HEALTH AND SPORT COMMITTEE

Wednesday 5 November 2008

Session 3

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HEALTH AND SPORT COMMITTEE
26th Meeting 2008, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Jackie Baillie (Dumbarton) (Lab)
Helen Eadie (Dunfermline East) (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)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Jamie McGrigor (Highlands and Islands) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Beth Elliot (Scottish Government Legal Directorate)
Kenneth Hogg (Scottish Government Health Delivery Directorate)
Robert Kirkwood (Scottish Government Health Delivery Directorate)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 5 November 2008

[THE CONVENER *opened the meeting at 10:05*]

Subordinate Legislation

Infant Formula and Follow-on Formula (Scotland) Amendment Regulations 2008 (SSI 2008/322)

The Convener (Christine Grahame): Good morning. I welcome everyone to the 26th meeting in 2008 of the Health and Sport Committee. I remind all members to ensure that their mobile phones are switched off.

Helen Eadie has sent her apologies.

Agenda item 1 is consideration of subordinate legislation, and we have before us one negative instrument, which amends the Infant Formula and Follow-on Formula (Scotland) Regulations 2007 (SSI 2007/549). The new regulations ensure compliance with a Court of Session judgment that the labelling requirements that were introduced by the 2007 regulations were invalid.

The regulations were drawn to the committee's attention by the Subordinate Legislation Committee on the ground that regulation 3 contains an error. The Subordinate Legislation Committee raised the issue with the Scottish Government. In response, the Food Standards Agency Scotland acknowledged the error, but gave the assurance that it does not affect the legal validity of the provision.

No comments have been received from members and no motions to annul have been lodged. Are we agreed that the committee does not wish to make any recommendations on the regulations?

Members *indicated agreement*.

Health Boards (Membership and Elections) (Scotland) Bill: Stage 1

10:06

The Convener: We move on to take oral evidence on the bill. Today, we are taking evidence from the Scottish Government's bill team. I welcome Kenneth Hogg, who is the deputy director of health delivery, Beth Elliot, solicitor, and Robert Kirkwood, policy officer. I will move straight to questions from members.

Mary Scanlon (Highlands and Islands) (Con): I have a couple of questions on paragraph 9 of proposed new schedule 1A to the National Health Service (Scotland) Act 1978.

I think that we all understand who is qualified to be a candidate, but who is likely to be disqualified? Would someone be disqualified on the grounds of age or political allegiance, or employment in the national health service?

Robert Kirkwood (Scottish Government Health Delivery Directorate): It will be open to people to stand for election and we would not put a bar on someone who had a particular political allegiance. Some people, however, would not be able to stand, perhaps because of their role in relation to the health board. That is in line with local government procedure, whereby some posts are specified as politically restricted, because the people in them have to provide regular advice or briefings to local government. We foresee something similar for health board elections.

Mary Scanlon: So would someone who works in a managerial capacity—as opposed to a doctor, consultant, nurse, physiotherapist, chiropodist, podiatrist or whatever—and fulfils their professional role but does not give advice to the health board be entitled to stand?

Beth Elliot (Scottish Government Legal Directorate): They would. The list of people who are disqualified from standing is set out in part 5 of schedule 1 to the draft Health Board Elections (Scotland) Regulations. I think that committee members have a copy of those.

Mary Scanlon: I did not get around to reading those regulations. Would you mind quickly running through the list?

Beth Elliot: It is basically those who are currently disqualified from standing as a member, such as undischarged bankrupts, those who are incapable, those who have been convicted of a criminal offence in certain cases, and those who have been disqualified from being a charity trustee. Those categories of people are set out in the regulations.

Mary Scanlon: So there is no bar on the basis of age.

Beth Elliot: No.

Mary Scanlon: There is only a bar if someone is employed in the NHS and gives advice to the health board, because that might cause a conflict of interest. Is that correct?

Beth Elliot: Yes. The regulations require the health board to have a list of restricted posts, and people in those posts would not be entitled to stand as a candidate. However, those are—

Mary Scanlon: Sorry, but I think that this is important, convener. Would Ms Elliot mind just giving me a brief outline of the restricted posts?

The Convener: Before we move on to that, I just point members to schedule 1 to the draft Health Board Elections (Scotland) Regulations, which refers to "List of restricted posts" at part 5, paragraph 12.

Mary Scanlon: That is fine. I will read that.

Paragraph 12(2)(b) of proposed new schedule 1A to the National Health Service (Scotland) Act 1978 indicates that, if a vacancy arose in a health board because, for example, an elected member resigned, someone could be appointed "to fill the vacancy." In our Parliament's electoral system, if a list member resigned, the next one on the list would be appointed. The bill indicates that, if a vacancy arose on a health board, an appointee would take the elected person's place. Can someone explain the rationale behind that?

Beth Elliot: If there was a vacancy, the bill would allow the next person on the list to be appointed. The draft regulations set out that the unelected candidate who is next on the list can be nominated. The provision in paragraph 12(2)(b) of proposed new schedule 1A to the 1978 act, which states that the Scottish ministers can appoint a health board member, is intended to cover the worst-case scenario of not enough candidates standing. In those circumstances, the Scottish ministers would appoint someone.

Mary Scanlon: Paragraph 12(2), to which you referred, states that ministers may:

"(a) direct the Health Board … to invite an unelected candidate … or

(b) appoint, in accordance with"

provisions.

Beth Elliot: The unelected candidate is defined in paragraph 12(5) of proposed new schedule 1A to the 1978 act as being

"identified by criteria specified in election regulations."

Mary Scanlon: So it would be someone who had stood.

Beth Elliot: Yes. It would be someone who had stood in the election.

Mary Scanlon: Okay. I have a final point for now. In elections for community councils, if there are 12 places and 12 people put their names forward, there is no election. If there were 12 vacancies for a health board and 12 people or fewer applied, would the election still go ahead?

Beth Elliot: No. If I can direct you to paragraph 7—

Mary Scanlon: Is that paragraph 7 of the regulations?

Beth Elliot: No, of the bill. Paragraph 7 of proposed new schedule 1A to the 1978 act states:

"If … the number of nominated candidates … is equal to or less than"

the number of members to be elected, then instead of having an election, the returning officer would declare those people to be elected.

Mary Scanlon: Okay. So there would be no need for an election, if the number of candidates was less than or equal to the number of vacancies.

Beth Elliot: That is right.

Mary Scanlon: I have other questions, but I will come back to them later.

The Convener: What would happen if, in an area where there was supposed to be an election, not enough people stood?

Beth Elliot: That would be covered by the provision in paragraph 12(2)(b) of proposed new schedule 1A to the 1978 act, which would be specified further in the election regulations.

The Convener: Have we got those?

Beth Elliot: You do have the election regulations.

The Convener: Is that the large document that I am holding up?

Beth Elliot: Yes.

The Convener: And where are the regulations in here?

Beth Elliot: I do not think that those particular provisions are in the election regulations at the moment. That is something that we need to consider further.

The Convener: So, in the case of an election being null and void because not enough people stood, we do not yet know what would happen.

Kenneth Hogg (Scottish Government Health Delivery Directorate): It is fair to say that if, under the proposed process, health board members were appointed by the Scottish ministers, they

would be bound by the public appointments system. The same process that is currently used to appoint chairs and non-executive members would be applied for any new health board members appointed by the Scottish ministers.

The Convener: So the process would revert to the old system.

Kenneth Hogg: If we reached the point of a directly elected board being unable to secure enough candidates for it to be quorate and competent and if the functioning of the board required the Scottish ministers to make appointments, we would revert to the public appointments system. However, that is very much a last resort, and the provisions are designed to avoid reaching that point.

10:15

The Convener: I do not want to hog the discussion, but I will pursue that point. Elections are to be held every four years. In the circumstances that we have discussed, would there be provision to hold an election within a shorter time, or would the reversion to the old system continue for the rest of the four-year period?

Kenneth Hogg: I think that that is provided for in the bill.

The Convener: What is provided for—the fact that an election could be held before the end of the four-year period?

Kenneth Hogg: Yes.

The Convener: Where is that?

Beth Elliot: We would have the power to have an earlier election.

The Convener: Where is that in the bill?

Beth Elliot: The power to have elections?

The Convener: Yes. Can you show me where that is?

Beth Elliot: The regulations do not currently include provisions on what happens if not enough people stand as candidates, which is something that we will consider further.

The Convener: I will finish this questioning, but the Subordinate Legislation Committee notes that the regulations will be made under negative procedure unless you substantively alter the bill. If you want a measure other than a four-yearly election—for when there is not sufficient interest to have an election under the new regime and you revert to the old regime—provision for that would have to be in the bill rather than regulations.

Kenneth Hogg: On page 3 of the bill, in the final part of paragraph 2, it says that

"a Health Board election may be held in a Health Board area before the day specified in sub-paragraph (3)"—

The Convener: Sorry, could you confirm where you mean?

Kenneth Hogg: Section 2(2) inserts some text into the 1978 act. The final part of that new text, subparagraph (4), is at the top of page 3 and states—

The Convener: Hang on. Please take me through the paper trail. You have taken me to section 2 of the bill, entitled "Health Board elections".

Beth Elliot: Section 2(2) of the bill inserts a new schedule into the 1978 act, and we are talking about paragraph 2(4) of that new schedule.

The Convener: That says that

"a Health Board election may be held in a Health Board area before the day specified in sub-paragraph (3) if the Scottish Ministers make an order under section 77"

of the 1978 act.

Kenneth Hogg: That provides that we would not have to wait a full four years for an acceptable outcome. Elections could be held much sooner.

The Convener: So that may remedy the point, although I will have to look at that again more closely.

Ross Finnie (West of Scotland) (LD): As this is stage 1, I want to go back a step to be clear about the principles, although I appreciate that other members will have detailed questions that raise matters of principle. I will ask a quick question as a preliminary to my two more substantive questions: does the bill improve accountability, or is it about representation?

Kenneth Hogg: Both. The accountability point comes into the concept of mutuality, which was introduced in the Government's "Better Health, Better Care" policy document issued in December 2007. That introduced the concept of co-ownership, including the public, of the NHS in Scotland. Accountability must continue to rest, through ministers, with the Scottish Parliament, but the concept of mutuality broadens the definition. The bill will allow for the voice of the public to be heard and to influence decision making in boards.

Ross Finnie: Which is representation.

Kenneth Hogg: Indeed.

Ross Finnie: I understand the rhetoric and the ambition behind mutuality. However, given that the Cabinet Secretary for Health and Wellbeing retains ultimate responsibility, I am not sure that you can argue cogently that the bill materially alters accountability.

Kenneth Hogg: That is correct. Accountability remains with the ministerial department and the directly elected members would be bound by the same corporate governance arrangements that other board members are bound by.

Ross Finnie: There are two parts to my question. I have learned from Mary Scanlon and others that what you should do is declare that you have one question and then ask it in three parts.

Mary Scanlon: It takes years of practice.

Ross Finnie: I know. I realise that I am new to all of this.

The Convener: I feel doomed.

Ross Finnie: I suppose that it depends on where you are, but certainly no less than 80 per cent of all health care is delivered in the community. How will the principles behind community health partnerships be developed if directly elected local councillors are pitted against directly elected health board members?

Kenneth Hogg: Community health partnerships already comprise local government and NHS—

The Convener: I must stop you there, Mr Hogg. Mr Finnie, we should be cautious and bear in mind the officials' remit.

Ross Finnie: Indeed. I do not in any way want to suggest that Mr Kenneth Hogg is not aware of the full extent and limitation of his powers.

The Convener: I just wanted to put that on the record.

Ross Finnie: But I am sure that he is extraordinarily able to express his views on matters of principle.

The Convener: I cannot tell them anything, Mr Hogg. Please proceed.

Kenneth Hogg: We must avoid a situation in which board members, however they have been established, are pitted against each other. After all, they are working within a single board's corporate governance arrangements for the single purpose of letting the board find the best ways of meeting its population's health needs.

As is the case with appointed board members, all directly elected members will receive training and development on the expectations of board members and the responsibilities that come with the position. The point that board members should maintain the board's unity and solidarity rather than take up opposing positions will be very much reinforced.

Ross Finnie: As the convener has rightly pointed out, there is a political element to all this that we are not going to pursue today. However, what is your view of the opinion expressed in written responses that, given the fact that accountability cannot be altered, the aim of broader representation might be better achieved by extending the membership of community health partnerships to the community? The view was not unanimously held, but elements of it were expressed in submissions by Glasgow City Council, East Lothian Council, the Royal College of Nursing, Argyll and Bute Council, NHS Forth Valley, Aberdeen City Council, the Convention of Scottish Local Authorities, North Lanarkshire Council, Highland Council and the City of Edinburgh Council. Are those organisations wholly misguided on that point?

Kenneth Hogg: Very mixed views were expressed in the consultation. For example, parties involved with the NHS were less or not at all supportive of the proposals, whereas those that were not involved were more supportive.

Although community health partnerships have a broader range of representation than other parts of the NHS, that representation does not include directly elected members of the public.

The bill would significantly broaden the ability of the NHS to engage with public representation. The bill puts on a statutory basis the requirement to include local authority representatives on health boards. Councillors do sit on health boards now, but not on a statutory basis, which the bill provides for.

I invite Robert Kirkwood to offer the committee some more detail on the consultation.

Robert Kirkwood: The committee's consultation responses closely replicated those that we got to our own consultation, in that there was a spread of opinion on the way forward. We received a number of representations about enhancing the roles of local authorities, community health partnerships and public partnership forums. That was taken into account when we examined our responses. The bill proposes a way forward involving direct elections. One message that came from our consultation was that the existing mechanisms for public involvement and engagement also need strengthened.

Ross Finnie: I like the phrase,

"there was a spread of opinion".

That interesting expression means, "The vast majority were against the current proposals," does it not?

Robert Kirkwood: In our consultation, we did not ask the question whether people were for or against. We received a genuine range of opinions.

Ross Finnie: One does not always need to ask the question—one often gets an answer anyway. It is difficult to read such responses without coming

to a conclusion that there was an overwhelming majority against—albeit with the split, to which Mr Hogg alluded, between those with health associations and those without—even within local authorities, which cannot be said to be in anyone's pocket.

Kenneth Hogg: That spread of opinion was a reason in favour of holding pilot exercises. We want to test how the arrangements would work in practice. Even some of the respondents who were not in favour of direct elections to health boards expressed a preference for holding pilot exercises.

Ross Finnie: If, in interpreting the responses, your reaction was to suggest pilot exercises—which I think is a constructive reaction—why did the pilots not include the other models that were being suggested by those parties who were encouraging you either to consider extending the participation of councillors or to adopt other forms of representation. Your pilots are predicated solely on one principle.

Kenneth Hogg: That was the basis on which the Government particularly wanted to strengthen representation on health boards. We have acted to strengthen the role of local authority members by putting their participation on a statutory basis. We are taking other action across Government to strengthen public engagement and participation more generally, but the key policy objective was around the public's voice being heard at the heart of decision making within health boards.

The Convener: I want to get this on the record for the sake of clarity—I do not want to contravene what you have just said. The responses that we got are shown on pages 9 to 11 of our briefing from the Scottish Parliament information centre. That is what we got, not what the Government got, and there is a difference. That is why I was getting a bit lost. In the table headed "Opinion on the principle of direct elections by category of respondent", four local authorities were for, six were against and six were "Unclear/no comment". Similarly, in the table "Opinion on the principle of election pilots", five local authorities were for and 10 were in the category "Unclear/no comment". We should not confuse the two sets of responses. You have been addressing the Government responses, I take it. They were different for us. I draw your attention to that distinction and to our SPICe briefing. I am not sure whether Ross Finnie wishes to return to the point.

Ross Finnie: No, I agree with what you said, convener, albeit with one reservation. If someone expressed a range of views including being against the proposal, but made a range of suggestions as to how they might approach the matter differently, that was recorded as "Unclear". That was a little unhelpful.

The Convener: I wanted to get that clear, because I could not follow the figures that were being used. I have now been helped.

10:30

Michael Matheson (Falkirk West) (SNP): I return to the issue of those who will be restricted from standing in the elections. Beth Elliot said that the political restrictions that apply will be similar to those that apply in local government.

Beth Elliot: They will be similar to those that apply to existing health board members.

Michael Matheson: In local government, there is a very different approach. I understand that the system is based on a grade. When I was in local government, people were politically restricted once they had reached a spinal point in the local authority grading system, irrespective of whether they provided advice to elected members. Am I correct in saying that, in health boards, restrictions will apply to individual posts? I presume that there will be something of a moveable feast. Someone who is practising in the NHS and is not advising the board on anything may be called in to give advice on an issue that has arisen because of their expertise or because the matter is relevant to their department. Would they automatically be restricted thereafter as a result of that request?

Beth Elliot: The list of restricted posts will apply to those who give advice to the board or any of its committees or sub-committees on a regular basis. A one-off case of giving advice would not come within the definition of regular. The list is designed to cover those who give regular advice.

Michael Matheson: Let me change the scenario. If someone gives regular advice over a short period, will they be precluded from making representations to stand for election to the health board in the future? Someone could be called in to give advice to a sub-committee over a three-month period. The elections might not be for another three and a half years, and the person might give no further advice during that time. Would attending meetings of a sub-committee on three occasions to give advice be classified as giving advice on a regular basis and prevent someone from standing?

Kenneth Hogg: We do not anticipate that the lists will be very long. They will be reviewed regularly to ensure that they are not set in stone for a four-year period. If an NHS employee were elected to the health board and their work during the period for which they were elected involved giving advice, they could simply declare an interest. It would then be incumbent on the chair to manage proceedings such that that person did not play an active role in taking decisions. That scenario is different from the one that you outlined,

but I do not think that a lengthy and bureaucratic process will be needed for health boards to modify lists to ensure that they are up to date and accurate at the point at which candidates are invited to stand.

Michael Matheson: I have concerns about the issue, because it is common practice in a range of public agencies, including the NHS, to set up short-lived working groups to give advice to boards on different matters. You need to think more carefully about the definition of regular advice and to specify in more detail what that involves.

I understand that the chair of the health board cannot be an elected member. Why is that?

Kenneth Hogg: The point relates to an issue that Ross Finnie raised. Accountability continues to flow from health boards, through ministers, to Parliament. In the context of public appointments procedures, having a ministerially appointed chair is an important part of ensuring that the accountability structure is maintained.

Michael Matheson: That is helpful.

My final point is on the pilots. I understand that the pilot areas have not been announced yet.

Kenneth Hogg: That is correct.

Michael Matheson: What criteria have been used to decide which areas will be used as pilots? When do you expect them to be announced? If, after the pilots, we decide not to proceed with elections in other health board areas, what will happen to the health boards that have directly elected members on them?

Kenneth Hogg: The names of the health boards selected will need to be identified in time to be included in the regulations that will be laid following the passage of the bill.

Ministers want to make public the criteria for selecting the health boards and they will do so once they have made their decision.

Ministers are minded that there should be two pilot health boards, which should, between them, cover a representative geographical area of Scotland. One board area is likely to be predominantly rural and the other is likely to be predominantly urban.

Another factor that ministers will consider is the ease of transition from the boards' current make-up to their future make-up. Board members serve on a rolling basis; their term of appointment expires. Ministers would not be attracted to making wholesale premature change to boards simply for the pilots. Therefore, they will take into account the extent to which boards include members who will come to the end of their term of appointment naturally between now and the time when the pilots start. The earliest date for elections would be 2010. Therefore, that is the earliest that pilots would start.

In the scenario that roll-out did not follow the pilots, the appointment of the elected members of the boards in question would expire. It would be for the Government of the day to decide whether to revert to the current policy of health board appointments or whether to introduce some other system.

Michael Matheson: So, if roll-out did not follow the pilots, the people who were elected to the two health boards through the pilots would serve out their four-year term.

Kenneth Hogg: That is correct.

Michael Matheson: That is helpful. Thank you.

Mary Scanlon: I made some notes, but I did not write down where I got the information from. It is my understanding that there will be only one pilot, but Michael Matheson is talking about two.

Kenneth Hogg: Ministers intend that there will be two pilot areas.

Mary Scanlon: Where is that stated? I cannot find a reference to it.

Kenneth Hogg: The bill does not specify the number of pilots. It would be possible to have more than two. One of the relevant factors would be cost. Our financial memorandum sets out costs based on the assumption that pilots will cover 20 per cent of the population at certain levels of turnout. There is an important correlation between the number of pilots and the costs of holding them.

Michael Matheson: I might have contributed to the confusion. There is one pilot in two areas, as opposed to two pilots.

The Convener: Section 5 provides that an appraisal and report must be submitted no later than five years after the election in the pilot area. That ties in with the timescale that we have discussed.

Jackie Baillie (Dumbarton) (Lab): A number of important principles have been established. I was worried about accountability, but it is now clear that that remains unchanged. It is equally clear that the single pilot is about a single approach, rather than a multiplicity of approaches to increase representation—that issue has been raised in evidence. What you said about that was enormously helpful.

I have some practical, detailed questions. You will forgive me if I start with the elections overall. I am slightly concerned that the nature of the election, its shape and form and who the candidates are—which are matters of substance—are dealt with simply in regulations. Is that

common? I seem to recall that when the legislation on the national parks was introduced, the form and substance of the elections was very much part of the primary legislation.

Beth Elliot: We have put some important matters of principle on the face of the bill, such as extending the franchise to 16-year-olds, having single wards and using the single transferable vote. We considered it appropriate to put in regulations the detail of the election regime because it is a detailed system. It is not uncommon for the detail of an election regime to be put in regulations. We think that that strikes the appropriate balance as regards what should be included in the bill.

Jackie Baillie: Am I therefore incorrect about the National Parks (Scotland) Bill?

Beth Elliot: No; that bill had more substantive provisions on the face of it. Another example is that much of the detail of the overarching election regime in the Representation of the People Act 2000 is contained in subordinate legislation.

Jackie Baillie: But there might be an argument to put more on the face of the bill given the newness of the situation.

Beth Elliot: We think that we have struck the appropriate balance, which is why we have put the regulations before the committee.

Jackie Baillie: Thank you; that is helpful.

Are you aware of the interesting submission from the Local Government Boundary Commission that suggested that you might need to alter the boundaries between local government and the health boards? I am conscious that in some areas, health board boundaries bisect council boundaries. Was any consideration given to that?

Kenneth Hogg: Given that the approach is to take two pilots to test the essential principles of the proposals, we are not attracted to wholesale change to boundaries. In order to achieve that, where possible we are trying to take the simplest approach to holding the election and to getting the pilots up and running. Therefore, avoiding boundary changes would be part of that.

That leads to a separate issue about the extent to which local authority and health board boundaries are coterminous. That is one of the factors that Parliament and ministers might want to take into account in deciding on the pilots and whether they are minded to go for as simple an approach as possible, but it is not an absolute criterion.

Jackie Baillie: Forgive me if I have picked you up wrongly, but you seem to create a distinction between pilots and the roll-out. Should the pilots be successful and the changes be rolled out, we would need to look at boundaries, particularly as you are relying on returning officers in that context to run those elections for you.

Kenneth Hogg: Under the current proposals, we have no plans to change either health board or local authority boundaries in the roll-out scenario.

Jackie Baillie: You do not think that it is required, given your earlier comments.

Kenneth Hogg: No, we think that the elections would be workable.

Jackie Baillie: That is interesting, thank you.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): You have a situation in which a particular health board might relate to a number of different registration officers. Have you included in your eventual costs the fact that they will have to work hard not only to create a specific register for each health board that they cover but to introduce the register for young voters of 16 and 17 for each area? They might have to cover one, two or in some instances three areas. That seems administratively cumbersome but, more important, very expensive. My colleagues will ask about costs in a minute, but what I am speaking about is part of that cost equation.

Robert Kirkwood: We have taken into account those costs. We have used the national park elections model. The national parks cut across numerous local authority boundaries and the returning officer for the most populous local authority within the boundary administers the election.

Jackie Baillie: Given returning officers' experience of running elections, you will appreciate that we find them a credible source of evidence. The returning officers expressed some concern at the extension of the franchise to 16 to 17-year-olds. Although I might be attracted to the idea, I was convinced by their evidence. They gave four principal reasons. First,

"it would depart from the consistency for different elections".

Secondly,

"it would go against 'putting the voter first'"—

that was in the Gould recommendations, which the Parliament accepted. Thirdly,

"the age of voting was recently reviewed by the Electoral Commission which recommended that 18 years of age remain as the age for voting".

Fourthly, they expressed concern about

"the practicalities of collecting information"

because the requirement to collect it from 14 and 15-year-olds might give rise to child protection issues.

Did you consider those concerns? What is the answer to them?

10:45

Kenneth Hogg: The principle of extending the franchise to 16 and 17-year-olds is a policy decision of the current Government. Other options were considered, but that is the policy that will apply to elections. You are right to point out that it raises a number of practical questions about how we achieve it in practice. We have given that quite a lot of thought and have changed our proposals to reflect some of the difficulties.

Robert Kirkwood will explain how we will undertake the process of registration.

Robert Kirkwood: The extension of the franchise was the subject of discussion between ourselves and the electoral registration officers. We agreed that they would keep a young persons register and we have given them the power to do so within the regulations. That will allow them to keep the register and supply details of people on it to the returning officer, who can then administer the election. That was agreed with the electoral registration officers as the simplest and most effective way forward. It will allow the officers in the areas concerned to use their own systems to record 16 and 17-year-olds.

Jackie Baillie: I am sorry that I did not make it to the Finance Committee when you gave evidence to it yesterday. Your financial memorandum mentions that the cost of elections to health boards will be about £13 million, and you have revised that to £16 million, which is helpful. However, the electoral registration officers said that your assumed unit cost per vote is shy by about £1. You estimated it to be about £2.60 or thereabouts, but they said that it is £1 more expensive than that. That would add quite a lot to the figure in your financial memorandum.

Given the tight financial settlement that we hear about for health boards, and given that the Government has said that there will be no extra money, how robust are your figures? Given the current context of health boards, will they need to take the funds from front-line services?

Kenneth Hogg: That is an important point. The scenario in which the cost increases by £1 per vote would arise if we used personal identifiers as part of the canvass. We do not propose to do so. We weighed up the advantages of the added security that personal identifiers bring and balanced that against the significant additional costs that are involved and the administrative complexity—throughout the process—of using them. We therefore propose not to use personal identifiers in the elections.

Jackie Baillie: Given that personal identifiers are integral to the security of the electoral system and our trust in the result, I am surprised by that. Do you not anticipate any difficulty?

Kenneth Hogg: We propose to take the approach that has been taken with elections to the national park authorities, which do not use personal identifiers. We agree that the use of personal identifiers has security advantages, but the cost difference in particular led us to decide against their use. The base cost per vote that is set out in our financial memorandum is £2.60. That would increase to £3.60 if we used identifiers. We discussed the approach with the registration officers and they agree that we have correctly assessed the issues of additional cost and complexity. They agree that our approach will be simpler. We accept that the downside is the loss of the additional security that is brought by personal identifiers.

Jackie Baillie: You chose your words carefully, but I will push you. What was the view of the electoral registration officers on whether you should abandon personal identifiers?

Robert Kirkwood: I am sorry, but I missed your question.

Jackie Baillie: That is okay; I am trying to push you to a conclusion. Were the electoral registration officers in favour of retaining personal identifiers, irrespective of their understanding of your analysis?

Robert Kirkwood: Yes. Electoral registration officers were in favour of retaining the identifiers.

Mary Scanlon: The evidence base for direct elections seems to come from Canada and New Zealand. The British Medical Association Scotland submission quotes research from Canada:

> "the experience [in Saskatchewan] has demonstrated that health board elections are costly, cumbersome and produce low voter turnout and have failed to foster a more active, engaged citizenry committed to common goals."

It also quotes research from New Zealand:

> "the electoral component of the DHB [District Health Board] system is failing to make a substantial contribution to the democratisation of health care governance in New Zealand".

Those are hardly ringing endorsements of health board elections. Is there another evidence base that is much more positive towards those elections and which I should read to get a bit more excited about the elections?

The Convener: I long to see Mary Scanlon getting excited about the elections.

Mary Scanlon: I was up until 4 in the morning watching the American presidential election.

The Convener: Ditto.

Kenneth Hogg: We have learned lessons from the experience of others. For example, in 2001 New Zealand began with a system whereby members were directly elected to the district health boards. Initially, there was a first-past-the-post system with multimember wards. In 2004, based on a not wholly satisfactory experience, New Zealand moved to the single transferable vote system and single board-size wards for those elections. We have sought, whenever possible, to reflect the learning from other countries.

Robert Kirkwood: New Zealand has had direct elections since 2001. A study, which is quoted from in the SPICe briefing, was carried out in 2007. To summarise the report, it was felt that the fears of existing executive directors about directly elected members taking their place on district health boards had not been realised. Perhaps the directly elected members taking their seats on the boards did not prove to be as big an advantage as it was thought that it would be in bringing local people on to the health board, but on the whole people are happy with what is now in place in New Zealand. The study stated that there was no case for change.

Mary Scanlon: So when you say that people are happy, you mean that patients are happy and that there is a feeling that there is greater engagement, greater patient involvement and so on.

Robert Kirkwood: There is evidence—

Mary Scanlon: Has the evidence from the BMA, which was sent to the committee a couple of months ago, been overtaken by time and experience?

The Convener: We have got the evidence from the BMA. The question was about whether we would find evidence elsewhere. You have dealt with New Zealand, although the evidence has perhaps not excited Mary Scanlon.

Mary Scanlon: I will keep looking for a ringing endorsement of elections to health boards.

I represent the Highlands and Islands. My question refers in particular to Highland Health Board, which covers about 40 per cent of Scotland's land mass. It has been put to me that all the elected members of the health board could come from the biggest population centre, which is Inverness, with no one representing the islands, Argyll and Bute, or Caithness and Sutherland. In that case, would there be an obligation on the health board to appoint members from the unrepresented areas to balance the geographic representation? If people were appointed on the basis of geography rather than on the basis of their ability, would that militate against the democratic principle that we are considering?

Kenneth Hogg: There will be no additional obligation on boards or anyone else to ensure that successful candidates provide a geographic spread or represent particular interests. However, in adopting an all-postal voting, STV, single-ward approach, we have identified the approach that is most likely to lead to the highest number of candidates standing and every vote counting, and to avoid a situation in which single-issue candidates might run—as could happen in the areas that you have identified—and be the predominant group among those who are elected to the board. We have come at the issue by choosing the best possible system up front rather than by seeking to apply balance retrospectively.

Mary Scanlon: So it is still possible that in the Highland NHS Board area all the elected board members could come from Inverness, even though it can take about a day to travel there from elsewhere. Is it true that there is nothing in the bill to redress that?

Kenneth Hogg: Yes.

Mary Scanlon: You mentioned single-issue candidates. Someone might stand for election to a health board simply because they do not want the local hospital to close. What have you done to address that? I missed that bit.

Kenneth Hogg: All that I was saying was that if we had opted for a multiward rather than a single-ward system, for example, a single-issue candidate would be more likely to be successful in such a situation.

Mary Scanlon: Let us say that someone wanted to save the Belford hospital in Fort William. Given that 22 per cent of the local population turned up to a public meeting on that subject a few years ago—it was one of the biggest public meetings ever to be held in Scotland—there is a significant enough vote there to enable a single-issue candidate to be elected under the system that the bill proposes.

Kenneth Hogg: Certainly. The use of STV rather than, for example, first past the post gives the best possible chance for such a voice to be heard.

The Convener: I suspect that that is democracy. Single-issue candidates have been elected to the Parliament.

Section 1 seems to enable Scottish ministers to redress any balance that might be missing across a large area, which is an issue that Mary Scanlon raised. Is that correct? Section 1(2) provides that

"councillors appointed by the Scottish Ministers following nomination by local authorities in the area of the Health Board"

are one of the types of member that a health board is to consist of, so a balance is provided for if there are several local authorities in a health board area. However, that does not quite deal with Mary Scanlon's point.

Section 1(2) also provides that

"a Board must contain at least one councillor member for each local authority whose area is wholly or partly within the area of the Board."

I am thinking of Penicuik in my area. Although it is in Tweeddale, Ettrick and Lauderdale, it is part of Midlothian. In such circumstances, an element of balance is provided for. Is that correct?

Kenneth Hogg: It is. The bill provides not that there must be a majority of directly elected members but that there must be a majority of councillor members and directly elected members. There is that balance.

The Convener: I just wanted to clarify that.

Ian McKee (Lothians) (SNP): I am delighted that our manifesto commitment on direct elections to health boards is coming to fruition. I advise the witnesses not to listen too closely to the people who feel threatened by the advent of democracy into their tight little world. However, I have one or two specific questions, the first of which is on a small point. I know from experience that some health board committees regularly have general practitioners on them offering advice to the health board, although they are not employees of the health board and do not hold a health board post. Will a GP in such a position be banned from standing for election to the health board?

11:00

Robert Kirkwood: That would be entirely a matter for the board to decide. The decision would be based on the frequency of the advice that the individual gives. The draft Health Board Elections (Scotland) Regulations, which we have supplied to the committee, contain provisions to allow employees of health boards to appeal if they feel that their post has been wrongly identified as restricted. They will be able to go to the adjudicator to address that.

Ian McKee: So the board that is to be replaced by a democratically elected board will decide who can stand for election to the board that will replace it.

Robert Kirkwood: GPs are not employees of boards, but a board will take a decision on the advice that is given to it. Therefore, a GP could stand for election.

Kenneth Hogg: That is an important point. GPs will be able to stand for election. I would like to write to the committee to clarify the issue of whether a GP who chairs an important board committee and who therefore advises the board could stand for election. That is a different scenario from that involving a board employee.

Dr Simpson: To be clear, GPs who are employed by a board for other work—30 per cent of GPs are employed in specialist capacities—will not, I presume, be eligible.

Kenneth Hogg: Yes—they will be caught by the wider provision on employees.

The Convener: It would be helpful if you would write to the committee to clarify some of those subtleties. The issue revolves round the definition of the term "Health Board posts".

Ian McKee: My next question is about the number of directly elected people that you envisage being on the boards. I might have missed something, but there are blanks in the draft Health Boards (Membership) (Scotland) Regulations. Obviously, there could be a majority of elected people on the board if there were enough of them. However, I gather from what you said earlier that that is not your intention. Is there a formula that you intend to use to decide what the number should be?

Robert Kirkwood: We do not have a formula as yet. We intend to specify different types of people who will be on the boards. In specifying those types, we will reach the balance that was alluded to earlier whereby the local authority members and the directly elected members, added together, will form a majority on the board. We do not intend to increase dramatically the overall size of boards.

Ian McKee: So there is no way in which a majority of board members could be directly elected.

Robert Kirkwood: Not under the current proposals.

Mary Scanlon: Just on that point—

The Convener: I feel redundant here. Is it a supplementary point, Mary?

Mary Scanlon: Yes.

The Convener: On you go.

Mary Scanlon: I will be brief. What restrictions will apply to dentists and to people who work in the Scottish Ambulance Service and NHS 24? What about people in the voluntary sector who are dependent on funding from a board? They may not give advice to the board but, if they are dependent on funding, they may therefore have an interest. Will you clarify that, too?

Kenneth Hogg: To clarify, the elections will not apply to special health boards; they will apply only to territorial boards.

Mary Scanlon: I understand that. I am asking whether someone from the Scottish Ambulance Service could stand for election.

Kenneth Hogg: Yes, they could, unless they were on the board's restricted list. However, it is highly unlikely that that would occur.

Mary Scanlon: What about people from the voluntary sector? That is important.

Kenneth Hogg: They will be free to stand.

Mary Scanlon: So someone who is dependent on funding from the health board could stand and therefore could have an influence in the allocation of that funding.

Kenneth Hogg: Yes. I cannot think of a scenario in which a person who is not employed by a health board could be excluded.

The Convener: The key is the term "Health Board posts". Perhaps I am wrong, but I cannot envisage how somebody in the voluntary sector can have a health board post. That is the first test and there are subsidiary tests that flow from that. I assume that, if somebody in the voluntary sector who is elected to a board has an interest, that will be declared and it will be for the chair to rule whether it is appropriate for them to take part in particular decisions. Is that a way of putting the situation?

Kenneth Hogg: Yes.

Ian McKee: Do you envisage that people who stand for election to a board will have the freedom to organise themselves along party-political lines?

Robert Kirkwood: There is certainly no proposal to proscribe political parties in the elections.

Ian McKee: Did you say proscribe?

Robert Kirkwood: Yes. If people are minded to do that, they will be able to.

Ian McKee: So that is a possibility.

Robert Kirkwood: Yes.

Ian McKee: You talked about the potential difficulty of non-coterminous boundaries between local authorities and health boards. How do boards cope with that at present, given the existence of community health partnerships, which are a mixture of both?

Kenneth Hogg: Many health boards have non-coterminous boundaries with local authorities and have to deal with the issue regularly in a variety of their committees, structures and processes. Greater Glasgow and Clyde NHS Board probably shares boundaries with the greatest number of local authorities.

Ian McKee: In practice, the situation raises no problem.

Kenneth Hogg: I mentioned it earlier in relation to the complexity or simplicity of organising elections. In relation to the substantive proposals, the situation will not cause any problems.

The Convener: I thank all the witnesses very much for their helpful evidence. Next week, we will have before us two panels—one made up of representatives of health boards and one made up of electoral registration officers and the Electoral Commission. I am sure that Miss Baillie will have lots of interesting questions.

That concludes our formal business in public. We will consider agenda item 3 in private.

11:07

Meeting continued in private until 12:13.

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