HEALTH AND SPORT COMMITTEE

Wednesday 19 November 2008

Session 3

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HEALTH AND SPORT COMMITTEE
28th 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:

Rachel Cackett (Royal College of Nursing Scotland)
Ron Culley (Convention of Scottish Local Authorities)
Liz Macdonald (Consumer Focus Scotland)
Dr Dean Marshall (British Medical Association Scotland)
Phil McAndrew (Voluntary Health Scotland)
Councillor Ronnie McColl (Convention of Scottish Local Authorities)
Pat McGuigan (Inclusion Scotland)
Bill Scott (Inclusion Scotland)
Douglas Sinclair (Consumer Focus Scotland)
Harry Stevenson (South Lanarkshire Council)
Graeme Struthers (West Lothian Council)
Dave Watson (Unison)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Wednesday 19 November 2008

[THE CONVENER *opened the meeting at 10:01*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning. Welcome to the 28th meeting in 2008 of the Health and Sport Committee. I remind all those present to ensure that their mobile phones and BlackBerrys are switched off. Apologies have been received from Dr Richard Simpson and Michael Matheson.

Agenda item 1 is a decision on taking business in private. The committee is invited to take item 3 in private, in line with our usual practices. Is that agreed?

Members *indicated agreement*.

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

10:02

The Convener: Item 2 is oral evidence at stage 1 of the Health Boards (Membership and Elections) (Scotland) Bill. I welcome our first panel of witnesses. They are Dr Dean Marshall, chair of the Scottish general practitioners committee of the British Medical Association; Rachel Cackett, policy adviser for the Royal College of Nursing Scotland; and Dave Watson, Scottish organiser on policy for Unison. After reading the written evidence from the BMA and Unison, I was tempted to open with a debate, to allow each organisation to make its case before taking questions from members. We may try that at some point, because a face-to-face debate would be quite useful; I am sure that we will get to that. I invite questions from members.

Mary Scanlon (Highlands and Islands) (Con): My first question is addressed to the witness from Unison. I note that you support the general principles of the bill. My question concerns the issue of equality. I understand that elected members of boards will not be paid, whereas appointed members will. In New Zealand, elected members are paid 24,000 dollars a year for 30 days' work. Is it fair and reasonable that elected members should not be paid for doing the same job as appointed members, who will?

Dave Watson (Unison): You would expect me, as a trade union official, to respond that there ought to be some equity on the issue. We favour payments being made to people, regardless of the capacity in which they serve—for us, that is an equality issue that relates to access. If reasonable payments are not made, there is a risk that retired, wealthy people who can afford to serve on health boards will be able to do so but people who are more representative of the wider community will not. We have no difficulty with the suggestion that payments be made to people who serve on health boards and similar bodies.

Mary Scanlon: Is it a condition of your support for the bill that all members of health boards should be paid equally for the job that they do?

Dave Watson: It is not a condition of our support for the bill, but I would go so far as to say that we would have no difficulty with such a provision if the bill were amended in that way.

Mary Scanlon: Do you support the provision that allows an elected member to be sacked and the minister to appoint someone in their place?

Dave Watson: No, we do not. Our view is that elected members are elected members in the same way as local councillors are and they should

be dismissed only on similar grounds—that is, the usual misconduct provisions would apply. That is a difference between elected members and appointed members.

Mary Scanlon: That might just be another condition of your support for the bill.

Dave Watson: I did not say that we agreed with every aspect of the bill; I said that we agreed with its principles.

Mary Scanlon: I thought that you might have some difficulty with that and I hope that you might have some difficulty with my third point. I represent the Highlands and Islands. Highland NHS Board, which we would think of as one ward, covers the area from Caithness down to Campbeltown and across to Nairn and the Cairngorms and includes 30 islands. It would be difficult for residents of Coll or Tiree to make themselves known. As health board members, they could be faced with a day to travel to a meeting in Inverness, a day for the meeting and a day to travel back. Given that the population centre for Highland NHS Board is Inverness, it is perhaps reasonable to assume that many of the people who would wish to stand for election to the board would come from there, which would disfranchise people who might wish to contribute to the health board but for whom that is impossible because of travel time, for geographic reasons and because of cost. How would you overcome that geographic, cost and time difficulty, which many people will face in an area such as the Highlands?

Dave Watson: In a previous existence, I was a union organiser for the Highlands, so I am well aware of the geographical challenges and the travelling. However, those challenges also apply at present to appointed members of any health boards that cover an area as large as the Highlands. We favour whole-board elections, but we have said that we are in favour of splitting up the elections in rural areas, of which the Highland NHS Board area is clearly one.

Mary Scanlon: Do you mean splitting the area up into the three community health partnerships—or four, as it is now with Argyll and Bute CHP?

Dave Watson: That is best decided in the Highlands, not imposed from Edinburgh, but what you suggest would certainly be a possible way of doing it.

Mary Scanlon: I have a question for the BMA. I asked the bill team about the BMA's evidence on the New Zealand elections—the BMA's approach is perhaps not quite as sceptical as mine, but it is on similar lines. The bill team said that

"the fears of existing executive directors about directly elected members … had not been realised"

and that

"on the whole people are happy with what is now in place in New Zealand."—[*Official Report*, *Health and Sport Committee*, 5 November 2008; c 1255.]

However, I note from our briefings that the number of candidates fell drastically from seven per seat in 2001 to four per seat in 2004, so the candidates for health board elections are not fired with enthusiasm. Voter turnout also fell from 50 per cent to 43 per cent over the three elections that New Zealand has had. The BMA says that people are not happy or that the system is not working well, but the Government officials seem to think that that is wrong.

Dr Dean Marshall (British Medical Association Scotland): From the evidence that we have, the people who have been elected seem to be quite happy but, as you say, the population seems turned off by the whole thing, given that the number of candidates has fallen significantly. Also, asking people whether they are happy with how things have gone is not really a great way of assessing impact.

Mary Scanlon: I am simply using the words that the officials used.

Dr Marshall: So am I. People seem to be happy with the process but, as far as we can see, the outcome has not been measured properly. That is what we are concerned about.

The Convener: Those questions were directed specifically to Unison and the BMA, but do any of the other witnesses want to come in on that point?

Rachel Cackett (Royal College of Nursing Scotland): The numbers that are given in the briefings for voter turnout in New Zealand—which started fairly close to the election turnouts that we would expect here—are set in the context of a general election turnout that often tops 80 per cent. Therefore, we are talking about only half the number of people who would vote in a general election turning out to vote in a health board election. If that was transposed to Scotland, we would be looking at a very low turnout for health board elections. I am wary of simply transposing the results from another culture, but it is worth making clear that that is the context for voter turnout in the New Zealand health board elections.

Mary Scanlon: The concern is not just voter turnout but the fact that half as many candidates put themselves forward for election in 2004 as in 2001. I understand that figures are not yet available—at least, we do not have them—on the numbers of candidates in 2007. That perhaps supports Unison's point about the spread of candidates that might come forward.

Dave Watson: It is difficult to draw comparisons between different electoral cultures, but I suggest that we should also consider the interest in health board issues in Scotland and the campaigns that

have taken place. I think that the broader interest in debates about the health service in Scotland might be reflected in people's interest in extending democracy to the health service.

Helen Eadie (Dunfermline East) (Lab): My question draws on the submissions from the Royal College of Nursing and from Unison, but I have other questions for the BMA later, so Dr Marshall need not feel left out.

The Royal College of Nursing and Unison clearly share the view that electoral accountability is an important element of democracy, but the Royal College of Nursing submission states:

"we would ask the committee to clearly note that this legislation is designed specifically to improve engagement and participation and *not* accountability."

I want to pick up on that important point. If the aim is to achieve much wider involvement from the community so that people are engaged in and can influence the decision-making process, is that addressed by the key element, or general principles, of the bill? I do not think that that is addressed by the bill.

Rachel Cackett: I welcome that question as, for us, that issue is key to the discussion of the principles of the bill at stage 1. The bill and the consultation paper state clearly that the proposals are designed to improve engagement. Although the principles of the evaluation that is mentioned in the bill are vague, it is clear that the evaluation will be about participation of the public and patients in decision making within the NHS. I know from hearing previous evidence to the committee that accountability is a key issue for committee members, but that is not how the bill is drafted and it is not the basic principle of the bill. The bill states clearly that accountability will remain with Scottish ministers.

The point that we are trying to make is that we support increased public engagement in health boards' decision making. However, if health board elections are the only way that is being piloted to achieve that outcome, we feel that that is not broad enough. If the committee, the Parliament and the Government want to ensure that best value is achieved from what will be a substantial amount of money, consideration should be given to piloting more than one approach to achieving that outcome of improving patient and public engagement.

The Government has proposed a number of other ways of improving public engagement, including through the participation standard that will be expected of the CHPs and the public partnerships forums, which are currently in varying stages of evolution. Our concern is that, if we plough forward with health board elections without testing other pilots at the same time, the pilot will simply test whether elections work. We believe that we should test how we ensure that the Scottish public are best engaged—and feel that they are being best engaged—within the decision making of their local NHS board. We are not convinced that, on its own, piloting health board elections will do that.

Dave Watson: Our position is that we do not believe that direct elections are a panacea for public engagement in the NHS. We have argued strongly that other initiatives—some are in the pipeline and others are proposed—would improve participative engagement. By engagement, I do not mean the exercises that some health boards have held in recent years, which were not participative at all. We would like those other initiatives to go ahead as well.

We should bear it in mind that MSPs are elected, but that does not mean that they do not consult. Governments are elected, but they engage in extensive consultations, as does this committee. No one suggests that electing people means that they can just go away into a darkened room to govern the country for four years. They engage in a variety of participative processes—

Ross Finnie (West of Scotland) (LD): Oh, I do not know.

The Convener: That point is being disputed sotto voce.

Dave Watson: Others might argue with that point, but I am more tactful—

Ross Finnie: I was referring to other countries.

The Convener: The reference was to other countries, I am being told in a postscript, rather than to democratic Scotland.

10:15

Dave Watson: Even councillors have been known to engage in citizens juries and other such arrangements. They get elected and participate and engage, so it not an either/or question. We can have direct elections and be accountable to an electorate as well as engaging and participating between elections in a variety of ways.

The key point is that, since it was created in 1948, the NHS has not been directly accountable to and engaged with the public. It has been a top-down organisation—a we-know-best organisation that thinks that all the issues are far too complicated for mere mortals to understand and that democracy is therefore not appropriate. We have to change that culture, and that is why direct elections have come in.

Rachel Cackett flagged up the subject of pilots. We would not want to stop all the other things. We supported the National Health Service Reform

(Scotland) Bill and are keen on trying all the various participatory arrangements that already exist or are in the pipeline. This bill deals with piloting direct elections, so the pilots should be about the different types of direct election that will complement the other participative engagement processes.

Dr Marshall: We certainly share the concerns that Rachel Cackett has expressed on behalf of the RCN. We also support public engagement and more transparent decision making, but we do not think that this is the way to do it.

On the back of Dave Watson's comments, we have already had experience in Glasgow with the health visitors issue and the petition on that, which shows how the public can get involved and make a difference. We are concerned that there is no evidence that elections to health boards will improve engagement. I know that we did not want to look at other countries, but elections to foundation trusts in England have a very poor turnout; people have to opt in to vote and the figures are dreadful. We can see no evidence that elections to health boards will make a difference.

We should be improving and beefing up the CHPs and their public participation forums because they can result in the public getting involved.

The Convener: To turn your statement round, perhaps there had to be a petition and demonstrations because there was no public engagement.

Dr Marshall: Absolutely, but do we believe that having elected people on a board would have made a difference? There is no evidence that such elections solve the problem.

The Convener: I thought that you were saying that the public already have a route to change things through petitions and so on, so why do this.

Dr Marshall: No. We fully accept that there is a problem, but we do not think that the bill is the answer to that problem, nor is spending close to £20 million the way to solve it.

We are not denying that there is a problem but, as the RCN says, there are other ways of solving it, such as independent scrutiny panels, the CHP public participation forums, and the Scottish health council.

Rachel Cackett: Alongside the other measures that the Government wants to put in place and those that the previous Government brought in, there is one other difficulty with the bill. If the evaluation is focused entirely on the pilots—and I hope that there will be more discussion about the evaluation if that is what the decision whether to proceed with elections is to be based on—how will it decide whether it is the elections or all the other measures that have been taken that have improved participation? The evaluation needs to set its nets wide at the beginning and understand the relationship between the increased power of the CHPs, the work of the public partnership forums and the participation standard alongside the proposed elections.

Our position differs from that of the BMA in that we understand that increasing public participation in the NHS will involve spending more money. However, if the Parliament and Government want to spend more money, we have to be sure that we get the very best value for that money and that it gets the desired outcome. To me, that is about public engagement.

Helen Eadie: I am quite taken by the idea of looking at outcomes and not processes, and the RCN's evidence says that that should be placed at the heart of the evaluation. I am also quite taken by the fact that you gave specific proposals for conducting the pilots in three different health boards, which would give a true comparison and allow better analysis and evaluation to be done. In light of that, I was also taken by a point in your evidence that was also made by other organisations, particularly those concerned with disability and equalities issues. How can we ensure that, in practice, it is not only those who, as you state in your submission, are

"wealthy enough, eloquent enough and/or 'acceptable' enough to be voted in"

who actually get elected to the boards? That is a critical point.

I wonder whether you can expand on your proposal to run three different pilots, which is worth considering. Further, I am concerned that the bill seems to point only to the end of the process. As the bill is framed, the Government could let the whole thing lie for seven years, which would bring the legislation to a halt without any recourse to Parliament. There seems to be no scrutiny role for the Parliament to evaluate what happens; it is simply down to ministers to do that. The Parliament must consider that issue. Can you pick up on those points?

Rachel Cackett: Certainly. We are keen to see more detail on the proposed evaluation before the bill process moves on. The bill is about piloting elections before the roll-out order is made. We are clear that the proposals in our written evidence for a tripartite approach are just our ideas. We feel strongly that having alternative pilots would allow a much bigger discussion.

Our proposal is that a pilot for direct elections should run in one board area and that only half the anticipated pilot money should be spent on that. In a second board area, we would like all the other processes that this and the previous Government

have put in place to be allowed to flourish for the same time as the direct elections pilot, using whatever new money is given to all boards but no additional funding above that. In a third board area, we suggest that the money that would have been spent on piloting a direct election should be invested in the other ways of increasing public participation that have been put in place. We would like an evaluation of those three different pilots that clearly focuses on outcomes, which would prevent the evaluation being about the numbers of people who vote. That criterion of itself would not allow public participation to continue through a four-year cycle.

Those are the proposals in our written evidence. We are happy to have further discussion on what they might look like.

Helen Eadie: I wonder whether I might ask a question of Unison as well, convener.

The Convener: Certainly. Is it on a different subject?

Helen Eadie: No. It is connected to this subject. I note that Unison said in its written evidence that it was not in favour of having any pilots. I wonder whether the Unison witness can comment on that. In doing so, he might give regard to the situation in Sweden and Denmark because I understand that health is a local authority function in those countries. That is another interesting example that the Parliament should perhaps consider. Perhaps there could be a visit to Denmark for the convener.

The Convener: I would love to go, but I will not get it. Every week a member suggests a trip, but we are just not getting anywhere with that. I do not know why. However, keep trying for us.

Dave Watson: I would go for New Zealand if I were you.

Unison is not in favour of the pilots per se, but we are happy to support them because we recognise their merit in building support in Parliament for direct elections and addressing concerns that colleagues here and elsewhere have raised about the measure. We say that because we come at the issue from a different perspective. That is why I am frankly not impressed by the argument that we should compare engagement models. For us, it is not an either/or issue. We believe that a principle is at stake. The difference between public and market-provided services is democracy—that is the key principle in this matter. Either we believe in democratic support for public services or we do not. Our strong view is that there should be wider democracy in public services because £8 billion of taxpayers' money is spent in health boards. At best, the democracy in health boards is indirect in the extreme, which we believe is simply not acceptable. There are many quangos in Scotland—140-odd at the last count—which spend an awful lot of taxpayers' money. Health boards are the biggest quangos in Scotland and they should be democratised. That is a matter of principle.

It is a dangerous argument, which we have heard before, to say that all sorts of people might get elected, such as the wealthy and strange, unacceptable people.

The Convener: Careful.

Dave Watson: Well, frankly, democracy is a strange beast. If we open up a Sunday newspaper, we might find a few views about people around this table.

The Convener: Some of us are feeling vulnerable, so do not go any further.

Dave Watson: I am doing my best to be tactful, but I am obviously not being successful.

In a democracy, unusual folk sometimes get elected, but that is the will of the electorate. I do not see how health boards will be any different in that respect. In fact, after my experience of serving on quangos, I am not satisfied that relying on the infallible ability of ministers to appoint wonderful people to such organisations is necessarily better than relying on the public's ability to elect sensible people to represent them in public services.

Helen Eadie: I do not think that you picked up on my point about the system in Denmark and Sweden.

Dave Watson: Sorry.

The Convener: I, too, must have missed that in Mr Watson's vigorous response.

Dave Watson: We are not in favour of that kind of solution; indeed, in 1948, Aneurin Bevan fought hard against it. We feel that the NHS is big enough in itself. Indeed, that is another reason why we are not much impressed by the argument advanced by the Convention of Scottish Local Authorities and local authorities that they should have the monopoly on local democracy. Health boards are large beasts, and the health service deserves to have its own democracy. It has never been our position that it should simply become a sub-committee of local government, and that view holds for the proposed structure.

The Convener: On the proposal to have councillors on boards, COSLA says that councillors represent the people in their area—and I might well raise that point with its representatives—whereas you argue that they are seen as representing their council.

Dave Watson: That is a very important point. I can think of many issues on which I have personally engaged with council representatives

on health boards. It should be pointed out that councillors were brought on to the boards not in an effort to promote local democracy but because local authorities have important health functions that, quite rightly, have to be joined up with the NHS's work. The best example of that work is probably joint future, but there are many others.

Councillors see their involvement in health boards as a means of ensuring that that work is joined up; they do not see themselves as acting as a kind of grand representative for a huge area. We believe that they should remain on health boards, but there is a distinction to be made. We disagree, for example, with the proposal in the bill that councillors should count towards the majority of directly elected members. They should be additional to that number.

The Convener: Thank you for putting that on the record.

Ross Finnie: I have two broad questions, the first of which directly follows on from Mr Watson's comments. The issue of governance is pretty fundamental to the bill and, although your views on the matter are clear, I think that we should test them a little. For a start, Government officials made it clear to the committee that all this is not about accountability. Secondly, although there are proposals to change the composition of health boards, there is no proposal to change the corporate governance arrangements.

I will have to resort to phraseology that is not used, but I believe that a health board is distinct from, say, a local authority in that those on the board with experience in health might be described as the executives and those holding the executive to account the non-executives. The argument is about the composition of the non-executives. In your interesting and challenging evidence, your fundamental view is that, in this case, health boards should be likened to local authorities because the issue is accountability. With all due respect, democracy is not simply a matter of elections. Elections take place in all sorts of places; they happen even in states where there is no rule of law and where, as a result, very undesirable Governments get into power.

I do not want to seem disrespectful, because I think that that this is a very important avenue of exploration. However, you are fundamentally challenging not only what is believed to be the status of health boards but their relationship to the people who are appointed to them and their relationship to the Parliament and the Cabinet Secretary for Health and Wellbeing. I would like you to tease that out a bit, because, with all due respect, some of the statements that you made do not quite fit—unless other changes are to be made to the corporate governance of health boards.

10:30

Dave Watson: I could not agree more that democracy is not just about electing people. I know that you have been to events that we have run where we have explained our broader views about public services and what we mean by democracy. Democracy should be about direct elections where that is appropriate, but we are also talking about broader participative engagement—we prefer the term "deliberative engagement"—of communities in the decisions of all public bodies.

There are different types of accountability. We are not proposing any amendments to the bill to change the corporate governance arrangements that are in place. Those structures remain in place and the bill does not propose to change them. There is national accountability for national initiatives through the minister and a form of local accountability, which is where we think that direct elections have a role to play in starting to engage people in their communities.

There are interesting issues around that. We would argue that, although local authorities are directly elected, they are still subject to forms of corporate governance at national level. The previous Administration introduced a range of legislation that gave ministers the power to direct local authorities and others over a variety of issues, such as best value and education. A range of national standards is set out in that regard. That is national accountability.

There will be tensions around that on occasion, but I do not think that that is necessarily a bad thing. People say, "We couldn't have that, because there would be a postcode lottery". As I said in our evidence, one person's postcode lottery is another person's local initiative and priority. Priorities in the Highlands might be very different from priorities in Glasgow. It is right that people on local health boards decide their local priorities on that basis.

One area where we think that there is an accountability issue and a need to change the bill and the current structure of health boards is the role of executive members. I do not think that executive members can be held to account when they are voting members of the board. The process at the moment is fundamentally wrong. Local campaign groups and others who are concerned about local health issues say that they are completely nonplussed by the notion that executive directors of health boards can propose local initiatives and then vote on those proposals later in the process. That is wrong and we would like to see boards revert to a more local government-style model, whereby executive members would become advisers and officers to the health board.

Ross Finnie: That is a fundamental change.

Dave Watson: It is a significant change. It is an important change. If you want to call it "fundamental", I am comfortable with that.

Ross Finnie: Come, come. We are agreeing about lots of things; let us not fall out about that. If you change a health board to a model where the only voting members are persons who have been elected to it and have no connection with the experience and knowledge of the affair, it would no longer be a board. I think that you are right; I am not disagreeing with you. You are proposing changing the health board model fundamentally to a local government model. I am not saying that that is necessarily wrong, but we should not try to fudge that. At the moment, the structure of corporate governance is more akin to a company structure, whereby the executive directors are persons who are believed—I choose my words carefully—to have some expertise in and experience of the subject with which they are dealing, and the non-executive directors are there to hold the executive directors to account. I do not want to fall out with you, but I think that what you are proposing is a pretty fundamental change. I do not dismiss it.

Dave Watson: Sure. It is a significant change, particularly in that area, but we are not saying that the only people who should have a say are the directly elected members. We are suggesting a halfway house. There would be people appointed for their expertise; clinical and staff representatives; and directly elected people. The only people who we are saying should not be voting members are the paid officials of the health board.

Ross Finnie: Would you apply that to all walks of life?

Dave Watson: Not in all walks of life. As a general principle, the present structure was a wrong move for a public service. It was introduced a few years ago, well before the Scottish Parliament was put in place. It became a trendy thing to do, in an attempt to ape the private sector. However, public services are not the same as market services—the values, ethos and structures are different. We cannot copy the market-tied provisions of a company and put them into a public service. The two are different, which is why, frankly, that approach has had its day. Having said that, we do not suggest that there should be direct elections to every quango in Scotland. Elections have been introduced for the national park authorities, which control a good deal less public money than health boards but, for small national quangos, it might be difficult to have direct elections. We might have to consider other ways of instilling greater democracy and participation. We want to consider a variety of options but, at present, direct elections are probably the best option for health boards.

Ross Finnie: My next question is for the British Medical Association and Royal College of Nursing witnesses, although Mr Watson may also want to respond. I have sympathy with the view that a raft of measures are already in play to improve public engagement in delivery of the health service—the composition of CHPs and community health and care partnerships points in that direction. However, I am not sure that such measures deal with concerns about the composition of health boards. We are back to the fundamental issue of the corporate governance of health boards. Regrettably, although all the measures to which the BMA and the RCN have referred will make fundamental differences to public engagement, they do not in any way touch on the public's perception of the legitimacy of certain non-executive members of health boards. There is a feeling that the composition and corporate governance of health boards might be improved if the qualifications of more board members derived from their legitimacy in having been directly elected by local people. There are some suggestions, not just from local authorities, that the number of councillors on health boards should be increased.

I disagree that local authorities just want to preserve their interests. To give a bit of history, in my 22 years as a councillor, I knew all sorts of councillors who did not think of their role on the health board as being simply to ape the local authority's view. They were independent people who represented the folk in their wards, and that was the only argument that they would ever hear.

Do you accept that the issue is not just about engagement—although that is crucial—but is also about the composition of boards? Although the suggestions from the RCN and the BMA are extraordinarily constructive, they do not address the heart of the issue, which is about the corporate governance of boards.

Rachel Cackett: In a way, I disagree with Mr Finnie about our proposal, as we say clearly that we are in no way against considering how members of the public are represented on health boards through non-executive directors. It will be no surprise to members to hear that the Royal College of Nursing also disagrees with some of Mr Watson's points about the future governance of health boards. We have made it clear that we are willing to see members of the public on health boards; indeed, they already are.

I have a question to ask to Mr Finnie. If the present appointments are not representative of local people and people do not feel that they have access to the nominated non-executive members of health boards, why not, and are direct elections

the answer? I am not sure that we have sufficient understanding of why people feel that way to allow us to decide that the answer is direct elections to health boards.

There is a role for consideration of the governance arrangements and for members of the public to have much greater involvement in health boards. I hope that the pilot will show whether the electoral mandate of members of the health board—however big it ends up being—gives members what I think they are looking for. I am not, however, convinced that it will, hence our evidence. However, if the will of the committee and Parliament is to test that issue, it should be tested, but that should be done alongside other measures. I return to the point that the principle of the bill is engagement.

Ross Finnie: Before Dean Marshall answers, I want to press Rachel Cackett a little further. Do you disagree with those who say that there might be merit in increasing the number of local councillors on boards, rather than engagement being achieved in some other way?

Rachel Cackett: Through the concordat, local councils are now responsible for delivering a number of outcomes that might once have been regarded as being within the remit of public health agencies—the concordat contains a lot of health outcomes. It is therefore clear that councillors have an important role in delivery—that role might even border on the executive functions of health board members such as the nurse director. There has been movement towards joint delivery.

I am not sure that increasing the number of councillors would give you what I think you are looking for. However, there is currently councillor representation from every council and we welcomed that extension. It is important that every council within a health board boundary be represented, although I accept that council and health board boundaries are not coterminous.

Before I could answer Mr Finnie's question, I would need to understand more about the expectations behind the wish to increase the number of councillors instead of having elections. Would having more councillors on the board increase the level of public engagement?

Dr Marshall: I share Mr Finnie's concerns about the corporate responsibility of boards. BMA Scotland does not deny that a problem exists, but we say that the bill is not the answer to the problem. We do not think that it will improve public engagement or make decision making more transparent. There is no evidence that it will do so. We are not saying that no changes are required to the way in which health boards are structured, but the bill—or the significant amount of money that might be spent on it—is not the answer.

Members have commented on the current structures within CHPs. Another concern is that something that has happened commonly will just happen again: we introduce a new structure, but we do not fund it properly and we do not develop it, but we then say, "Oh—that's not working. Let's do something else." Money is not the only answer. There are in place structures that could, if they were funded and developed properly, and if they were given powers, achieve some of what we want. They could get the public to engage more at local—CHP—level. Such structures exist but have never been properly developed. Our concern is that they will simply be forgotten and that we will have to move on to the next thing. That will not solve the problem.

Jackie Baillie (Dumbarton) (Lab): The trouble with being one of the last members to ask a question is that Ross Finnie has already asked it.

The Convener: Bid early for the next panel, Jackie.

Jackie Baillie: I will.

The witnesses have been shaped by their experiences. I, too, have been shaped by my experience—first with Argyll and Clyde Health Board and then with Greater Glasgow and Clyde Health Board. I want to push the witnesses on the composition of boards. We might not improve accountability, because the existing arrangements will still stand, but I feel that we have a clear opportunity to improve engagement, participation and ownership.

I have witnessed payroll votes, I have witnessed a chief executive putting his hand up to vote, and I have witnessed the people responsible for drafting proposals voting for those same proposals. Should executive directors continue to have a vote? I know Unison's position, but I am interested in the BMA's position and the RCN's position.

Dr Marshall: We are getting a little away from what I had thought this discussion was to be about. I do not think the bill proposes a change to the voting arrangements.

Jackie Baillie: No—but if we are discussing improving participation, engagement and accountability, the question is legitimate. The bill will affect the composition of boards.

Dr Marshall: As I have said, the BMA has issues with what happens in health boards.

The Convener: Is the issue that Jackie Baillie has raised among them?

Dr Marshall: Absolutely. However, I still cannot see how the proposals in the bill will change such arrangements. From examples in other countries, we can see that the people who would get positions on boards would not be the people we

really want to engage. The people we would get would be the people with time on their hands and the financial means to do it.

10:45

Jackie Baillie asked about the outcome; we are talking about the process. Our view is that the process will not get the people who can challenge the kind of thing to which you referred. A small sector of the population will stand for election and will be elected. That will not improve public engagement.

Many doctors do not get involved at health board level because of concerns about being bound by corporate responsibility. Doctors are employed by the board and issues arise in that regard, about which I also have concerns. The bill will not solve the problem. I thought that the bill was about improving public engagement. Our view is that it will not do that.

Rachel Cackett: I agree with much of what Dr Marshall said. It took a long time for nurse directors to become executive directors of health boards. They bring to boards their great expertise and promote the views of the staff with whom they work. The policy memorandum makes it clear that directors of nursing will continue to play their role: nowhere in the bill have I seen anything to suggest a change to their current role, except in respect of their part in the composition of a slightly changed board.

At this stage I am reluctant to go any further than what is set out in the bill. As Dr Marshall said, the bill is specifically about public engagement. I cannot see how taking a vote away from one or other clinical lead on a board—someone who comes to the board with specific expertise—would necessarily lead to increased public engagement.

Jackie Baillie: It might make it more transparent.

Rachel Cackett: If the process is transparent, how would taking the vote away from one or another member improve transparency? Boards simply need to make it clear how votes are cast.

Jackie Baillie: In some cases, the electoral ward area could be quite large. I am concerned about that. One need only consider the size of Highland NHS Board's and Greater Glasgow and Clyde NHS Board's areas. Many people in those areas do not fit the stereotype that you perhaps have in mind. In my area, 20,000 people take a very active interest in what goes on in their local health service—they come from all walks of life. You have to believe me on that.

Can the argument be made in favour of more localised elections, as with elections at local authority level? Are there inherent dangers in that approach? I am interested in the view of each panel member.

Dave Watson: If elections were broken down into groupings, a small pressure group could be elected and bat for one small area. The case for whole-board elections addresses that risk. We are talking about small numbers of directly elected members whose role will be slightly more strategic than that which local authority members have traditionally played.

As we said in our submission, since we first gave thought to the idea of directly elected members improving democracy in the NHS, changes have been made to health boards, including to their size. We have always said that a case can be made for rural health boards. We also see that a case can be made for boards in places such as Jackie Baillie's area. NHS Greater Glasgow and Clyde covers a large area and serves very different communities. There is a case for splitting up health boards in such areas, and the resulting boards would still serve quite large areas. We would not want to be overly prescriptive on that, however.

As we said in our submission, we favour three pilots involving a rural health board, an urban health board and one that is a bit of both. I am happy for the pilots to test different ways of organising elections and to consider the size of electoral wards. Whatever we do, the areas will still be quite large; boards will not be parochial. There is not too much risk of losing the strategic role of health board members.

Rachel Cackett: There are risks either way. I return to the equality issues that we raised in our submission. If an electoral ward is too large, how will people know who they are voting for? How will people living in Lochgilphead feel engaged if they are represented by someone who lives in Wick? If the point is engagement, the proposal comes with its own problems.

I agree with Dave Watson: if electoral wards are too small, there is a risk that people will stand for election on a single issue. The problem was raised in the debate on Bill Butler's Health Board Elections (Scotland) Bill. Both approaches raise issues of representation—that is why it is a good idea to have pilots. Only by testing the system will we be able to assess its impact.

Dr Marshall: The size of wards is important, but even small wards would not make a great deal of difference. If we have small wards in the Borders, people from the bigger towns of Galashiels and Peebles may still end up making decisions about a community hospital in Jedburgh.

The Convener: There is no longer a community hospital in Jedburgh.

Dr Marshall: I was giving an example. When I mentioned the Borders, I was aware that you represent the area, convener.

The issue of whether elections mean democracy has been raised. Do we really believe that elections to health boards will improve public engagement? I do not. As a general practitioner, I think that involving people at CHP level is a much more effective approach. It has been pointed out that there are concerns about single issues. Sometimes that is good, because people will engage on issues in which they are particularly interested. However, they may not want to stand for election in order to express a view on every part of the health service. Improvement of public engagement at local level would be a more effective approach. People find standing for elections quite daunting. They may want to engage on one issue and to disengage until another issue comes up. That is why we think the proposed electoral process will not improve public engagement or enable the people from whom we want to hear—because their voice is not heard anywhere else—to have their say.

Ian McKee (Lothians) (SNP): I return to an issue that Ross Finnie raised. The underlying reason for the introduction of the bill is that the public are not only users and potential users, but owners of the health service. For that reason, they should be represented on health boards not just as users, but as proprietors.

We have been told in evidence that elections to health boards could result in unbalanced representation of the public—the election of people who are wealthy and so on. This morning I looked at the website of Lothian NHS Board to see who is on the board at the moment. I found that members include an accountant, an ex-NHS civil servant, an ex-NHS nursing academic, an ex-NHS councillor, an investor from a large financial company and a housing association executive. At least one member has a close relative who is involved in NHS management, and the majority of members have close links with NHS management. It struck me that the current situation is a bit unbalanced. If we do not have direct elections to boards, how can we ensure that the public are represented on boards, as opposed to community health partnerships, where they give advice as users? How can the public's ownership of the health service be reflected?

Rachel Cackett: It is possible at the moment for any member of the public to put themselves forward for membership of a board. As you said, at the moment only a certain group of people seem to do so. Health boards are multimillion-pound organisations, so we must ensure that board members have the skills to work with a multimillion-pound budget and to make the necessary decisions. There are more people in our communities who could take on that role than do so at the moment. What has happened to the current process to cause only the people such as those whom Ian McKee described, who are already part of the NHS, to apply for board posts? It would be interesting to find out how many members of the general public know that they currently have that option. I suspect that not many do, as it is not well publicised or advertised.

In our written evidence, we suggest that members of the public should play a different role on health boards. We would like more investment in that local approach, through things such as public partnership forums. That would mean that, rather than have a plethora of new initiatives to deal with a problem that we can all see, we would build up public partnership forums and acute-care based patient forums so that people who are engaged at local level can be upskilled and voted on to the board by their peers or local communities.

To pick up on what Dr Marshall was saying, it is fairly daunting to find oneself on the board of an organisation the size of those about which we are talking. If we want members of the public to have a fair say, to make a real difference and to hold those boards to account, we must ensure that they are upskilled to enable them to do that effectively, which is why the approach needs to start at the grass roots.

Dr Marshall: I would echo Rachel Cackett's comments; the issue that she identifies is important. Being involved in a democratic organisation, I know that as soon as one is elected, one is seen to have lost touch with the real world and the grass roots.

I direct members' attention to the composition of the elected boards in New Zealand. Some 37.4 per cent of the people who were elected to the boards had experience in the health professions, 30 per cent worked in things such as business or law or were company directors, 10 per cent had backgrounds in community work and 11.6 per cent were directly employed by the health boards. That shows that, even once they had direct elections to the health boards, they were still getting the same type of people—35 per cent of them had experience in local government. As Rachel Cackett said, we need to train people and give them the skills that they need to enable them to engage properly. The New Zealand experience does not support the view that the proposal would improve engagement among the people who do not currently engage with the health service.

Ian McKee: The training needs of people who are appointed must, however, be the same as those of people who are elected. Do the people

who are appointed magically come into possession of those skills?

Rachel Cackett: That is not really the point that I was trying to make. The New Zealand experience suggests that the people who currently put themselves forward for appointment are the same people who will put themselves forward for election, which means that the boards would continue to come from a fairly small pool of people who already possess a certain level of skill that can be built on through board training.

We all want boards that represent the length and breadth of each health board area and we all believe that the board should include people who have valuable skills and knowledge. However, it is unfair to expect people who have not had a senior management position and are not used to working at that level to immediately step up to that level if they have not been upskilled in a way that means that they want to put themselves forward for appointment or election. Every community organiser knows that you start at the base that you have and you build up from it. That is a key point.

Ian McKee: Some people who are elected to Parliament and to councils need to be upskilled. Would you suggest that people should be appointed to Parliament or councils rather than elected?

Rachel Cackett: It is always difficult to talk about elections to a bunch of elected members.

The Convener: I should point out that we come from pretty much the category that you have described—we have lawyers, accountants, economists and so on sitting around this table.

Helen Eadie: Not me.

The Convener: Helen excepted.

Rachel Cackett: One of the points that I wanted to make earlier about equality was that, unless you can meet people in their own environments and bring them up to a point at which they are able to stand for election to Parliament or to a health board, there is an unfair playing field. No one feels that any electoral system in the world has yet dealt with the issues of gender equality, race equality, lesbian, gay, bisexual and transgender equality and so on, because it can be hard for people who are affected by those equality issues to stand.

Dave Watson: One of the central issues is people's view of public services and the role of the public in the democratic running of those services.

Sure—democracy is not perfect: we have all seen studies about the age of councillors, the gender mix on councils and so on. However, dressing up resistance to the proposals by saying that members of health boards should have appropriate skills is symptomatic of the health service's paternalistic approach—I am sure that that is not the intention of those who have just spoken, of course. The health establishment has always had a top-down view of how the service should be run. The risk of following the suggestions that we have just heard is that not only would the "Joe Public" members have a different role on the board, but they would be second-class members, coming after the appointed experts on boards.

That would be a dangerous road to go down. To be frank, the health service is no bigger or more complex than local government, and if we went down that road, we would turn to local administration, with governors being appointed for areas. That happens in some parts of the world, but we do not have that culture in Scotland. I am pleased that we have a democratic culture instead, which we should be extending to the quango state.

11:00

The Convener: We are not going to get agreement on that, so let us move on.

Ian McKee: I have another couple of questions, convener. First, how are people chosen for public partnership forums? Is the choice democratic, and how representative are they? They will have a big influence on health care. Secondly, what influence do they have on overall health board policy and secondary care policy?

Dr Marshall: I will take the second question first. At the moment, the answer is that they have zero influence because of how the structures work. CHPs were introduced to create a more bottom-up approach, to engage the public and to allow them to influence how health boards make decisions. The structure exists, but it has never been properly implemented. We have conducted surveys of doctors who are involved in CHPs, and they have provided no evidence that partnerships influence matters at board level, because the system works from the top down. Basically, the boards tell them what to do and give them all the difficult jobs that they cannot resolve themselves. However, that is not a reason for saying that we should just get rid of them. We should be making the CHPs work—

Ian McKee: I have not suggested that we should get rid of them.

Dr Marshall: I am sorry. I did not mean that you had—I am saying that the structure exists but that we need to work with it. Patient participation workers try to engage members of the public by going to local meetings and trying to get people involved. When they work well, they succeed in engaging a variety of different people. In my area, that includes people who are not the usual

suspects, which is interesting. That level can work, but the problem is at the next step up, as CHPs do not have any chance of altering health board policy. We should do something about that, rather than work the other way round.

Rachel Cackett: At the risk of sounding like a woman who is being paternalistic, I agree with what Dean Marshall has just said in that the structures are not right in all PPFs. Unless those structures, which this and the previous Government have been committed to, are given the teeth that they need to make a difference and be influential, they will never succeed. They will not be developed—as we have suggested would be a good way forward—to ensure that the people at the grass roots who have real commitment to, and interest in, what happens to local services can make their voices heard at board level. We are keen that some of the work during the pilot period should examine the structure of a PPF and its relationship with both its CHP or CHCP and the board. At the moment, voices do not pass in the way that they should in many PPFs.

Dave Watson: We strongly support PPFs. They currently make a limited contribution, but they provide an opportunity. As we have said, democracy is about the opportunity to engage at different levels, and it is right to engage people in the limited way that, as Dean Marshall indicated, some people want to participate. Others may be prepared to participate in the wider sense, which is true for all our democratic institutions. However, that is not a substitute for having a say at the top level in the organisation, which is the whole point of having democratic levels at each stage.

The Convener: Nobody has raised this issue, so I want to challenge the panel on the role of the Scottish health council. The BMA says that the council's role is

"to improve the way in which the public, patients and other stakeholders are involved in service design".

Let me use a slightly parochial example. When the closure of hospitals in Coldstream and Jedburgh was taking place and the health boards sat in front of the public, the public had no idea who the board members were. They perhaps knew the chair of the health board, but it was the first time many of them had seen other board members—people who were taking important decisions. The Scottish health council was required to determine how the process had taken place. The process was as clean as a whistle. All the proper procedures in the consultation had been gone through, but members of the public were not there to hear about that—they were there for the substance of the decision being dealt with.

We have heard about existing organisations that are not functioning. I am interested in the Scottish health council. You have said that its role is not clearly defined. I think people expected it to be almost appellate and to defend their interests with respect to the substance of decisions; they did not expect it simply to tell them that all the boxes had been ticked and that a decision had been made. Will you say something about that, as that is what you said in your submission?

Dr Marshall: We had the same view. Local health councils were disbanded and a new body was developed that was going to do all such things. However, as the convener said, it seems that a box is simply ticked to say that consultation has happened. There are no challenges on whether the consultation was appropriate or whether people were informed about what was going on.

The Scottish health council's role must be clearly defined and it must be given a much stronger role in calling boards to account, because things are not working—I agree that it did not seem to develop as we expected it to. I am not clear about why we got rid of the local health councils, which were quite effective in raising issues in some areas.

The Convener: You are saying that there could be reforming and strengthening of the various branches that are supposed to increase public participation and make the public feel that they are being listened to. Strangely enough, all the decisions in the example that I used were taken as if there had been no consultation; in other words, it looked like a fix.

Dr Marshall: Absolutely. I return to the comment about being paternalistic. The medical profession feels just as disengaged from the consultation process. It would be a fine thing to have the chance to decide what we want to do, but everyone whom the consultation is meant to cover needs to get involved and to give their opinions. That said, because of the way in which health boards run consultations, they are paying lip service to those opinions. What has happened in Glasgow is the prime example of that.

The Convener: Mary Scanlon may ask a short supplementary question. There will be a short break after it is answered, as we have had quite a long session. I want everyone to know that, in case you are getting a little weary.

Mary Scanlon: Given all the points that have been made about potential candidates, what do you think about 16-year-olds standing for election to health boards?

Dave Watson: We are in favour of extending the franchise; in fact, we are in favour of extending the franchise in parliamentary and local government elections. At 16, people pay taxes, they can fight in the Army and so on, so why

should they not vote? Engaging people would provide an opportunity to build greater understanding of democratic institutions, particularly at the level in question. We are in favour of extending the franchise more broadly, and we think that the bill presents a good opportunity to get younger people more involved in the political process.

The Convener: Do the BMA or the RCN have any views on that?

Rachel Cackett: No.

Dr Marshall: No.

The Convener: Thank you very much for that extensive session. I suspend the meeting for four minutes.

11:09

Meeting suspended.

11:13

On resuming—

The Convener: I said that there would be a four-minute suspension, and I meant four minutes.

I welcome our second panel of witnesses and remind members that there will also be a third panel. The second panel sat through the previous evidence-taking session, so it knows where we are starting from.

Councillor Ronnie McColl is a spokesman on health and wellbeing for the Convention of Scottish Local Authorities; Ron Culley is a policy manager for that organisation; Harry Stevenson is executive director of social work resources for South Lanarkshire Council; and Graeme Struthers is head of support services for West Lothian Council. I thank all of you for providing written evidence, as the previous witnesses did. That evidence is before us.

We move straight to members' questions. Does Jackie Baillie want to ensure that she is in early this time?

Jackie Baillie: Absolutely.

The Convener: You may ask a question after Ross Finnie. Ian McKee is not here yet, so he will ask questions at the end.

Ross Finnie: As I listened to the previous panel, I was concerned that, although much is being done to improve engagement, there is still a perception that an insufficient number of non-executive members of health boards—as opposed to bodies that filter into those boards—are able to understand or properly represent the public at large. In its evidence, COSLA clearly states that there is an argument for increasing the number of democratically elected local authority members of health boards. That is also South Lanarkshire Council's position, although it is not West Lothian Council's position, so we can have a healthy debate on the matter.

I would like COSLA and South Lanarkshire Council to expand on how that increase might be achieved and what a board's structure should be. After that, I—or rather, the convener—will allow West Lothian Council to tell us why it thinks that that would be the wrong direction to take. First, though, I ask COSLA and South Lanarkshire Council to say why what they propose would be better.

Are you influenced by the fact that about 80 per cent of care in our communities, as further refined by the single outcome agreements, necessitates greater co-operation, collaboration and breaking down of barriers between health boards and local authorities? Alternatively, do you believe that having directly elected health boards as against local councils is more a recipe for tension than a way to ease the problem?

11:15

Councillor Ronnie McColl (Convention of Scottish Local Authorities): When COSLA's health and wellbeing executive group discussed the issue, many views were expressed on how we should achieve a more democratic and publicly accountable health board system. However, it was clear that the current system was acceptable to no member in the room. Some wanted directly elected boards and some wanted an increase in council representation, but everybody wanted more elected people at the table—no matter how—with voting rights, rather than unelected executive members with voting rights. Perhaps it is because we come from local government that we find it strange that an officer should be able to vote on a report that he or a member of his staff will have prepared, as a staff member will prepare a report for his director in the way that the director wants. That is a strange anomaly in the health board system.

The previous witnesses talked about whether local councillors see themselves as representing the council or the people. When I was a member of Argyll and Clyde Health Board, I saw myself as representing the public who had elected me, rather than the council. I have never seen an executive member hold a surgery on health board issues, but MSPs and councillors hold surgeries at which people come to them to discuss health board problems. We need that direct accountability, which is why we think that the number of elected members should be greater than the number of unelected executive members.

Ron Culley (Convention of Scottish Local Authorities): I will build on that and return to what a previous witness said. COSLA's view is certainly not that local authorities should have a monopoly on local democracy. If that were the case, we would have a resounding consensus on health board elections, but committee members will know that COSLA's member councils have reached different perspectives on health board elections. That must frame our response to the committee, because we must present a balanced view. COSLA has agreed a view on some issues, but not on others.

As for the precise question about local authority members on health boards, councillors have the dual function of representing the local electorate and representing the council. Both functions are important to address the obvious direct democratic issue and to apply the thinking behind the joint future agenda. Mr Finnie spoke about partnership, which is central to the aspiration for the relationship between the health service and local government.

We should not forget that mechanisms for that already exist in other areas. Community planning partnerships will be responsible for single outcome agreements. In the context of single outcome agreements, it is recognised that in a number of areas, particularly in relation to health, neither health nor local government alone will be able to advance the agenda. That is why, on balance, we have come to the view that stronger representation by elected members would be to the benefit of health boards and would allow for a process that ties all the elements together.

Harry Stevenson (South Lanarkshire Council): My comments are partly based on my experience over the past seven or eight years of briefing two senior elected members in South Lanarkshire to be members of health boards: Greater Glasgow and Clyde NHS Board and Lanarkshire NHS Board. They have taken their role as board members very seriously. At no time, particularly in the early years as they developed their knowledge and experience, have they taken the view that they are there to get the best for the council. They genuinely have taken the view that they are members of the board and, on sensitive issues, the maturity of their approach has been helpful to everyone who lives in the local communities. They have a local mandate, they live locally and they see people in surgeries. They see the wider role of local government in relation to health and wellbeing. The issue is not only the delivery of services; the joint future initiative is about how we deliver services well to the public, but local government has a much broader interest in health and wellbeing, which the councillors I have briefed take seriously.

Although our response to the proposal of having direct elections is focused primarily on the specific issue, another point is that I have seen the councillors' capacity and confidence build. If that continues with the addition of more representation and we get the balance right, it would not be unhelpful for boards.

Having spoken to senior colleagues in the health service over the years, I have no doubt that elected members have made a difference to how business is conducted at board meetings. I do not know whether the difference has been significant, but there is no doubt that a different form of questioning has taken place, in particular about the impact of decisions on the public and communities; so, to some extent, the presence of elected members has changed people's behaviour at health board meetings. The conclusion we came to, therefore, is that if we have in place a system and structure that the public understand, is it not best to build on that?

Graeme Struthers (West Lothian Council): I will give some background information on the situation in West Lothian. I do not know whether committee members are aware that West Lothian Council has a coalition administration that includes three members who were elected on the single mandate of saving St John's hospital. Therefore, we are perhaps unique among local authorities. That has helped to shape and mould our council's response to the committee.

We want to open up democracy and increase the active role of the elected membership of health boards. Equally, we are not of the strict view that such members must be from local authorities. We want to move down the road of increasing democracy and accountability in health boards and see clearly the benefits of such an approach. We also have a view on the voting rights of officers. Our view is that we want to move away from officers having voting rights towards democracy and elected health board membership.

Ross Finnie: I do not know how many of your other directly elected members were representatives of the 80 per cent of care that is delivered in the community. It is an interesting point, and might make the other, single-issue councillors equally representative.

I would like all three witnesses to take up Graeme Struthers's last point. Views are emerging about the fundamental structure of health boards. You come from local government backgrounds so, not surprisingly, you appear to be saying—West Lothian certainly is—that we should remove executive members' vote, which, given the corporate governance structure that is in place, is not surprising. I am bound to say, in parenthesis, that if people are exercised by the performance of executive members, they must, by logic, be

appalled by the performance of non-executive members, given that one is supposed to hold the other to account. West Lothian Council's suggestion is that we should remove executive members from the board, which would mean that we would have, as we do in local government, a completely different structure of elected persons. Graeme Struthers might wish to elaborate on that point, but I would be interested in the views of others on the issue.

Graeme Struthers: In West Lothian Council's view, a minimum of 51 per cent of board members should be elected members. The benefits and merits of having appointees to the board aside, our issue is with officers having voting rights. The council's view is that, on balance, it is better to have a majority on the board being elected members, although we accept that there may still be appointees among the board membership. We disagree with having officers with voting rights.

The Convener: Your written submission says:

"The preferred option of West Lothian Council would be that 100% of NHS Board members be directly elected".

Graeme Struthers: Sorry—

The Convener: Page 1 of the council's submission says "100%".

Graeme Struthers: I apologise. The response that I have before me says that we are keen to have a minimum of 50 per cent plus 1 board member being directly elected to the—

The Convener: I cannot hear you clearly. Could you move your microphone?

Graeme Struthers: My understanding of the council's response is that we seek a minimum of 50 per cent plus 1 being elected to the board.

Ross Finnie: That is not what it says in the paper that we have.

Graeme Struthers: My apologies. I have a different paper.

The Convener: So you seek a minimum of 51 per cent—

Graeme Struthers: Fifty. Yes.

The Convener: But you want it to be 100 per cent elected members. I am trying to follow this—I have jangling in my head, you see.

Graeme Struthers: Our starting point is a minimum of 51 per cent, acknowledging that an element of the board could be made up of unelected appointees. The 100 per cent figure takes it to one extreme.

The Convener: Are we clear?

Ross Finnie: Yes.

The Convener: If it is clear, that is fine. I will read the *Official Report* afterwards, because I got lost just now, although that is my fault.

Councillor McColl: Although we want a majority of elected members on boards, the executive members have an important role to play. The health board will sometimes deal with technical or clinical issues. It is appropriate to have the executive members' expertise at the table, and it is probably appropriate that they are allowed to vote. Local government and COSLA consider that the structure is far too top-heavy at the moment, with the non-elected element far outweighing the elected element at board meetings. The elected-member element, even if members were all to join together on a certain issue, would have no way of outvoting the non-elected element. I know that to my cost from my experience as a member of Argyll and Clyde NHS Board. About 70 to 75 per cent of members were executive members rather than local councillors.

Ross Finnie: So you are broadly in favour of those elements of the bill that require the majority of places to be held by non-executive members.

Councillor McColl: Yes.

Ron Culley: That is the view, but there is no consensus on a fundamental overhaul of the composition of health boards to make them entirely directly elected. We did not achieve consensus on that, so COSLA could not support it.

A number of arguments were presented. One of the issues was around accountability. If the purpose of a wholly democratic process was the creation of greater accountability, questions would remain around the role and accountability of health boards to ministers, particularly with regard to health improvement, efficiency, access and treatment—HEAT—targets. There were questions around how that relationship would work. Such views were expressed by those who did not agree with the idea that boards should be made up of 100 per cent directly elected representatives.

Jackie Baillie: I wish to pursue Ron Culley's last point with Graeme Struthers. According to West Lothian Council's paper, its optimal position is

"that 100% of NHS Board members be directly elected".

Let us stick with that optimal position, rather than with what you will settle for as a compromise. Do you have any concerns that such an approach signals a greater emphasis on local priorities than on national priorities? Do you think—as some people have suggested—that that could lead to the break-up of the national health service as we know it?

Graeme Struthers: As you point out, there could be issues with going to the extreme of

having 100 per cent elected members, for example about how that would be perceived and about the emphasis being placed on local issues, and we acknowledge those. However, a number of members on West Lothian Council were elected on a single issue, and our experience is that what you suggest has not transpired. It is a concern, but it has not been our experience. Therefore, I would not be concerned about the potential impact on the national health service.

11:30

Jackie Baillie: You say that three local candidates were elected as a consequence of the situation regarding St John's hospital.

Graeme Struthers: That is correct. Yes.

Jackie Baillie: However, the electoral ward for your area would be substantially larger than the area that the hospital covers.

Graeme Struthers: It would cover the Lothian area.

Jackie Baillie: Indeed, and the prospect of such people getting elected might diminish as a consequence.

Graeme Struthers: Yes.

Jackie Baillie: NHS Greater Glasgow and Clyde covers a huge area—Ronnie McColl and I have been through the wars there. Does the panel have concerns about the electoral ward area being the same size as the health board area?

Graeme Struthers: Our proposal was for the ward size to be the same size as the local authority area. We had concerns about reducing the size to the size of local wards. Of the local authorities in the NHS Lothian area, the City of Edinburgh Council is the largest, but East Lothian Council, West Lothian Council and Midlothian Council are also in the mix. We thought that that would be an appropriate geographical allocation.

The Convener: Thank you. That is helpful. It is in your written submission.

Councillor McColl: I share those concerns. My local health board is NHS Greater Glasgow and Clyde and if the electoral ward covered the whole health board area, there might be nobody elected from the Clyde area. Personally, I would like to follow the model of the national park authorities. For example, the Loch Lomond and the Trossachs national park is very large and was split into electoral wards. That is the only way in which to ensure local democracy.

Harry Stevenson: It seems to me that the principle behind CHPs is to build local communities. In South Lanarkshire, they are organised into four localities within the local authority area, which builds engagement and capacity at a local level. That seems to make a bit more sense. In our written submission, we comment on the concerns that exist about that larger geography. Across Lanarkshire as a whole we have different communities, from urban to rural, and it would be difficult to get representation from them all.

Another issue could be the distortion of interest. A local interest might bring forward for election a lot of people who might not represent wider issues or the wider geographical area.

Jackie Baillie: I have one tiny point to take up with South Lanarkshire Council, which has the anomaly of Cambuslang and Rutherglen being part of NHS Greater Glasgow and Clyde but receiving services elsewhere. I am conscious of similar but small anomalies in different health board areas. The Boundary Commission for Scotland has recommended that small changes to health board boundaries should be considered to regularise those anomalies. Do you agree, especially in the context of the Government's saying that it intends to make no changes whatever?

Harry Stevenson: To be frank, views on that have changed over the years. The key issue for local people and local members is being able to get good-quality services from the health service. Some of the issues in the past were more administrative and were to do with planning and policy rather than the delivery of services. We have seen changes anyway, over the past few years, and, to all intents and purposes, the NHS CHP for South Lanarkshire, which covers all the localities, including Rutherglen and Cambuslang, is now responsible for the delivery of services.

Guarantees were sought from NHS Greater Glasgow and Clyde on continued investment in the area, and mechanisms are in place. We have worked hard to ensure that the area is not disadvantaged by the fact that, by our terms, it has quite a large population even though it is only a relatively small part of the NHS Greater Glasgow and Clyde area.

The position on that moves around, but the key issue for the council is that people get good services.

Jackie Baillie: Thank you.

Councillor McColl: We did not take a view on the size, but it makes sense that people should know the voting areas. We should try to align all our voting systems, including those for Westminster and Holyrood, so that people vote for the same area each time and know the area that is being represented.

The Convener: That would be a bit difficult, and of course the current boundary changes are going in completely the opposite direction.

Helen Eadie: I was interested in South Lanarkshire Council's submission, which says:

"Consideration will also need to be given to where students will register and/or vote if they are living away from home for a period of time to study."

That made me think about other people who might have occasion to be away from home temporarily, such as people who are living away from home for a time because of work. I ask Harry Stevenson to expand on that point, which is important, especially if we are extending age limits.

Harry Stevenson: We should take a fairly simple approach to it. If we change the constitution and expect people to participate in health board elections, they will be the same as any other elections, and we will have to ask what arrangements will be made to ensure that people who are out of the area when an election takes place have a say in its outcome. I suggest not a sophisticated solution but that we recognise the technical matters to do with the administration of the elections, which are important to people. People will want to ensure that they have the opportunity to register their vote.

Helen Eadie: We spoke about international experience with the previous panel of witnesses. In our papers, we have seen experience from Saskatchewan in Canada, New Zealand and a little bit from Australia. I know about Denmark, Sweden and other Scandinavian countries, which do not treat health like a sub-committee of the local authority, as previous witnesses have said. Has COSLA or have any of the individual local authorities considered what happens in other countries about local authority responsibility for health? The budgets are big, particularly in Denmark, which I have visited. Will the witnesses comment on the international experience?

Ron Culley: I do not think that local government has any grand intention to build an empire around health at this minute.

The Convener: At this minute? You may regret having tagged that little phrase on at the end.

Ron Culley: We are committed to closer partnership working between local government and the health service. Our firm view is that there are structures in place that facilitate that process, such as community planning partnerships. They, of course, are broader than local government and the health service and bring in other interested parties such as the police and fire services. Through the single outcome agreements, there is a clear way for local community planning partners to work together to deliver for local communities. As we have discussed, a large part of that is to do with health outcomes. It is now recognised that not only the national health service but all the community planning partners should contribute to improving health in communities. That is beginning to be recognised in national policy that has been agreed between COSLA and the Scottish Government.

Partners can work together to promote health in diverse ways. Community health partnerships have a different role but, nonetheless, provide opportunities for local government and the health service to work together towards the improvement of health. That mechanism could be exploited more. There is a view among our members that CHPs have not always worked particularly well. It is clear that, in some parts of the country, they have been more successful than in others. That is why we welcome the Scottish Government's commitment to undertake research to identify why some have worked and others have not worked so well.

Health bodies and local government—and other partners—need to work together, but the structures that are in place can facilitate that.

The Convener: So it is not a takeover.

Ron Culley: No.

Harry Stevenson: As I said earlier, the broader role of local government in health and wellbeing is important. Services that are delivered through leisure or housing channels and the regeneration of communities are key to how we improve the health of Scotland in the longer term. We have not had any discussions about that approach to things.

I happened to visit Denmark not long ago because of a contact that we have there, and I visited an acute hospital. From what I heard, some of the boundary issues that exist here, and the challenges around how to support patients or service users, were the same over there—there were still bits that did not quite fit in, regardless of the fact that the hospital was within one local authority. In every country, how well people work together, communicate and train staff for the same common purpose make a difference to people's lives.

Helen Eadie: Denmark also has regional authorities, which are much bigger than our authorities in Scotland, and it is clear that that has an impact on the approach to the issue in the Danish system. We ought to make more such international comparisons, particularly with our European partners—we have something to learn from one another.

Graeme Struthers: West Lothian Council has not examined any of those other models. We have a successful CHCP partnership with NHS Lothian,

which has been running for more than three years. We are quite comfortable with the model that we have just now for meeting the requirements of the communities that we serve.

The Convener: So West Lothian Council is one of the good guys, but we do not know who the bad guys are in the CHPs that are not working. Nobody has named anyone.

Ron Culley: And I am not about to.

The Convener: I know you are not—I threw out the fishing line, but nothing got hooked.

Mary Scanlon: I will follow up some of Ross Finnie's points. From the evidence that we have received, the committee has discovered that four local authorities out of 32 were in favour of direct elections. Does that tally with the responses that COSLA received? Those four authorities include Graeme Struthers's council, of course.

Councillor McColl: There were various views. Some councils were not fully in favour of direct elections—there was a halfway house. There are very mixed views in the responses to COSLA, but the overriding issue is that the system that is currently in place should not be in place in the future. That is our position.

Mary Scanlon: The committee received responses from four councils that were in favour of direct elections, six that were against, and six that were unclear or wished to make no comment. Does that more or less reflect the responses to COSLA?

Ron Culley: I do not have that information to hand just now, but I am more than happy to re-examine our responses. It sounds about right, but we are happy to send the information on to the committee.

The Convener: Thank you.

Mary Scanlon: I would like some clarification on a point that Ross Finnie raised. COSLA's submission states:

"There is strong support for an increase in the number of democratically elected local authority members".

I am not sure that you told us what percentage of a health board you would want to be democratically elected local authority members.

Councillor McColl: We did not take a view on the number of local authority members. The mix of local authority members and directly elected members does not matter, as long as the number is greater than the number of executive directors who are not elected. The principle is that there should be a greater number of members who have been elected in some way than non-elected members.

The Convener: So it is a case of shifting the balance.

Councillor McColl: Yes.

Mary Scanlon: You are looking for an increase there.

Several witnesses have mentioned that health board elections might produce single-issue candidates. South Lanarkshire Council's submission states:

"single issue candidates … could bring a narrow focus to discussions at Board level."

We have also heard that that there could be a clash of opinion between the two types of elected member. Given that West Lothian Council has experience of the campaign to save St John's hospital, has it had a problem with single-issue councillors? Have such councillors had a problem with embracing the full challenges and responsibilities of local government? I hope that that is not a difficult question.

11:45

The Convener: What gave the game away, Mary? Was it the expression on Graeme Struthers's face?

Graeme Struthers: I am being put in a difficult position, but I will answer as best I can.

The Convener: You will have to learn to be a politician and keep a straight face for difficult questions.

Graeme Struthers: Absolutely.

Mary Scanlon: Ten out 10 for diplomacy.

Graeme Struthers: I will try to put my poker face on for this one. We have three council members who were single-issue candidates, but it is important to point out that they are part of, and support, the minority Scottish National Party administration. We have a complex situation in West Lothian. Initially, there were perhaps concerns about what the election of those members on a single-issue mandate would mean for their roles on the council and the health authority. However, their mandate has not affected their roles, which is down to the individuals themselves.

Mary Scanlon: So although they stood as single-issue candidates, they were obviously aware that that they had broader responsibilities.

Graeme Struthers: Absolutely.

Mary Scanlon: That is helpful.

Harry Stevenson: The election of single-issue candidates to a board to represent particular communities could distort board matters for the

duration of their membership. That is not to say that such board members could not develop wider interests, skill and expertise and contribute more fully. However, at the point of their election, matters could be distorted.

Mary Scanlon: Would single-issue candidates be an obstacle to the change that is necessary? Would their election be detrimental to progressing health care?

Harry Stevenson: We did not intend to imply in our submission that that would be the case. However, there is a risk that single-issue candidates could distort the election process because of strongly held feelings in a community or board area about a particular issue. That situation could change the dynamic and deter people who might otherwise have stood and been elected.

Mary Scanlon: I understand. My final question is one that I have asked before. You will know that all councillors are basically equal, at least from the payment point of view. How would a directly elected member who was paid only for their bus fares feel if they were sitting beside an appointed councillor member who was paid for doing the same job? Would that be fair? How would it work?

Harry Stevenson: At the most recent council elections, the decision to remunerate elected members was intended to ensure that a wider range of people would stand as candidates and be elected to councils. There are sometimes issues with volunteers. For example, if someone is a carer, support care must be provided to allow them to get out and participate in the life of their community, and—this is particularly important for someone on a low income—essential costs, such as bus fares and lunches, must be covered. It seems to me that it would be fair to look at such issues across the board and to treat everybody in the same way.

Mary Scanlon: I am really just asking what your view would be if half your councillors were paid and half were unpaid. How do you think they would feel about that? They would all have the same responsibilities and be expected to give the same commitment. In fact, they would all have a democratic mandate, rather than just being appointed. How would that situation affect morale?

Harry Stevenson: There is a good tradition of volunteering, and people give a lot of their time now. However, you are right that people would take a different view. You would have to be careful to guard against that.

Mary Scanlon: What do other witnesses think?

Councillor McColl: I speak as an elected member, but COSLA has not discussed the issue. However, it might become a problem because a directly elected member of a health board should get the same recompense as somebody who was appointed through the council system. It is probably more incumbent on us to ensure that directly elected members are looked after because they could have more training to do than an elected member who comes through the council system, as they would have access to in-house training in their council. A member of the public who was elected to a health board might have to put more time into getting up to speed on the issues, particularly if they were a single-issue candidate, because they would obviously have to vote on more than that single issue, and would need training and expertise to be able to do so. Remuneration must be considered.

Graeme Struthers: We do not want inequity between those who are remunerated and those who are not; neither do we want lack of remuneration to be a barrier to those who are considering standing as a candidate. We support equality around remuneration.

The Convener: The clerks have passed me a copy of the policy memorandum to the bill, which states, under the heading "Membership and Accountability", that

"the elected members will be remunerated at the same rate as current non-executive Health Board members."

Mary Scanlon: That is not what I read.

Helen Eadie: The forthcoming regulations will distinctly not say that. Dr Ian McKee and I picked that up at the Subordinate Legislation Committee.

The Convener: I am obliged to hard-working committee members who sit on other committees—the Subordinate Legislation Committee shines again on the details that we need.

Mary Scanlon: My understanding is that such members will not be not paid.

The Convener: Thank you.

Helen Eadie: The other issue is that elected members could be sacked by the minister.

The Convener: I am obliged to Subordinate Legislation Committee members, who will scrutinise the draft regulations.

Ross Finnie: I direct a supplementary question to Councillor McColl, but others witnesses might wish to respond as well.

I appreciate that COSLA did not take a unanimous view on the matter, but you propagated a notion in your earlier evidence that, on balance, having greater numbers of local councillors on a health board might improve and strengthen the health board. Although we are still

taking evidence, I am already attracted to that direction of travel.

In response to Mary Scanlon, you said that as long as the councillors and directly elected members amounted to more than 50 per cent of board membership, your members might be satisfied. I am interested in how a local councillor who has been elected in a local government election and who then serves on a health board would respond when confronted by a person who has been elected for one purpose and one purpose only, given that that person would have the right to represent their constituents on the health board. How will that strengthen the local councillor's role in making a broad contribution to the workings of the health board?

Councillor McColl: I think that you are speaking about two different avenues. The directly elected person has a direct mandate from the electorate to be on the health board, but a councillor also has a direct mandate as an elected person, although not necessarily in relation the health board. However, such a councillor certainly has responsibility for many health issues, as we have just heard. More and more often, matters are being dealt with jointly by health boards and councils, with more joint accountability, involving more projects—around, for example, "The Road to Recovery, "The same as you?" and "Equally well"—and legislation. For many such initiatives the money comes via health boards, not councils, although councils and elected members are responsible to their communities for helping to deliver the policies. I suppose that we have a mandate to be on a health board because—

Ross Finnie: I am not questioning that mandate, and I agree whole-heartedly with your proposition. My question is whether it helps the governance of a health board if councillors—whose legitimacy you have just explained very eloquently—are confronted by persons who might make a different claim because they have an explicit mandate. Does that not create a tension?

Councillor McColl: I do not think that it creates any tension. We have come across the same situation with national park authorities, to which councillors are appointed and other members are directly elected. Having been a member of one of those authorities for four years, I saw no such tension whatsoever. The idea is that everyone is there to work for the good of their community, regardless of the avenue through which they have been elected. That is the overriding consideration, and I do not think that there is a tension.

The Convener: There might be a slight confusion in the eyes of the public, who will not recognise that there are two different types of councillor on boards. They will think that all councillors are there on the same ticket. They will not discern between councillors who have been directly elected to a board and those who have been appointed to it. I am not challenging your view that all councillors will represent the people, but the public's perception will be that they all have the same mandate. They will not notice that different electoral methods have been used.

Councillor McColl: Yes, but I do not think that that is a problem. At Holyrood, there are directly elected members and list members. The public do not think any less of a list member than they do of someone who was elected in a first-past-the-post system.

Ross Finnie: Come, come. List members are elected at the same election, on the same day and for the same purpose as constituency members. There is no connection between the situation that we are talking about and the situation at Holyrood. Such an analogy could be drawn if list members were elected in a different place, in a different vote and on a different mandate from constituency members. If list members were elected at a different time and for a different purpose, the Parliament would be very different.

Councillor McColl: Possibly. Okay.

Harry Stevenson: I make the observation that the scenario that we are considering would not be a new one. In the past, single-issue candidates have been elected to the Parliament and to our council—

The Convener: That is not the point. There will be two groups of people on health boards with the label of councillor. Councillor A will have been appointed to the board and councillor B will have been directly elected to it by the public for that specific purpose. Ross Finnie is quite correct. There will be two types of councillor on boards for different reasons and with different mandates. The public will perceive that they are all councillors; in that regard, there will be public confusion, which will not be good for councillors.

Harry Stevenson: The point that I was about to make was that when people phone up a local elected member, they will not think about whether that person was elected on a single-issue ticket; they will simply pass on to them the issue that they are concerned about.

The Convener: We will leave the discussion there.

I would like each of the witnesses to comment briefly on whether they are in favour of the proposed extension of the franchise to 16 and 17-year-olds. We have touched on that issue—students and lists have been mentioned. In addition, should health board elections take place on the same day as local authority elections, if—although I do not think that this has happened

yet—those elections are detached from Scottish Parliament elections? Please give short answers.

Councillor McColl: Again, COSLA did not take a position on that, but my view is that we should try to engage 16-year-olds. As has been said, a 16-year-old can go off and fight a war for us, so I think that they should be able to vote in health board elections.

The Convener: What about the date of the elections?

Councillor McColl: It would help with the issue of perception that you mentioned if they were held on the same day as council elections.

Harry Stevenson: I agree that holding the elections on the same day as council elections would ensure the maximum voter turnout and would avoid apathy. That would make a lot of sense. We have not taken a view on the extension of the age range.

Graeme Struthers: We did not take a view on the age range. We think that health board elections should be held every four years, in line with local authority elections, but obviously there is a lesson to be learned from what happened in 2007, when elections to the Scottish Parliament coincided with local authority elections, which created confusion. We support elections being held every four years, but we do not have a specific position on 16 and 17-year-olds being able to vote.

The Convener: Will extending the franchise to 16 and 17-year-olds and holding health board elections on the same day as local authority elections not cause confusion, as the franchise will be granted at a different age for health board elections?

Councillor McColl: Perhaps by that time 16-year-olds will be able to vote in local authority elections.

The Convener: Oh, I see—you have a hidden plot.

Helen Eadie: A point about administration was made in, I think, South Lanarkshire Council's submission. When a register of voters is established, a mark is made on it to indicate whether someone is 16. Do you want to comment further on that?

The Convener: Very briefly, please, Mr Stevenson.

Harry Stevenson: That is a technical issue to do with the running of elections, which would need to be arranged properly.

12:00

The Convener: I thank all the witnesses for their evidence.

I welcome to the meeting our third and final panel of witnesses and thank them for sitting through the other evidence sessions. It has been a pretty long haul.

We have, from Consumer Focus Scotland, Douglas Sinclair, chair, and Liz Macdonald, senior policy advocate; from Inclusion Scotland, Pat McGuigan, director, and Bill Scott, policy officer; and from Voluntary Health Scotland, Phil McAndrew, information officer. We thank you for your submissions.

We will move straight to questions.

Helen Eadie: Good morning, everyone—or should I say good afternoon.

On page 3 of its submission, under the heading "Inherent tensions between the political decisions taken by Ministers, and decisions taken by boards", the Scottish Consumer Council comments:

> "There is danger that this will lead to tensions and disputes between Ministers and elected boards, and to unrealistic expectations on the part of patients."

Local government has experienced such tensions, because the parties in power locally and nationally have not always been the same. I believe that in New Zealand there is a protocol that establishes some kind of modus operandi in that respect. Will you comment on that point?

Douglas Sinclair (Consumer Focus Scotland): There is a contradiction at the heart of the bill between what the public think it is about and what it is really about. When the public see the phrase direct elections in the title of legislation, they think that it is about local accountability and the capacity to change policy.

I do not think that the comparison with local government is fair. After all, the health service is a national service; it is about consistency. There is no evidence that consumers in Aberdeen and, say, Glasgow want a different service; both groups want a consistent health service with common standards. The difficulty is that the bill will raise expectations that cannot be delivered, and that it will cause confusion and create disillusionment.

The difference between local government and the NHS—

Helen Eadie: Will you comment first on the New Zealand example? I accept some of your points about the national aspect of the health service. However, in New Zealand, people have been able to accommodate such issues in an agreement.

Douglas Sinclair: With regard to Unison's evidence, my question is where we draw the line between local and national issues. You and I might agree that hospital car park charges are a local issue; however, the Cabinet Secretary for Health and Wellbeing made it into a national issue. John Swinney cannot do that in relation to local government. As you have already pointed out, ministers can sack health board members; John Swinney cannot do the same in local government.

The problem is that, if you raise the prospect of elections to health boards, people will naturally think, "Oh, it's going to be like our council." If I may say so, having the elections on the same day rather than on separate days will simply compound that confusion. Our view is that the proposal is not in the consumer's interest because, rather than clarifying accountability, it will create confusion.

I ask Liz Macdonald to talk about the New Zealand experience.

The Convener: Liz, that was thrown at you.

Liz Macdonald (Consumer Focus Scotland): I have to admit that I do not know about the national-local relationship in New Zealand. We support the view that the BMA expressed in its evidence. The evidence from New Zealand suggests that elections have not significantly contributed to the democratisation of the health service. There are concerns about falling voter numbers and that the same people end up being elected to health boards. We note that evidence, but I am afraid that I am not aware of the agreement that you mentioned.

Helen Eadie: I am really struggling with the issue. When the Health Committee in the previous session considered the matter, we heard evidence that an agreement between the Government and the health boards would set the parameters and clarify how things would work. Could an agreement between central Government and local government not be set up in the bill? There will always be a degree of tension, but professionals can work out ways to address the issues.

I hear what the witnesses say, but I wonder whether we are commenting too much without really understanding what has been done in New Zealand, which might merit closer examination.

Douglas Sinclair: The issue is the extent to which the public wants variations in health standards. That relates to your point about local factors. What factors would you want to be different in, say, Argyll and Clyde or Highland? I do not know the answer, but I think that it would be difficult to have such differences. People want the same standard of treatment from the national health service regardless of where they are located.

Helen Eadie: They want the fundamental standards to be the same, but allowances must be made for local factors. For example, the health boards in Highland and Argyll and Clyde cover massive areas. Given our earlier discussion, it cannot be beyond the wit of professionals in the Government and elsewhere to sit down and set up agreements between the health boards and the Government.

Douglas Sinclair: With respect, that could be done within the existing system. Elections are not required to bring that about. There could be an agreement between the health minister and the health boards as to the division between decisions that health boards can take and decisions that are appropriate for the minister to take. That does not require legislative change.

The Convener: Before we move on, I ask you to consider making a distinction between national standards—we accept that there should not be a postcode lottery—and the method of delivery. Local people tend to raise issues about how things are delivered in their area. That includes issues to do with remote and rural areas. In my view, the concern is about delivery. Do you agree—you probably do not—that democratising the boards is about the delivery of services?

Douglas Sinclair: I do not disagree that the concern is about delivery. However, the issue is not democracy but something that Mr Finnie mentioned—the perceived effectiveness of the boards. Changing the status of members and making them elected rather than appointed will not change the deficiencies. That is the issue.

We suggest that there are three solutions to the problem. We agree with the proposition that the public lack trust and confidence in their health boards. They might like their GP and their hospital, but they have deep concerns about the effectiveness of the operation and responsiveness of health boards. We do not believe that elections are the answer because, as I said, they will confuse accountability.

We believe that there are three things that need to be done. First, we agree with the Royal College of Nursing that we must build on and increase patient involvement. If I may say so, there is a read-across to local government, in that there is a skills issue. In a study that we did on school closures, we found that education officers lacked training and skills in consulting the community. They did not know how to do it. That is equally true across all our public services, and there is a huge amount of work that we can build on there.

I agree with the convener's point about the question mark over the Scottish health council. Is it an improvement agency or a scrutiny agency? If it is a scrutiny agency, it should be independent of

the NHS, otherwise the public will not have confidence in it.

Secondly, we believe that issues around governance need to be revisited. The skills, training and qualifications of non-executive members of health boards were highlighted in the Audit Committee's report on Western Isles Health Board. Does the board have the right mix? Does it have the skills to hold people to account? Those are fundamental issues. At one level, we could see the Cabinet Secretary for Health and Wellbeing's decision to appoint independent scrutiny panels as a vote of no confidence in the ability of the non-executive members of health boards concerned to do their job properly.

Do we have the right balance in health board governance? One must recognise that the health service is a national service. There is an accounting officer requirement, but there is a debate around whether health boards need the number of executives that they have.

I was interested in the RCN's views on expertise and on making sure that expertise is listened to. People do not need a vote in order to be listened to. I draw an analogy with my experience in local government: if a director of social work had a fundamental issue, he had the right to be heard by the council. He did not have a vote, but he had the right to be heard. That relates to the transfer of the proper officer concept from local government and its potential application in the health service. There are some big issues around governance.

I come back to Mr McKee's point about who owns the health service. The public own it, and they want continuous assurance that their local health board is fit for purpose and continuously improving. Our view is that health boards need independent scrutiny, which does not exist at the moment. Health board finances undergo partial scrutiny by the Auditor General for Scotland, but NHS Quality Improvement Scotland and the accountability reviews are internal to the health board and are not independent. Crerar made the fundamental point about scrutiny being independent.

To draw an analogy with local government again, we can look at the Accounts Commission for Scotland's decision to hold a public hearing into Aberdeen City Council's financial situation. That secured public confidence and shone a beacon of light into the operation of that council. We should compare and contrast that approach with accountability reviews and Western Isles Health Board. I am not seeking to score political points, but only the minister could decide whether to have an independent review into the health board. That does not give the public confidence, nor does it assure them that there is transparency and that all is well.

Therefore, the third element of rebuilding trust is to introduce independent scrutiny of health boards in the same way as there is independent scrutiny of local government. Our two biggest public services are health and local government. It is critical that they work together, which can be brought about by extending the duty of best value and independent inspection to health in the same way as those apply to local government. That is how to rebuild public confidence, rather than holding direct elections to health boards, which will confuse accountability.

The Convener: Mr Scott can comment on that in a moment. Before he does that, I welcome to the public gallery a contingent of Vietnamese politicians. I hope that this meeting does not put them off having committees. We are on our best behaviour. I welcome our visitors to the Scottish Parliament and to the Health and Sport Committee.

Bill Scott (Inclusion Scotland): We strongly support the principle of direct elections because we think that they bring a good method of scrutiny and accountability to the governance of health boards. Democracy is the best method that we have come up with so far. The public must be able to decide whether the services are being delivered locally in the way in which they want them to be delivered. Services such as maternity and accident and emergency services are crucial to local people, and we think that local people should have some input into the decision-making process.

12:15

Jackie Baillie: I have a short supplementary question. I do not think that the approaches that have been mentioned are necessarily mutually exclusive. I am interested to get more detail, because I care about independent inspection in the health service for other reasons. Which vehicle do the witnesses think would be appropriate to ensure that health boards are truly independent of ministers? Which would restore public confidence?

Douglas Sinclair: In his statement on scrutiny, John Swinney proposed that NHS QIS, parts of the Scottish Commission for the Regulation of Care and parts of the Mental Welfare Commission for Scotland should join to become an independent body. The bit that is missing is accountability review by ministers, which is the bit that needs to be independent. That function needs to be built into an independent scrutiny body that is accountable to Parliament and scrutinises the performance of health boards, not only on clinical issues but on the same issues that are scrutinised in local government. Under the best-value regime in local government, councils are asked whether they are continually improving and whether they are fit for purpose. The same question should be

asked—independently—of health boards. That could be done by Audit Scotland reporting to a scrutiny body.

Jackie Baillie: That is interesting. I would like to clarify one point. My understanding of NHS QIS and the proposed new body is that they would still be accountable to ministers.

Douglas Sinclair:, NHS QIS is actually accountable to Kevin Woods.

Jackie Baillie: So it is not even accountable to ministers.

Douglas Sinclair: That is not transparent.

Jackie Baillie: The key issue for you is accountability to Parliament rather than to ministers.

Douglas Sinclair: Absolutely.

Jackie Baillie: Thank you. That is helpful.

Ian McKee: I am interested in other panel members' views on what we have heard so far. I want to explore the interesting concept of independent advice to non-executive board members and ask Consumer Focus Scotland what it thinks the right balance of non-executive members on the board would be.

The problem is that non-executive board members use executive board members as their source of advice; there is a teacher-pupil relationship during the non-executive members' term of office. It is therefore not surprising that they do not subject the board to the rigorous scrutiny that we would expect from the models that we have discussed. Rather than having an independent scrutiny panel, which would appear to be set up for specific instances, do you envisage the creation of a public body that is a continual source of advice to non-executive members of health boards throughout Scotland? Do you envisage the creation of a new institution?

Douglas Sinclair: No. There are two issues. First, there is the argument for external independent scrutiny, which is good practice in any public service. Secondly, there is the need to enhance the role of the non-executive members so they can challenge the executive members—I agree that it is difficult for them to challenge professional opinion. Our submission suggests that, on major issues, the non-executive members should be able to access independent advice. A fund of money in each health board should be ring fenced for the non-executive members to draw on if they feel that, although they have listened to the advice of the board's experts, they want to take independent advice. That would help them to develop the confidence and the skills to undertake effective scrutiny of the executive members, which is not happening in the way that it should.

Ian McKee: Is there not a risk that the dominant role of the executive members has already been established? Non-executive members might not seek such advice because they are already immersed in the administrative culture.

Douglas Sinclair: There is a case for reviewing the governance of the health boards to consider the balance and the number of executive members on the board. I have given the reasons why such a review needs to be conducted. I am not arguing that there should be no executive directors on the health board, because it is a national health service and the accountable officer has specific responsibilities, but there is a debate about whether we need to have the current number of executive members on the health board or whether we could use different models. We could perhaps use models taken from local government, such as the proper officer model, in which the officer has the right to be heard, but not to vote. That model is capable of some degree of transfer to the health service.

Ian McKee: Of course, the local government model has elected members, which you are arguing against. I would be interested to hear the views of other panel members.

Douglas Sinclair: It comes back to the point that we are not comparing apples with apples. Local government is a separate tier of government that is accountable to its local electorate and people; the national health service is, as it says, a national service that is accountable through ministers to Parliament. The bill will not change that accountability. The difficulty is that the public will think that, as a result of these direct elections, accountability will change. It will not, the public will find that confusing and I am worried that it will lead to even greater disillusionment with the health service.

The Convener: Before I let Ross Finnie in, I wonder whether the other witnesses will defend direct elections in the face of Mr Sinclair's robust rejection. We have heard from Mr Scott; does Mr McAndrew or Mr McGuigan have anything to say?

Phil McAndrew (Voluntary Health Scotland): Voluntary Health Scotland supports the general principle of direct elections as a means of increasing the public's democratic involvement in health delivery. Direct elections will provide patients with a stronger voice on health service delivery decisions and open up a channel for hard-to-reach or excluded equalities groups such as young people not in work or training, homeless people and isolated older people.

The Convener: How do you refute the evidence that suggests that those are exactly the people who do not put themselves forward for such roles and that the positions are filled instead by the

usual middle-class professionals and people who have connections to the NHS?

Phil McAndrew: Perhaps we are not approaching those people in the correct way.

What channels can members of the public use to get involved in the health service? Although a lot of good work is being done through the patient focus and public involvement programme in getting patients and the public involved, there is still room for improvement. As a layman with an information technology background, I tried to find out how I could get involved by using all the NHS board websites. Most websites had a section on getting involved and mentioned CHPs; some even mentioned public partnership forums, which is indeed the route by which the public can get involved. However, as I said, things could be improved, and I believe that direct elections will complement the PFPI programme.

Pat McGuigan (Inclusion Scotland): Direct elections are important, because the general public should be involved more. In the past, too many decisions have been taken without any consultation with the general public, and this move will give people more involvement.

Bill Scott: I listened with great interest to the suggestion that there is greater concern for equalities in an appointments-based system than there would be in a system of direct elections. Elections at least create the opportunity for people from all backgrounds to become involved.

At the moment, although 20 per cent of the population is disabled or has long-term limiting health conditions, disabled people make up only 2.5 per cent of all appointments to public bodies in Scotland. It is clear that the appointments system is dramatically failing disabled people and patients and there is simply no case for arguing that it results in a better outcome for equalities than direct elections. That is not borne out in fact. In fact, the proportion of disabled people being appointed to public bodies is falling: it was 2.5 per cent two years ago and dropped to 2 per cent last year. Disabled people make up 7 per cent of those who apply to become members of public bodies, but only 2.5 per cent of those who are appointed, which suggests that the numbers appointed do not replicate the numbers of those who put themselves forward. There are genuine difficulties with the appointments system selecting out people who are not considered suitable.

I listened with great interest to some of the earlier comments about the suitability of people from certain backgrounds to be involved in decision making. I began to think that the 19th century chartists worked in vain because if that sort of argument had prevailed then, we would not have now the direct election of ordinary people to Parliament, local government and so on. Such comments are elitist conceptions. Disabled people have been excluded from public life for so long, but here is an opportunity for them to become involved in public life and they want to seize it with both hands. They are often, but not always, users of the health service—like everybody else, some of them use it more often because of conditions that they have—and they are experts on their conditions and the type of service that is being delivered to them. They should be allowed to get involved in making decisions about how that service is delivered to them, as should the general public.

The Convener: You might not have this information, but might we have a breakdown of the percentage of disabled people on boards, and on health boards in particular?

Bill Scott: I tried to get a breakdown of the numbers of disabled people on health boards, but was unable to get it from the Office of the Commissioner for Public Appointments in Scotland.

The Convener: We might see whether we can source it because it would be interesting to committee members.

Ross Finnie: Those last two pieces of evidence illustrate graphically the difficulty of where we are. Mr Scott argues cogently for a different form of representation, but I am not entirely clear that any of us—I include myself—are clear about where we are going in relation to the question that we are being asked.

We are not being asked to change. We are not being asked to address the point that Mr Sinclair raised. We are looking at a body that is directly accountable to ministers—that was confirmed by the officials' evidence—so we are not looking at a different form of health board, à la local government; we are looking at a very different corporate model. Douglas Sinclair posited that we might need to rewrite that model and, although I do not disagree with that possibility, I am not sure that that is the question that we are being asked.

The difficulty for you—and for us—is to work out not how to get greater representation and engagement on health boards, legitimate though that undoubtedly is, but how to influence or affect the corporate governance of NHS boards.

To come back to Mr Scott, or indeed to Mr McAndrew, I am not at all clear about how the electoral wards that are posited in the bill will result in better representation for disabled people. If the present legislation for dealing with disability equality is failing, that is a separate question that needs to be addressed. If your figures are right, we are manifestly not doing enough about the representation of disabled people on public

bodies, but the fundamental question before the committee is how we affect the governance of health boards. That goes back to Mr Sinclair's point that we are dealing with a body that is different to a local authority and, therefore, we need to ask whether direct elections would improve its effectiveness. That is fundamental. Mr Sinclair is suggesting that we need to take a fundamental look at the issue, but at this point I want to confine him and the rest of the panel to the question whether health board elections will prove more effective. That is, after all, the issue that we are dealing with. The issue of engagement might well be under discussion, but we are certainly not talking about accountability, which is already defined in health legislation.

12:30

Douglas Sinclair: Our position is quite clear: electing rather than appointing people will not, per se, remove the deficiencies of governance that you have mentioned.

I will make this point quickly, as I am in danger of repeating myself. Three things need to be done. First, health boards must become more responsive and their mechanisms for patient involvement and community engagement must be enhanced. There are good ideas out there, but they need to be rooted.

Secondly, there needs to be a review of governance, particularly with a view to increasing the effectiveness, skills and ability of non-executive members with regard to challenging decisions. Thirdly, there must be independent scrutiny. Those three measures will address not only your question of how we improve the corporate governance of health boards, but the equally important question of how the public's trust in their local health board can be re-established.

Bill Scott: Opening the system up to democracy will fundamentally change it. Of course, that will not happen overnight—it will take some time—but the public's perception of health boards and their views on what they want from them will change over time. It is no bad thing to let the light of democracy into the decision-making process. After all, although doing so will fundamentally alter things, we will still want national standards. There is no problem in that respect.

Jackie Baillie: But can we not have both approaches? As I said, they are not mutually exclusive.

Bill Scott: I do not think that they are.

Helen Eadie: I certainly agree with the approach that Ross Finnie has taken in his question; he analysed the difficulties quite well.

The evidence that we have taken this morning and the written submissions that we have received suggest that there is some merit in extending the couple of pilots that are proposed to be introduced across Scotland to the three-stage approach outlined by the RCN. Voluntary Health Scotland says that it accepts the bill's general principles, but its submission is nevertheless peppered with caveats and concerns from its members that, for example, boards might be

"dominated by 'a few knowledgeable and politically astute individuals.'"

Would the pilots proposed by the RCN allow us to analyse and evaluate what is happening?

Moreover, certain points in Voluntary Health Scotland's submission that have not yet been highlighted include the hidden costs in setting up and administering direct elections. One thing that people like me who have a local government background have always argued for is expenses for elected members with caring responsibilities. If, as the Subordinate Legislation Committee has said is likely, the people elected to these boards will not be remunerated, how on earth are some of these inequalities to be addressed?

The Convener: So the first question is about the three pilots and the second is about expenses for carers. If we can start with—

Helen Eadie: My question was about basing pilots on the RCN model.

Liz Macdonald: As the lady from the RCN pointed out, the bill has been presented very much as a response to the question of how the widest possible range of patients and local communities can be involved more in the health service and whether direct elections can contribute in that respect. The first question is the more important and certainly provides a very good argument for testing different models. Rather than putting considerable sums of money into piloting elections, it could be used to develop public and patient involvement in other board areas in different ways. We would definitely support that.

The Convener: We have had quite a long meeting, but I do not want to put words in your mouth, Mr McAndrew. Can I take it that you would not agree with that view?

Phil McAndrew: I agree with the RCN's pilot proposal. It is a very good idea to have controls, instead of just doing the two pilots as proposed in the bill.

Bill Scott: I have not been able to consult my membership on that, but my personal view is that I do not see why the other things could and should not be done to increase public participation.

The Convener: I want to move on to the funding issue.

Bill Scott: There is a particular issue about public appointments and the fees that are paid to those who serve on public bodies. Most disabled people cannot benefit from those fees because they are clawed back by the benefits system. Most disabled people put themselves forward in the knowledge that they will be sitting alongside people who are being paid quite generously for giving their time to the public body, but that they themselves will not end up any better off for having served on the board. Disabled people have to live with that at the moment.

I am in favour of people being paid something for contributing in that way, as councillors are, but that is not on the table just now. We would be in favour of people being properly rewarded and compensated, because there will be care costs for some disabled people who take part in the boards. Personal assistants might need to be brought along, and so on, and if someone cannot meet those costs, they will be excluded whether they are appointed or elected.

The Convener: I take it that that is your position too, Mr McGuigan.

Pat McGuigan: Yes.

The Convener: Mary Scanlon, do you have a final point? Time is running on.

Mary Scanlon: I have a point that should be raised. It is from Consumer Focus Scotland. There is a danger that having elections

"would be considered to be a substitute for an NHS board's statutory duty to consult"

and that money would come from the existing budgets for patient involvement. That is saying that the bill would not be of benefit, and the situation would be worse than what we have now. Is that a reasonable interpretation?

Douglas Sinclair: It is fair to say that elections are not cost neutral. The money has to be found from somewhere. That is self-evident.

Mary Scanlon: Yes, but my point was about health boards being less willing to consult and involve local communities because the assumption would be that elections—

Douglas Sinclair: All our public service organisations have to create a culture of engagement with the public. They should be doing proper consultation and they should be proper customer-led organisations, whether they are in local government or the health service.

Mary Scanlon: Are you saying that the elections might be seen as a substitute for proper involvement?

Douglas Sinclair: That is a possibility.

Mary Scanlon: Okay. My second question is for Phil McAndrew.

Someone said, on the theme of politically astute individuals, that health board elections would need to remain true to their original intent and not be hijacked by party politics. I wonder, however, given the financial and time costs of standing and the travel times involved in attending meetings, whether the people whom you have mentioned this morning and would want to see included, will be.

Phil McAndrew: I certainly hope so. The comment to which you refer was not about the expenses and so on that board members would receive, but about the total cost of running the elections. The concern is that it should be beneficial in the medium to long term.

On the point about the more excluded groups having access, as I understand the bill there are expenses of £7,500 per year per person. I did not realise that the Subordinate Legislation Committee had removed that.

Helen Eadie: We did not remove it.

Mary Scanlon: We are a bit confused about that just now.

My point was really about people having the money and time to stand for election; Dr McKee made the point earlier. Are the elections likely to be hijacked by party politics rather than lead to the conclusion that we all seek?

Phil McAndrew: That is a difficult question to answer. I hope that excluded groups will be able to find some funding—obviously not from the health boards—or backing so that people can stand for election.

Helen Eadie: For the record, convener, the Subordinate Legislation Committee did not remove the provision on expenses. It recommended that the Health and Sport Committee's attention should be drawn to the issue.

The Convener: I do not know the correct position. We will try to clarify it, but I know that it will not have been the Subordinate Legislation Committee. We will find out what the position is on remuneration.

Helen Eadie: The minister made a proposal to the Subordinate Legislation Committee that we said we would draw to the attention of the lead committee. It is a policy matter for this committee.

The Convener: I do not want to get into a debate about it just now because there are conflicting views. We can find out; it is not rocket science. We will get that sorted out for our next meeting.

I thank you all. That concludes this evidence session.

12:41

Meeting continued in private until 12:43.

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