something of the order of £250 to £5.

I should declare an interest, as I have worked with the Skin Care Campaign Scotland and one of its sub-groups—Alopecia Help and Advice (Scotland)—which has been heavily involved with the Scottish Government's task force both previously and currently.

I know that the campaigners welcome the reduced charges, but they also raised a concern with me when I met them on Monday in preparation for today's meeting. They are concerned that, following the alteration to the charging policy, patients may be entitled to have a new wig on prescription once every three years, whereas they are entitled to two wigs every year under the existing charging regime. Will there be any restrictions on the number of wigs per year that people can have? Alopecia Help and Advice (Scotland) believes that that could be a major concern. Clearly, we welcome the reduction of the charge to £5, but we do not want that to diminish the supply of such units.

Deirdre Watt (Scottish Government Primary and Community Care Directorate): Guidance will shortly be issued in a circular to boards to clarify the number of wigs that can be prescribed per annum. The advice is that the number of such prescriptions per annum to which people will be entitled should be doubled from two to four as from April this year. The people who will benefit include those who suffer from alopecia, from cancer or from burns.

Helen Eadie: I welcome that.

Mary Scanlon (Highlands and Islands) (Con): I have my usual list of questions, but I will ask only two, on wastage and on demand, and trust that fellow committee members will pick up my other questions.

First, the Scottish Executive estimated in 2002 that drug wastage cost around £15 million a year. Have any estimates been carried out of a potential increase in the wastage of drugs due to the phased abolition of prescription charges?

Secondly, according to Scottish Executive research—this information was provided in relation to Colin Fox's bill in the previous session—20 to 25 per cent more people would be likely to ask the doctor for a prescription if it was free. Have any estimates been done of the potential increase in demands on the time of general practitioners and in the demand for drugs as a consequence of the reduction and eventual abolition of prescription charges?

Dr Jonathan Pryce (Scottish Government Primary and Community Care Directorate): I will answer the second question and then ask Deirdre Watt to respond to the question on wastage.

We recognise that there could be increased demands on the time of GPs—and, indeed, of pharmacists—if the demand for prescriptions increases. We are very much resting on the latest data from Wales, where no significant increase in such demand has appeared that is attributable to the Welsh policy. We take a degree of comfort from that, but we are continually receiving updates on the latest data from Wales and we will continue to monitor the situation going forward.

Mary Scanlon: The number of people who would be more likely to go to the doctor would be between a quarter and a fifth, according to a survey that was carried out for the Scottish Executive in May 2006. That survey is less than two years old.

Dr Pryce: I recognise that, but at that point we had very little data from and analysis of what was happening in Wales. You are absolutely right that we have some evidence to suggest that demand could increase, but preliminary evidence from Wales suggests that that has not become an issue. In a sense, we will need to wait and see, but we will monitor the situation carefully as we implement the policy.

11:00

Deirdre Watt: In response to the question about wastage, we recognise that in a drugs bill of some £900 million, there is always a need to ensure that waste is minimised. A range of measures is in place, and we will be looking further at developing a broader strategic response to target waste. We are not aware of any evidence that phased—or even total—abolition of prescription charges will exacerbate wastage. I would welcome the committee's comments on the measures that are in place. According to the briefing from the Scottish Parliament information centre, the previous Health Committee believed that

"prescribing clinicians are the 'gatekeepers' of prescribed medicine and improved prescribing practices should minimise the impact of abolition."

That would certainly be our focus as well, along with a range of other measures.

Mary Scanlon: So you do not expect anything significant.

Deirdre Watt: No. We are not anticipating anything more.

Rhoda Grant (Highlands and Islands) (Lab): I am interested in regulation 9, which says that a qualifying patient is someone who is resident in Scotland. The explanatory note says that if someone goes to an English general practitioner but can prove Scottish residence, they can get an entitlement card. Will everyone start living with

their Scottish auntie just to get free prescriptions? How will entitlement be restricted?

Deirdre Watt: The Scottish Government is concerned to ensure that the 1,200 or so people—a relatively small number—who are resident in Scotland but are registered with a GP practice in England benefit from the change in policy. Scottish residents registered with a GP based in England would not get the appropriate prescription that they could simply take to their pharmacy—it is a different prescription form. In order to ensure that those Scottish residents benefit from the change in policy, they will be issued with an entitlement card. The practitioner services division of NHS National Services Scotland knows exactly who those patients are and where their GP practices are. The PSD will be the gatekeeper of the process. To minimise fraud, the PSD will contact those patients, who will be sent an application form. They will also be sent a declaration form, on which they will be required to tick to confirm that they are resident at the given address. When they send that back, they will be issued with an entitlement card.

Rhoda Grant: What happens to new people? The people you are talking about live in the Borders and perhaps find it more convenient to go to an English GP. How will you police that in future? People are signed up at the moment, and you can easily identify them. I guess that what you are saying is that a limited number of GPs qualify, because they have to be within travelling distance of the border, but what happens if people on the other side of the border say, "I've got a cousin who lives a couple of miles over the border. I'll give that as my home address"?

Deirdre Watt: The onus is on the person who ticks the box on the form that they are sending back. If it is found in future that they are not resident at that address, it would be a case of fraud and procedures would go ahead. Ticking the box confirms that they are resident at that address.

Rhoda Grant: But there is no proof of residence, other than ticking a box.

Dr Pryce: It would be a serious matter for a patient to give an invalid address to their GP practice. The main check will be that the address that the patient declares that they are resident at is the same address that their GP has as their place of residence. If someone were to give fraudulent information to their GP, not only would it be fraud but that person would be putting their health at risk. If they had to have a home visit, there could be delays that would impact adversely on them. It would not be an attractive proposition for people to mislead us and their GP in that way.

Rhoda Grant: I find that hard to accept. There is not an awful lot of cross-checking. Someone might think, "How often am I going to get a home visit? If I need a home visit, I'll say that I'm staying with a friend in such-and-such a place." They will give an alternative address. To me, the system appears to be open to fraud.

The Convener: Perhaps we should ask about Wales. What has been the experience there?

Dr Pryce: In effect, we are matching the arrangements that are in place in Wales. Our colleagues there are certainly not aware of a significant problem with people trying to put themselves in the wrong place.

Deirdre Watt: We are talking about a small number of people, because the population in the area of the border is relatively small. The number of people who live in England but are registered with a Scottish practice is 1,800 to 2,000, so the pool of people who could be eligible is limited.

If someone falsely claims that they are living in Scotland with their auntie, they will face some practical issues. How will they visit their GP? Where will they take their prescription for it to be dispensed?

There are two points. First, only a limited number of people will have the opportunity to practise fraud. Secondly, Dr Pryce highlighted a range of practical issues, to which I add the points about people's ability to visit their GP and have their prescription dispensed.

The Convener: As someone who represents an area close to the English border, I note that, if someone is resident in Scotland but has a GP in England, they are entitled to the rates in Scotland. I take it that we have a note of the number of people who are in that position. You told us the figure for the converse.

Deirdre Watt: Yes. The number of people who are resident in Scotland but are registered with a GP who is based in England is 1,200 to 1,300.

The Convener: There seems to be a clash between two parts of the Executive note on the regulations. On prescription charges, it states:

"as a result of the fact that different charges will now be applicable in different parts of the UK, provision is also made in the instrument for persons presenting prescription forms issued in England, Wales or Northern Ireland to a Scottish pharmacy to pay the per item prescription charge which is applicable in the equivalent instrument in force in England."

However, on cross-border issues, it states:

"Persons in possession of a prescription form issued in Scotland will be able to benefit from the reduced cost of prescriptions in Scotland provided they go to a Scottish pharmacy to have their prescriptions dispensed. Pharmacies in England, Wales and Northern Ireland will

levy the charge applicable in that country for out of country prescriptions."

If a Scot goes to Wales, they will get their prescription free, but if somebody from Wales comes to Scotland, they will be charged at the English rate. Is that right?

Deirdre Watt: Not quite. We confess that this is a complex area, and you are right to ask the question.

If a Scot with a Scottish prescription tries to have it dispensed in England, they will pay the English charge. They might be on holiday, travelling or on business. If they go to a pharmacy in Wales to have the prescription dispensed, they will pay the English rate. They will not get it free. For such a person to benefit from the Welsh charging policy, the Scottish Government would have to negotiate a reciprocal arrangement with the Welsh Assembly Government. The same applies in Northern Ireland. The person would pay the English rate.

The Convener: So the Executive note is wrong.

Deirdre Watt: Not quite. David Smith might want to assist me, but—

The Convener: The Executive note clearly says:

"Pharmacies in England, Wales and Northern Ireland will levy the charge applicable in that country for out of country prescriptions."

Dr Pryce: Yes. The charge is for "out of country prescriptions." In Wales, out-of-country prescriptions are charged at the English rate.

The Convener: So, people who are out of their country will pay the rate that applies in the country where they are, but that will be the English rate wherever they go, including Wales.

Dr Pryce: Yes.

The Convener: Fine. I just thought that there was something wrong in the note. I appreciate that that is not specified in the instrument itself. I might need to get a prescription to clarify that for me, but that is fine.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): My question is also about people coming into the country. At the moment, someone from a non-European Union country pays a private prescription charge if the issue is acute. They might get free prescriptions, but, basically, they are charged. What happens with temporary residents? Will they be charged at an English rate, a Welsh rate or a Scottish rate, or will they get a private prescription?

Deirdre Watt: If they are registered with a Scottish GP, they will benefit from the policy of phased abolition. They will pay the Scottish rate and, on total abolition, their prescriptions will be free.

Dr Simpson: So the temporary resident is charged the Scottish rate.

Deirdre Watt: Yes.

The Convener: Are we all clear about that now? I see that Mary Scanlon is rallying.

Mary Scanlon: I am just thinking about temporary residents. In the Highlands in the summer, we have many thousands of tourists. Is a tourist classed as a temporary resident?

Deirdre Watt: No, as they would not be registered with a Scottish GP. A temporary resident has to be registered with a Scottish GP.

Mary Scanlon: It is an important point.

The Convener: Yes, and we will dip further into it.

Dr Simpson: People can register temporarily with a GP. If a tourist goes to a GP and asks for a medical service, they register with that GP on a temporary resident basis. If they are temporarily resident as a tourist, they sign up for a temporary resident fee and get free prescriptions. Tourists would therefore be entitled to free prescriptions.

The Convener: I like it when members give evidence. Can you corroborate that, Dr Pryce?

Dr Pryce: Yes, that is absolutely right. Deirdre Watt said that the test is whether someone is registered. If tourists need to see a GP while they are visiting the country, they register temporarily with a Scottish GP and therefore benefit.

Dr Simpson: So they will be entitled to free prescriptions. All our tourists will get free prescriptions.

The Convener: Is it at the discretion of the GP whether to accept someone's application as a temporary resident, so that people do not just come and use the service?

Dr Simpson: Not if they are an EU citizen.

Mary Scanlon: If someone comes up here from England and works in the Highlands for a month, he or she is therefore a temporary resident. If they went along to the local GP to get a prescription, would it be free?

The Convener: I ask one of the witnesses to give evidence about that—however tempting the alternative.

Dr Pryce: I am happy to be corrected by Dr Simpson if I get any of this wrong.

Dr Simpson: No—please.

The Convener: He is blushing.

Dr Pryce: If somebody is living temporarily in Scotland, away from their own GP, and they need to see a GP, there is a duty on the local practice to accept that person and see them. Somebody who is up here working for a month would be able to see a local GP.

Mary Scanlon: So they would be a temporary resident, and they would get free prescriptions.

Dr Pryce: Yes. If they stay for longer than three months—I think that that is the period—they are required to register formally with a GP.

Ian McKee (Lothians) (SNP): Let me clarify the point. If someone comes to Scotland on holiday, goes to a GP and says that they happen to have run out of 10 items from their regular prescription, they will get those items free of prescription charges if they sign on as a temporary resident. Is that correct?

Dr Pryce: It would be for the GP to confirm that there was a genuine medical need for the prescription to be written at that point.

Ian McKee: What if someone says, "I've run out of pills," or, "I forgot to bring my pills with me"?

Dr Pryce: The GP would have no real option other than to respond accordingly.

11:15

Mary Scanlon: So if a person lost their wig, for example, they would get a free wig. They would get what they are entitled to through free prescriptions.

Dr Pryce: There is probably a reasonable test for the GP to follow in determining whether an item is an emergency item and is therefore required or whether the problem could reasonably wait until the person returned to their place of residence.

The Convener: It is not as if we are talking about an umbrella that has been left in a taxi.

I want to move on. Members have a timetable that they want me to keep to, so I am in their hands.

Rhoda Grant: May I ask a short question?

The Convener: Yes.

Rhoda Grant: What about a person who flies up from London for a day to attend a meeting or for a weekend? Is there a minimum length of time for which a person can sign on as a temporary resident?

Dr Pryce: I do not believe so. It would depend on whether the problem could wait. A GP would not be impressed if a patient flew up for the day and said that they needed to see them, unless there was a genuine emergency and the person could not wait.

Ian McKee: I think that a person must wait 24 hours; otherwise, it is an emergency consultation.

The Convener: Another of the professionals has spoken.

Helen Eadie: The final paragraph on page 13 of the SPICe briefing is devoted to that topic. It states that regulations had to be introduced as a consequence of health tourism and that

"the Welsh Conservatives claimed that the phased abolition had resulted in 'prescription tourism' from English patients and had subsequently cost the Welsh NHS £3m"

in 2005. I draw that to Mary Scanlon's attention. The briefing gives reasons why regulations had to be introduced. I do not know whether the witnesses have copies of that briefing.

Dr Pryce: The regulations seek to put in place the same cross-border arrangements that exist in Wales. Therefore, account has been taken of what has been learned there.

The Convener: I am sure that we can revisit the matter if we find that there is an explosion of health tourism. Perhaps England could go the same way as Scotland and Wales—that might be the simplest solution. We could then rest easy in our beds and not worry about a flurry of entitlement cards and prescriptions.

No comments on the regulations have been received and no motions to annul have been lodged. We have aired matters clearly. Do members agree that the committee does not wish to make any recommendation in relation to the regulations?

Members *indicated agreement*.

Petitions

Methadone Prescriptions (PE789)

11:17

The Convener: Under agenda item 2, we have two petitions to consider.

PE789, from Eric Brown, calls on the Scottish Parliament to take a view on the need for regulation to ensure that methadone prescriptions are taken by the patient while supervised by a suitably qualified medical practitioner. I am glad that Mr Brown is here to hear what we say about his petition.

I refer members to paper HS/S3/08/7/4 and, in particular, to the options in paragraph 21. I invite members to comment on this interesting petition.

Helen Eadie: I was impressed by the Public Petitions Committee's consideration of Mr Brown's petition. I sympathise with him, although I do not know whether the professionals around the table do.

Iain Gray makes a powerful point in his letter. He is really saying that every life is worth protecting and that if methadone is leaking on to our streets, we must ensure that there are ways of avoiding its diversion to protect children, given that some have been tragically affected by methadone.

Methadone is getting into our communities, and my favoured approach is for the committee to consider how we supervise its provision. The options that have been presented to us are particularly helpful, including option b), which suggests:

"close consideration of the petition on the grounds of the earlier work carried out by the PPC".

It is certainly appropriate that we closely consider the petition.

We should also write to the Scottish Government to ask for further information on the research into methadone that it has already commissioned. I know that the Government will publish a strategy later this year. There is a degree of urgency because, as I recall, Mr Brown's petition first came to the Parliament in 2004, and four years is a long time, during which children could have been put at risk. We have work to do on the petition.

The Convener: Paragraph 13 refers to a Scottish Government news release dated 10 February 2008 and headed "Spending Watchdog to review drugs cash", which states that

"a new national drugs strategy will be published later this year."

Does that influence what we want to do? I concur with everything that Helen Eadie has said, but I would like to hear other members' views.

Ross Finnie (West of Scotland) (LD): I understand where Helen Eadie is coming from, but she is asking us to choose options a) and b). I do not dissent on the need to make some progress—the petitioner is right—but option a) asks us to await the publication of that strategy. If we are dissatisfied with that, pursuing option b) remains open to us.

The Convener: I think that option b) is being misread; I am probably guilty of that too. Option b) is to "close consideration" of the petition—to end our consideration of it—rather than to consider the petition closely. That does not mean that we cannot closely consider it as an alternative approach under option c).

Helen Eadie: I think that you are right.

The Convener: It is not a problem—we all looked at it in that way.

Ross Finnie: I wish that things would move on, although we will get a strategy. The Government must be aware of all of the evidence that the Public Petitions Committee has put forward and of the very real concerns that exist over the way in which methadone is being dealt with, so it would be surprising if the strategy did not incorporate a response to those concerns. I am interested to see that response.

Rhoda Grant: I agree, but we should still write to the Scottish Government prior to the publication of its strategy, to draw its attention to the petition.

The Convener: That is option a).

Rhoda Grant: I also want to ask the Government to examine the barriers to the supervised dispensing of methadone. Although I see no reason why the petitioner's request cannot be fulfilled, there are obviously reasons why people are allowed to take methadone away, and we need to consider the practical aspects. I suggest that we hold on to the petition until we see the strategy, because the committee will want to examine the strategy.

The Convener: We will hold on to the petition. You are quite right. Many of us here represent rural areas, and we understand why close supervision is just not practical—for example, for someone who lives on a remote island.

Mary Scanlon: That was really my point. I am sure that we all want to say how sorry we are that Mr Brown lost his son due to diverted use of methadone. It has taken tremendous courage for him to bring the petition this far. Like the convener and Rhoda Grant, I had not appreciated the number of methadone-related deaths involving

unprescribed, illegal methadone until I read about the petition—I did not know that the situation was quite so bad. I understand that, as others have said, the forthcoming strategy will include options in addition to methadone, such as more options for rehabilitation, which Mr Brown is asking for.

As Iain Gray has pointed out, the main problem in methadone-related deaths is the use of unprescribed, illegal methadone, and no amount of GP supervision of methadone prescriptions will solve that. As a result, I am content to go with option a).

Rhoda Grant: At least the methadone would not be available illegally and would be consumed in front of the GP.

The Convener: We will follow our usual practice and circulate a draft letter to committee members. The committee's view is that we go with option a), which is to

"write to the Scottish Government … on how its commissioned research on methadone and the specific issue of supervised consumption will be incorporated into its new drugs strategy".

I think that that takes into account Rhoda Grant's point about supervision.

We will draft and circulate a letter and set a time limit for members' comments. If members are content, we will also send a copy to the Public Petitions Committee and to Mr Brown. Are members happy to take that course of action and to leave the petition open?

Members *indicated agreement*.

Mental Health Services (Deaf and Deaf-blind People) (PE808)

The Convener: PE808, by Mrs Lilian Lawson, on behalf of the Scottish Council on Deafness, calls on the Scottish Parliament to urge the Scottish Executive to develop and establish a specialist in-patient mental health unit for deaf and deaf-blind people and to provide resources such as training for mainstream psychiatric services in the community to make them more accessible to deaf and deaf-blind people in Scotland. The petitioner is in the public gallery this morning.

Do members have any comments on the briefing paper on the petition and on the options that are set out in paragraph 19 in particular? The issue is certainly relevant, given what we have discussed this morning.

Helen Eadie: I am in favour of option a), which is that we take the petition into account in our deliberations on the committee's proposed inquiry into the adequacy of Scotland's mental health strategy. After all, we have already heard this morning about the importance of this issue.

The Convener: Given that we agreed at our away day to try, as far as possible, to absorb petitions into our work, I suggest that we leave the petition open and take it into account in our discussions on what we should cover in our proposed inquiry on mental health issues. Are members agreed?

Members *indicated agreement*.

The Convener: That concludes our business in public.

11:27

Meeting continued in private until 12:33.

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