HEALTH AND SPORT COMMITTEE

Wednesday 3 June 2009

Session 3

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

CONTENTS

Wednesday 3 June 2009

HEALTH AND SPORT COMMITTEE
18th Meeting 2009, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

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

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
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:

Theresa Fyffe (Royal College of Nursing Scotland)
Alex MacKinnon (Community Pharmacy Scotland)
Dr Dean Marshall (British Medical Association Scotland)
Dr Beth McCarron-Nash (British Medical Association)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Wednesday 3 June 2009

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

Tobacco and Primary Medical Services (Scotland) Bill: Stage 1

The Convener (Christine Grahame): Good morning. Welcome to the 18th meeting of the Health and Sport Committee in 2009. I remind members, witnesses and people in the public gallery to switch off their mobile phones and any other electronic equipment. No apologies have been received.

Item 1 on our agenda is consideration of the Tobacco and Primary Medical Services (Scotland) Bill. This is an oral evidence session, as part of our stage 1 consideration of the bill. We have before us a panel of witnesses representing primary medical services organisations, who will give evidence on the proposals in part 2 of the bill. The witnesses should feel free to comment on part 1, if they wish, although they are primarily here for part 2.

The committee has received from the witnesses written submissions, which are included in committee papers. The panel consists of Dr Dean Marshall, chairman of the Scottish general practitioners committee of the British Medical Association Scotland; Dr Beth McCarron-Nash, a general practitioner, from the British Medical Association; Alex MacKinnon, head of corporate affairs for Community Pharmacy Scotland; and Theresa Fyffe, director of the Royal College of Nursing Scotland. You probably know this already, but you should signal to me if you want to answer a question; I will then list those who want to comment.

Helen Eadie (Dunfermline East) (Lab): I have questions for the BMA and the Royal College of Nursing.

I refer you to the BMA's written evidence on part 2 of the bill, "Primary Medical Services". I thought that the submission was fairly lean—it amounts to only three short paragraphs. In its evidence, the BMA says that the Cabinet Secretary for Health and Wellbeing is addressing the issue that was raised at the BMA's annual representative meeting in Edinburgh last summer. However, in her written evidence to the committee, Professor Allyson Pollock of the University of Edinburgh says that the bill does not close off the possibility of private companies working in the health service and that there is still scope for that to happen.

At our meeting last week, Dr Ian McKee and others clarified that it will be possible for private companies to be involved in the health service, provided that they are run by GP professionals. Would you like to comment on that issue? I do not know whether you have read Professor Pollock's evidence. Do you share her understanding of the bill?

Dr Dean Marshall (British Medical Association Scotland): We believe that anyone who runs a national health service general practice contract in Scotland should have a long-term commitment to the population that they serve and that they should have day-to-day involvement in running the practice. There are issues to do with the definitions of the words "private" and "commercial". We have particular issues with commercial companies, which the bill will prevent from coming in and running NHS general practice contracts, because of our concerns about what has already happened in England.

Helen Eadie: The bill will not stop that happening. We all know that there are various ways of setting up private companies—a private franchise company could be established throughout the United Kingdom, for example. God forbid that we will have "McDoctors", but that could happen. That could be a franchise and the health service would not be prevented from contracting with it. Provided that GPs run and are in control of such companies, the health board will not be prevented from contracting with them. Does the British Medical Association really understand that part of the bill?

Dr Marshall: We do. As I said, we have lots of experience from what has happened in England, which we can tell members about. My understanding of the bill is that one of the GPs holding the contract will need to have day-to-day involvement in the practice, but that does not happen when large commercial companies take over lots of practices, manage them from a distance and the doctors are not contract holders. Contract holders will work in the practice. There is a difference between that and what Professor Pollock has issues with.

Helen Eadie: But essentially, the private element will still—

The Convener: Before you proceed, does Ian McKee want to ask a supplementary question on that particular point?

Ian McKee (Lothians) (SNP): Yes, if that is all right with Helen Eadie.

Helen Eadie: Certainly.

Ian McKee: On 13 May, we took evidence from Dr Pryce of the Scottish Government's bill team, who agreed that it would be possible for a doctor or a nurse to do what is done in England. Day-to-day involvement in the health service is defined as involvement for a minimum of one day a week, so a doctor or nurse could set up in a practice for one day a week and the provisions of the bill are such that that doctor or nurse could then run other practices with which they did not have day-to-day contact—nothing is said about having to be in a practice. That is the problem. The person does not even need to be a doctor or a nurse. Administrators who work in an NHS practice could run 40 other practices. That would rule out a commercial company per se, but such an arrangement would still, in many people's eyes, be a commercial one if people were running practices without having a say in day-to-day clinical matters. That explains the situation as I understand it. Dr Pryce agreed that that was possible under the bill.

Dr Marshall: Perhaps we need to look at the wording in the bill on day-to-day involvement. I suppose that there could potentially be involvement for five days in five different practices. If, as you say, day-to-day involvement is defined as involvement one day a week and a person with that involvement could run 100 practices in Scotland, we would not necessarily support that; we would need to look at that.

Ian McKee: A person could work a whole week in a practice and run other practices.

The Royal College of Nursing Scotland's evidence states that contracted clinicians should actively practise for

"*at least* one day a week in a practice for which they are party to a contract."

That would be more logical. A person should work a minimum amount of time in a practice. To work in a practice in Edinburgh, say, and run practices in Glasgow, Stirling and Aberdeen, would seem to verge on a commercial organisation.

Dr Beth McCarron-Nash (British Medical Association): I agree with that summary. If that is the case, we need to look further at the bill. What you describe is the case in the majority of the GP-led health centres in England. The view of GPs in England is that that is happening. Having a contract holder who lives and works in the community and stays as the GP for patients in the long term is different from having a group of GPs or a commercial company working across primary care organisation areas and providing services on a much larger scale.

Theresa Fyffe (Royal College of Nursing Scotland): We believe that there must be a connection to the day-to-day contract and that there should not be something outside that. That is why our evidence is on our understanding of who will provide the contractual services and how that will be done.

We commented on the Government's original proposals that would have provided an opportunity for nurses to be party to a general medical services contract, as they can be party to a primary medical services contract. There was a consultation, but we do not believe that it was done well or that the proposals were understood. As we know through the quality and outcome framework, nurses provide 36 per cent of care, so, if you go by the premise that that is where the actual contracted services are, we are asking why those proposals cannot be considered for the future.

We understand that neither the consultation nor the debate was conducted well, so we are seeking an amendment at stage 2 to say, "This shouldn't be closed down, because the future is that others will provide those services." We are absolutely committed to the service provider being somebody who is connected to the practice and the community. We believe that that is an important premise.

The Convener: As you are aware, amendments can be lodged either by the Government or members of the committee. You know your routes in.

Helen, you had not finished.

Helen Eadie: Yes. I wanted to—

The Convener: Sorry—Dr Marshall wants to come back on that.

Dr Marshall: There are a couple of problems with nurses holding GMS contracts. First, it is important that the holder of each GMS contract is a doctor who can provide medical leadership. The GMS contract is a United Kingdom contract. Any nurse holding a GMS contract would not have any ability to negotiate our terms and conditions and they would have no one to represent their views. Secondly, there are disciplinary regulations that relate to GPs who hold contracts. It would not be fair if the GPs who held contracts were under disciplinary regulations that did not apply to a non-GP who held a GMS contract.

Theresa Fyffe: In our view, the Government was brave to consider the proposal, but it said that the response was against it. According to our analysis, five parties were for it. We believe that the issues that I have raised were not properly consulted on or understood. We are not saying that there are no issues to be considered. My view of the future is that it will be not nurses against GPs, but a team of nurses, GPs and others. I am firmly committed to that. There is an example in England of an out-of-hours service whose lead

clinician is a nurse who has a GP and others working with them. We sometimes think that "lead clinician" means that there is no commitment from other services.

I take the point that Dean Marshall is making. The consultation was not conducted properly because the issues were not understood or properly consulted on. All that we are asking is for the door not to be closed on proper consultation and for an amendment to be considered that would allow us to open that debate and understand the issues fully. Out-of-hours services are provided mainly by nurses, and there are teams in Scotland that are entirely led by nurses with salaried GPs working alongside them. That is working extremely well.

I am talking about the future. The bill should be thinking of the future, not staying where we are, although I understand that there are issues that need to be considered.

Ian McKee: Can I ask a question on that point, convener?

The Convener: I feel that I am holding medical jackets, here, with nurses in one corner and GPs in the other. I will let Dr Marshall come in first—

Ian McKee: My question is for Theresa Fyffe.

The Convener: Please go ahead.

Ian McKee: I am asking for some information. New section 17CA states that arrangements could be made for a partnership in which

"at least one partner is a medical practitioner or other health care professional".

Does that not cover what you are suggesting? Could the "other health care professional" be a nurse or even an administrator?

The Convener: Can you refer us to the relevant subsection, Ian?

Ian McKee: It is new section 17CA(2)(a)(i) of the National Health Service (Scotland) Act 1978, which is inserted by section 30 of the bill.

Theresa Fyffe: When we met the legal team and debated that with them, they told us that they believed that it was closed down. That was the Government's response to us—that the way in which it is defined just now closes it down and there is no opportunity for nurses to hold GMS contracts. That is how the issue has been led to us. We went back to consult the Government, which is why we submitted—

The Convener: We can raise the issue with the minister if there is a conflict of interpretation.

10:15

Dr Marshall: I take your point, convener, that you do not want to be holding jackets. Nevertheless, I take issue with some of the comments about who provides out-of-hours services. I realise that, under sections 2C and 17C of the National Health Service (Scotland) Act 1978, nurses and other health professionals can hold a variety of contracts, but we are talking about offering others GMS contracts. I simply point out that, at the moment, I cannot hold a pharmacy contract.

In Scotland, there are GMS practices in which nurses and practice managers are partners; indeed, many practices are quite keen on such arrangements. However, that is totally different to a situation in which nurses can be the sole holders of contracts, with GPs working under them. As we have said, that is inappropriate because of issues of representation and the ability to negotiate terms and conditions. Sections 2C and 17C of the 1978 act clearly provide opportunities for nurses to hold contracts and to negotiate their own terms.

Dr McCarron-Nash: As Dr Marshall has pointed out, other contractual options are available to nurses. I also urge the committee to consider the knock-on effect of this provision on the other countries of the United Kingdom because, after all, what has been negotiated is, in effect, a four-country GMS contract.

The Convener: That stirred up a wasp's nest. Helen, on you go.

Helen Eadie: I wonder whether Theresa Fyffe or the other witnesses have anything to add to the suggestion that the bill represents a complete turnaround by the Government on its approach to section 17C arrangements.

Theresa Fyffe: The provisions were not trailed well, which has caused concern and has perhaps led to a lack of understanding about what the wording actually means. I entirely understand what the Government is saying about the current arrangements for and issues around the GMS contract; indeed, that is why we are not asking to take things back to square one and go back to the table. If we can get an amendment lodged, we can have a better discussion of the matter and come to a better understanding of what the future might hold. I am not in any way suggesting that nurse-led services should stand alone, although I point out that certain services in Scotland—homelessness services, for example—already stand alone in that respect and will, because of their nature, always do so. All I am saying is that we should keep the discussion open. I simply do not think that it was reasonable to close down the conversation just because one party did not agree

with the proposals. After all, five other parties said yes.

Helen Eadie: I will leave it at that for the moment, convener.

The Convener: I call Michael Matheson, to be followed by Mary Scanlon and Rhoda Grant.

Michael Matheson (Falkirk West) (SNP): I was going to ask about smoking issues, convener. Do you want to continue with the current line of questioning?

The Convener: Well, you could ask your question and see whether someone wants to answer it.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Perhaps we should stick to part 2 of the bill for the moment.

Michael Matheson: I agree. That might be helpful.

Mary Scanlon (Highlands and Islands) (Con): The Confederation of British Industry's submission says that, as a result of commercial companies getting involved in providing services in England, there has been a 33 per cent increase in patient lists; surgeries are open from 8 am to 8 pm; mobile units are going round rural areas; and there is

"a 97% patient satisfaction rate".

The difficulty with the bill is that, because we have no experience of commercial companies providing such services, we do not really know what we are talking about.

With regard to Dr McCarron-Nash's comment about the four-country GMS contract, my understanding is that the Primary Medical Services (Scotland) Act 2004 was necessary to introduce that contract, which had been negotiated between the four Administrations. Am I right in suggesting that, of the four Administrations involved, only we in Scotland are diverging from the contract in order to bar commercial contractors?

When the Primary Medical Services (Scotland) Bill was going through Parliament, every political party apart from the Scottish Socialist Party, then led by Tommy Sheridan, supported the introduction of commercial GMS contracts. At the time, did the BMA oppose the introduction of commercial contractors set out in the bill? If so, did the rest of the political parties disagree with your position?

Dr McCarron-Nash: I am actually a GP in England, so I cannot answer for what happened when commercial GMS contracts were legislated for here but, if you wish me to, I can discuss the impact of commercial companies on GP services in England.

The Convener: Let us have the answer to the question first.

Dr Marshall: When the Primary Medical Services (Scotland) Bill was introduced, we were reassured that the only reason that the provisions on commercial providers were included was so that they could be used as a last resort when no other arrangement could be found to provide services. That has clearly not been the case in England, where the whole thing has been turned round and the use of commercial providers has become the contractual arrangement of choice. Dr McCarron-Nash can tell you about that. We were not necessarily against the use of commercial providers because the Government of the time led us to believe, and reassured us, that it was an option of last resort, but that is not what has happened in the rest of the United Kingdom.

Mary Scanlon: The point is that, five years later, we do not exactly have to close the flood gates because we still have no commercial contractors in Scotland.

I would like to bring in Alex MacKinnon, if I may—he has been quiet so far. I found his submission excellent. It says:

"Community Pharmacy Scotland has reservations",

and states that the GMS contract is

"delivered by practitioners who are perceived to be in tune with local need".

It also mentions the discussion, in "General Practice in Scotland: The Way Ahead", of the ageing population, the increasing public expenditure and the increasing demand for GP services and says:

"One option would be to allow other health care contractors to bid to provide those primary medical services for patients using a salaried GP."

The pharmacy contract is up for review. Does Alex MacKinnon foresee that, in future, salaried GPs could be located in community pharmacies in hard-to-doctor areas to increase access to GPs? Could the pharmacist be the commercial provider?

Alex MacKinnon (Community Pharmacy Scotland): I could answer that in a number of ways, but our main reservation was about amending the criteria. The unified NHS structure in Scotland is inclusive for patients, public and staff. We were concerned to ensure that, in the drive to a totally mutual NHS, we do not exclude or lose the benefits of private sector investment and innovation, which may be the only means of finding a solution to a particular problem.

We have an increasingly ageing population and there will be massive demands on all primary care

practioner services because of conditions such as diabetes and obesity. We also face other challenges. This morning, there was an item on the BBC news saying that, by 2017, there will be more female medical practioners, including GPs, than male. That brings with it challenges. We will face massive workforce challenges, and changing the criteria completely would put us in danger of preventing innovative alternative partnerships that could help to meet future service demands and needs. Are we really saying that a potential alternative, innovative solution from a provider that does not fit the proposed new criteria has no place in our mutual Scottish NHS? That was our main concern.

We do not envisage pharmacies having doctors' surgeries in them, but that might be a one-off solution to a particular problem in a rural area or a socially deprived inner-city area. Unless we all work together, we will not be able to cope with the future demands on the NHS. The legislation on commercial providers may never be used but, if we leave the criteria alone, at least such a solution could be triggered. If they were changed, new legislation would be needed to enable it.

Dr McCarron-Nash: I disagree with that view because of the experience in England. We thought that the provision would never be used in England but every primary care trust or primary care organisation there now has a GP-led health centre. Plurality of provision and commercial providers are being promoted as the vehicle of choice and short-term contracts are offered. In my view, there is no evidence that such contracts increase patient choice or improve patient care. They could also have a detrimental effect on local health economies, at vast expense to the taxpayer.

Based on the evidence from England, I see no reason why allowing such contracts to slip through into Scotland will improve health care in Scotland. There is no reason why a PCO, such as a health board, cannot run those contracts. Our concern is that such organisations in England tend to employ salaried GPs and other health professionals. The number of doctors that they employ to see patients is a lot lower than in GMS and PMS practices. That has an effect on patient care. Patients do not have the same continuity with their GP that they currently have in Scotland. We run the risk of that happening here unless we close that loophole.

Alex MacKinnon: We are now in a position where we have two very different NHSs going in different directions: we have co-operation and collaboration in Scotland and competition and choice in England. The clear message coming out is that Scotland is going in a different direction by trying to have the public, patients and staff working in partnership. That aim could still be achieved through guidance without needing to remove, through the bill, a potential solution to future problems.

Dr Marshall: Obviously, the provision of services in deprived and rural areas is an issue of concern, but we see no evidence that commercial providers or contractors will address that problem. The experience in England, where bidding processes have been used, is that people realise that commercial companies cannot provide the services for the price that is tendered. There is actually no evidence that such contracts can resolve problems in hard-to-doctor areas.

To go back to Mary Scanlon's previous question on how the existing provisions in the 2004 act were introduced, they were brought in without any real scrutiny. At the time, it was explained that the provisions were included only for use as a last resort and that, if they ever needed to be used, they would be brought back for proper scrutiny. They were not subject to scrutiny at the beginning because it was suggested that they would be used only as a last resort—

The Convener: Sorry, by the existing provisions, do you mean—just to clarify for the record—those that were introduced by that previous legislation?

Dr Marshall: Yes.

Removing the ability of commercial companies to operate in that way is about future-proofing general practice in Scotland. We are seeing devastation in England that we need to prevent from happening here. Otherwise, we will regret the consequences.

The Convener: Does Mary Scanlon want to respond to that point about devastation?

Mary Scanlon: There are no such commercial companies in Scotland, so the BMA can come up from England and tell us all sorts of horror stories but we have no proof whether it is right or wrong. I do not know whether any of my colleagues has been to Tower Hamlets or Canary Wharf, but the only evidence—it is unfortunate that people from the Confederation of British Industry were unable to give evidence in person—is from the CBI. The CBI submission mentions mobile units in six rural areas that received 97 per cent patient satisfaction rates; a 33 per cent increase in the size of patient lists; and surgeries that are open from 8 in the morning till 8 at night and at weekends. When I was in Kinloch Rannoch on Monday, I found that the out-of-hours service is provided by first responders. Therefore, any suggestion that all of Scotland's rural areas are covered by GP out-of-hours services is untrue.

I have another question for Alex MacKinnon. As we know, there is considerable discontent about

GPs losing their dispensing ability, which is an issue that will be debated in Parliament quite soon. Alex MacKinnon's submission states:

"There is no guarantee that the existing practice model will survive for another 10 … years".

His submission also points out that the BMA paper "General Practice in Scotland: The Way Ahead" states:

"At present, patients are not consulted, despite potential risks that loss of dispensing to a remote and rural practice could affect … the future sustainability of the practice."

Alex MacKinnon's submission says that, as we do not have a perfect model, we should allow some flexibility in future and that it is essential to leave people with the ability to provide commercial practice because the existing model will not survive 10 years. Why do you think that the existing model will not survive 10 years?

10:30

Alex MacKinnon: We do not know what the future holds as far as pressures are concerned. There are many different factors involved and pressures on the NHS, not least on GPs, nurses and pharmacists. We are advising caution, as the bill reduces options and the flexibility to find a solution. The Government has itself said:

"the proposals could potentially reduce competition by excluding providers".

That has already been identified by the Scottish Government as a risk, but it has been discussed in terms of price. The much bigger risk lies in potentially missing out on an innovative alternative solution, and the possibility of entering into certain partnerships with providers is excluded in the future. A year ago, the BMA mentioned that 20 per cent of GPs would be retiring in the next five years. It is a challenge, in itself, to replace them, and the same goes for pharmacies and other practitioner groups—never mind the increased workload pressure that comes with new roles, the pressures from the public and the demands for health care.

The matter should be kept open. The subject of dispensing and pharmacy contracts is one for another day; it deserves a full debate in itself, and I would welcome the Health and Sport Committee taking a look at that in future.

The Convener: Two other members want to comment on this point.

Mary Scanlon: Dean Marshall mentioned negotiating with the Government for the GMS contract. Is it not the case that, when you are a monopoly, you have a very strong and powerful hand in negotiating? Is that not the case, under the contract?

Dr Marshall: Well, the NHS is a monopoly.

Mary Scanlon: But the GPs would be a monopoly provider if we barred commercial companies.

Dr Marshall: Only if we had somewhere else to go, but we do not. It is the opposite, in fact: we suffer because the NHS is a monopoly market. In my experience, it is the exact opposite when we are negotiating on behalf of GPs—we can negotiate only with the Government, and we cannot go anywhere else, so we cannot—

Mary Scanlon: But the health service can negotiate only with you.

The Convener: Let the witness finish. Sorry, Dr Marshall.

Dr Marshall: We cannot threaten to take away our services, so we basically have no power, and I therefore take the opposite view. Can I—[*Laughter.*]

The Convener: Committee, please.

Dr Marshall: I want to make a couple of comments following what Mary Scanlon just said about providers down south. The evidence that she cited was the result of significant extra funding being put in by the NHS in England on top of and above the normal NHS spend. A huge amount of funding was invested. Furthermore, each PCT was told that it had to provide the service. Many trusts did not want to, but it was forced on them. If we got the same level of extra funding that the health service got down south, we could easily provide equivalent or better services.

Community Pharmacy Scotland has commented on the risk, but the bigger risk involves commercial providers. Given the current financial situation, what happens when commercial providers that run lots of practices have their funding decreased, as has happened to GP practices throughout the UK over the past few years? We have not cut our services, but that is what commercial providers will do. If the providers become insolvent, someone has to pick up the pieces—and providers can run hundreds of practices, not just individual ones. We are indeed talking about risks. The Scottish Government has pointed out the risk, and there are plenty of other risks, mostly to patients, of going down the route that is being discussed.

Theresa Fyffe: I return to the point about enhanced services. The Government has allowed boards to provide enhanced services, which is an interesting way for boards to get close to local community planning needs and to particular issues in remote and rural areas. In its recent report, Audit Scotland cited Lanarkshire NHS Board, which has gone back to providing its own drug services in a very different way, because that is what met its needs. That is a positive way forward,

and perhaps that is where there is a difference between Scotland and England. We are saying that boards should get close to their local communities and should find ways of providing services accordingly. I support that.

Rhoda Grant (Highlands and Islands) (Lab): The evidence that we have received this morning seems to tell all of us that GPs are simply trying to protect what they have. They are private practitioners. Nobody has been able to tell me the difference between a private practitioner and a commercial one. That distinction seems to be splitting hairs. [*Interruption.*]

The Convener: Oh! Excuse me, Rhoda. That is Richard Simpson's phone going off, so no Danish pastry for him. That is the ultimate punishment in the Health and Sport Committee.

Dr Simpson: It is too late.

The Convener: He has already had one. Now all the members are rummaging and checking their phones. Sorry, Rhoda.

Rhoda Grant: Not a problem.

It has always seemed a huge anomaly to me that although people talk about health service privatisation, the biggest part of the health service is private—the part involving GPs. I have a suggestion that follows on from your evidence. If all GPs were salaried and employed directly by the NHS, that would overcome all the problems that we are talking about and would get rid of privatisation in the health service. [*Interruption.*]

The Convener: Oh—technology! That is the difficulty with mobile phones.

Dr Marshall: GPs are not private practitioners. We are not private. We are part of the NHS pension scheme, which puts us in a different situation from commercial providers. In our view, commercial providers are those who are responsible to groups of shareholders, but that does not apply to GPs. GPs have independent practices and are independent contractors, as are pharmacists, opticians and dentists. We are independent contractors who contract solely with the NHS and we are not responsible to groups of shareholders, as commercial companies are. That is what we consider to be the difference.

Rhoda Grant: Who are you responsible to, then? As private contractors, you are not responsible to the NHS, you can opt in and out of delivering services and you do not have shareholders on your back. Where is the pressure on behalf of the patient for the delivery of services? Like Mary Scanlon, I cover an area where GPs have opted out of delivering services and where it has fallen to nurses and first responders to deliver them. You will understand our frustration when you say that GPs deliver a service and do so well, but we see that that is not the case on the ground.

Dr Marshall: We are independent contractors, not private providers. Where GPs have opted out, that is because of the service that was offered and the cost. There is no evidence that commercial companies can provide the service better for less money and there is clear evidence that they cannot do so.

Enhanced services were mentioned. GPs gave up a huge number of things when the new contract was introduced in 2004, one of which was preferred-provider status in relation to enhanced services. We do not have that status, so anyone can provide those services, but no one has taken that up. There was a push by Government to encourage pharmacists to take up a lot of work, but they have not done so, because they cannot do it for the price that we do it for. We do many things that do not make good financial sense, but we do them because of our patients. I am responsible to my patients every single day, because I see them across the table in my consulting room. No one else does that. Our concern about commercial providers is that they will pull out of services. We do not do that—we continue to provide them even when doing so does not make good financial sense.

Out-of-hours services are a prime example. We have never had a proper debate about out-of-hours services in Scotland, and that is one of the things that our document "General Practice in Scotland: The Way Ahead" tries to achieve. GPs were offered two options on those services: to return to what they were doing previously—which was unsustainable because of the changes in demand and in the medical workforce—or to take on NHS 24. That is why we got into that situation and missed the middle ground. We are happy to have a debate with anyone about how we can provide better out-of-hours services in Scotland, but we were not given the opportunity at the time—we were simply offered two options. That goes back to my point that if we are contracting with a monopoly—the NHS—we have nowhere else to go.

So there is a variety of issues. The issue is not quite as clear cut as saying that GPs do not want to provide services. Drug services are a good example. In some areas, boards have decided to provide those services themselves. I understand that success on that is varied, but boards have the opportunity to do things that best suit the population in their areas.

The Convener: I will let Ms Fyffe and Mr MacKinnon answer before Rhoda Grant responds to that point.

Theresa Fyffe: I disagree entirely with what has been said about enhanced services. Although the Government provides boards with a minimum amount of funding for enhanced services, evidence suggests that they are increasing their spending on such services—I am not saying that they did not use enhanced services at the beginning—and are now using the model differently. The Audit Scotland report to which I referred shows examples of how boards have addressed local needs by providing enhanced services. That might be done by entering into a contract either with the GP practice or with others. I believe that the enhanced services mechanism could be utilised further in the future. The mechanism was not taken up at first, but there is evidence that its use is growing and increasing.

Alex MacKinnon: For primary care contractors, the ownership, investment and commitment—as well as, ultimately, the risk—rest with the contractor owner who has the contract with the NHS board to deliver NHS services. In pharmacy, we have a mixed model, in that we have independently owned individual contractors as well as large multiples, which are responsible to their shareholders. I do not think that the large multiples provide any less a service than the single independent contractors who have a contract with the NHS.

The Convener: We are perhaps straying a bit, but I think that we are hearing important background information on the conflict between what might be called public delivery and commercial delivery.

Rhoda Grant: To return to my original question, why cannot we just employ all GPs directly under the NHS—we could then have shift work in areas where out-of-hours cover is difficult—rather than incur the enormous costs that are currently involved in providing those GP-led services? For me, the answer to the problem is to take everyone under the NHS as direct employees.

Dr McCarron-Nash: For several reasons, that would be bad for patient care. First, it would stifle the innovation that is being sought. Secondly, it has never been offered. Thirdly, as someone who has been both a salaried GP and an independent contractor who is a partner, I always describe the issue as being a bit like the difference between driving a bus and driving a train. They are completely different jobs. Independent contractors tend to stay in a practice where they look after patients over the long term, so they have a different relationship and investment in that local health economy. As a salaried GP, I was employed to provide a certain number of hours' service to patients. Yes, professionally, the job is done to the same standard, but it is a very different type of job, in that the salaried GP is paid to go to work and can then leave. I think that many independent contractors go far above the terms of their contract and stay until the job is done. Even when funding has been withdrawn from the GMS contract over the past three years, patient satisfaction has continued to remain high and GPs have continued to deliver services, despite the decrease in funding for practices. I think that we get excellent value for money from our independent contractors.

Rhoda Grant: Arguably, health professionals who are directly employed do not just leave when work still needs to be done. In all fields—certainly in hospitals—professionals do not leave the job just because they clock in and clock out. I resent the implication that only those who have a direct financial stake in delivering the service will go the extra mile and that those who do not have such a stake will not care what happens to the patient.

Dr McCarron-Nash: That is not what I said. Salaried GPs still have a professional duty of care, so of course they stay until the clinical contact is completed. However, they tend to work in a different way. Under the European working time directive, if everyone is employed, they will need to leave after 48 hours and hand on to someone else. That is a different way of looking after patients. We would run the risk of losing the relationship that independent contractors have with patients. It is a different way of working. In England, where there are an awful lot more salaried GPs, evidence suggests that salaried GPs tend to stay in post for less time and move on more quickly. That will have an effect on patient care.

Ross Finnie (West of Scotland) (LD): Can we hear Ms Fyffe respond to that grotesque allegation of unprofessionalism by nurses and other salaried professionals? That is dreadful.

Dr McCarron-Nash: That is not what I said.

The Convener: Let me say to committee members that I think that Dr McCarron-Nash was trying to make a point about the relationship that a GP contractor might have with an entire family possibly over the patient's lifetime—from whenever the woman becomes pregnant, if we consider the issue from a woman's point of view, right through to old age—because the GP contractor stays in that practice. Therefore, there is a different kind of relationship. I do not think that Dr McCarron-Nash meant to impugn the professionalism of other health care workers.

Dr McCarron-Nash: I did not mention nurses at all. I would never imply that another professional group is not professional—that is not what I said.

Ross Finnie: Please explain to me why you said that salaried people—

Dr McCarron-Nash: I did not say that. I said "salaried GPs".

10:45

Ross Finnie: You did say that. You made the point that you had a different relationship with a practice because you were independent and not salaried, and that, if you were salaried, you would clock on and clock off and be worried only about your time and not about your patient. I regret to say that that is what you said.

Dr McCarron-Nash: No, I never said that. There is a difference between someone who is employed to provide a service, which may mean seeing patients, and someone who runs a practice. A lot of what GPs do falls outside the face-to-face time with their patients. As a salaried doctor in the posts that I have had, I have worked in a clinical capacity and—yes—I have stayed until the job is done, like any professional. However, that is a very different role from running the practice, which involves a much more longitudinal relationship with my patients. That is the evidence from England, where salaried GP turnover is higher. I did not comment on other professionals.

Theresa Fyffe: In fairness, it would be reasonable to say that Dr Marshall and Dr McCarron-Nash did not comment on nurses. The debate about salaried versus independent is interesting, but I am not going to go there. Dr Marshall and Dr McCarron-Nash feel very strongly about that issue, given their particular role. However, I will say that someone's commitment to a service is not necessarily different depending on whether they are salaried or independent.

I can give you countless examples of the commitment of people who run services, such as homelessness services. The people who run the service in Glasgow that I know about are there at 10 o'clock and 11 o'clock at night because they feel responsible for it. Further, I spent four hours on Friday night in accident and emergency in Edinburgh royal infirmary. Three members of staff did not turn up for various reasons and a receptionist did not turn up. The receptionist who was there that night freely stayed on for two hours to cover the service: she made a commitment. I know that that was at 2 o'clock in the morning, because I took her home when I left.

We need to be careful about saying that there is a difference in commitment between salaried and independent people. It is important to understand that health care professionals do not require to be independent contractors to give a commitment to innovation or whatever.

The Convener: I do not think that the committee thinks that. I think that we may have gone down the wrong route here. I accept that Dr McCarron-Nash did not mean to impugn other professionals in talking about the slightly different relationships involved in the long-term treatment of a patient or family and so on. I see that Miss Fyffe is nodding to that. We will move the discussion on from that issue.

Dr Simpson: My basic concern is monopolies, which are not a good thing because we do not get competition with them. There is evidence that we do not get competition in the sense of people being prepared to look very carefully at what they do. The problem with general practice in Scotland, which is pretty good on the whole, is that there are areas where it is not good and there is no significant mechanism to improve it. I will give two examples, one of which is about the management of care homes and the patients there. The recent evidence about the use of drugs in care homes is not new information, as that practice has been going on for years. The primary care aspect of the management of care homes has been neglected for many years. Individual patients register with individual GPs who have no expertise in dealing with such patients, there is no partnership with pharmacists, which is very important in terms of the drug issue, and there is no integrated care.

The other example is a much more fundamental one about the right of the independent contractor to opt in or opt out of services. I worked for a spell in an area in Glasgow with a very high density of drug users. There were three practices in a particular health centre, two of which took patients with a drug problem on to their lists, while the third did not—it refused. If someone came in and said that they had a drug problem or were on a methadone script from my specialist service, they were not allowed to register with that practice. Which of those three practices do you think got the new award from the Royal College of General Practitioners for excellent practice? It was the one that did not take the drug addicts. In my view, that practice is not providing a service to that community.

What concerns me about the bill is that it will exclude something that has not been a problem in Scotland up to now. We heard evidence last week that Harthill was the only area in which the possibility of a private company providing GP services has been an issue.

As I said last week, I am concerned that if we get to a situation in which the number of medical students in Scotland is reduced—Crerar recommended that, as part of the process of reducing costs in Scotland, we should reduce the number of medical students by 40 per cent because that is the extent to which we overproduce them, and I think that future Governments will be tempted to move in that direction—we will have the same undersupply

problems that were experienced in England, where the level of practice in many areas, particularly in London, was appalling.

I have one more point to make before I ask my question—I assure the convener that I am coming to it.

The Convener: I have lost the will to ask members of the committee whether that is the case; I just let them speak.

Dr Simpson: There was an excellent article in the employment section of the *British Medical Journal* about the setting up of a quasi-commercial operation in London, which has taken over a number of practices that were regularly staffed by locums because no GPs would take them over. If a similar situation should arise in Scotland, the bill will mean that a Scottish health board would not be able to ask such a commercial company to provide a service to patients. What guarantee can you give us that that will not happen in Scotland? Surely a provision of the sort that you seem to favour, whereby the use of a commercial company should be a last resort, would be preferable to ruling it out altogether.

Dr Marshall: You have raised a whole load of issues, which I am happy to deal with, but I must provide a bit of historical perspective. The contract that was brought in was negotiated by the BMA and the Government at the time. The Government's big thing was to remove the preferred-provider status of GPs so that we would not be the only people who could provide services. The Government wanted to have a market and it got it, but very few other people have ever entered that market because of the cost of providing those services.

The care homes issue is interesting. NHS Greater Glasgow and Clyde set up its own service and NHS Lothian has been considering doing the same. The problem is that every time they cost the service, it turns out that it costs a lot more money than they were paying GPs to provide it. That is the problem—it is a question of money.

I do not know which three practices Dr Simpson was referring to, but not all practices are funded to the same extent. Practices' funding is based on historical funding. We would be delighted to have a discussion about how to even out some of the issues to do with the funding of practices in Scotland.

I am not sure which quality award Dr Simpson was referring to. If it was the Royal College of General Practitioners' quality practice award, that is something that practices need to go for—to be eligible for it, a practice needs to enter the competition and to pay money to do so. Did the other two practices even go for the award? The fact that a practice has received the QPA indicates that a certain standard has been met, but it is necessary to go for that standard. Many practices, including my own, choose not to go for it.

Practices that refuse to register people or which discriminate against people are breaking their contracts, and the health board needs to sort that out. A practice cannot refuse to register someone just because they have a drug problem. It can opt out of providing care because it is additional to normal NHS care, but if it refuses to register someone for GMS, it is breaking its contract and it is up to the board to take remedial action.

The Harthill situation was extremely interesting. The fallout from the board's decision to go down a particular route was amazing. Various public meetings were held, because the public recognised the risks and were extremely concerned about what might happen. I take you back to the fact that there is no evidence that a commercial provider would be able to resolve such issues, which are to do with funding. In our view, many commercial providers have taken on contracts as loss leaders. The Tower Hamlets situation has been mentioned. We have members who were intimately involved in the tendering process in Tower Hamlets, and we could give the committee some background on that, if it would like. Commercial companies such as Tesco or Virgin often use loss leaders. Our understanding of why commercial providers have taken on such contracts is that they thought that they might be given lots of other contracts. That is commercialisation for you, and that is our concern.

Dr Simpson: A number of the companies that have been set up in England have been set up by general practitioners. People such as Richard Smith are heavily involved in that.

Ian McKee: He is not a GP.

Dr Simpson: No, he is not. He is a former editor of the BMJ.

Dr Marshall: He is an employee of a large, worldwide company. He is not a partner.

Dr Simpson: No, but he is heavily involved.

I know that you are collecting evidence of where things have gone wrong, but will you look at the other side of the argument? In areas that were poorly served, where there were repeated locum services that did not provide a good service, there is evidence that the new system has provided a better service. Will you look at that, too?

If the bill is passed, what would happen if the Government of the day wanted to set up town centre practices for commuters at railway stations of the sort that exist in England? Would they have to be contracted with a GP?

Dr McCarron-Nash: You asked whether we would be looking at where the system worked well as well as where it did not work well. We have to remember that the commercial firms that have won the tenders have had an awful lot of pump-primed money. Each polyclinic or GP-led health centre has had an extra £1 million per PCT spent. The playing field is certainly nowhere near level. In three or four years' time, when the money has to come out of the PCT, the issue will be what effect that has on local services. GPs who already have contracts with the PCTs were not offered the chance to provide extra services, so we are not comparing like with like.

Ross Finnie: It is always interesting that when we consider the principles of a bill we expose slightly different issues from those that we started asking about. I do not think that any of the members or witnesses is unclear about what the Government is trying to do in placing serious restrictions on the development of private contractors in the NHS in Scotland. However, the more one looks at the wording of the sections, the more questions one has about whether they will deliver what the Government intends.

I seek clarification on a few points. First, Dr Marshall and Dr McCarron-Nash talked about our being cautious because what the bill proposes could have ramifications across the UK. I am interested in that, because the rest of the UK does not seem to have been too concerned about the ramifications on us of its developing private medicine. Nevertheless, perhaps we should be cautious about the implications for the rest of the UK, although the provisions are intended to impact only on practices in Scotland.

Secondly, if we are seeking to restrict the development of private contractors, how does that compare with allowing independent GP practices to develop different models? That is what Dr Simpson was concerned about. You have made much of the independent and different nature of GP practices. Is that to be totally constrained by the current contract?

Theresa Fyffe and the witness from the Community Pharmacy Association made much of this. We are looking at provisions that have to endure for the next 20 years, not provisions that deal with the past. Are we talking about a UK contract being stuck in aspic jelly, which would mean that different developments north and south of the border could not be reflected in different contractual arrangements and that the option to look at provisions that might more properly address those issues would not be open to the committee?

11:00

Dr McCarron-Nash: I will answer the first couple of points. You may have heard of the BMA's support your surgery campaign, in which I was involved. The public in England were not asked about the change in policy towards a more commercial system: 1.3 million people have said that they are not happy with the route taken by the Department of Health in England. I agree that everything that happens in England seems to arrive north of the border at some point, and there is a concern that if we do not close the loophole, we will not future-proof general practice in Scotland.

The four-country GMS contract was negotiated by the BMA on behalf of GPs as the contract holders. If the situation is changed to allow other people to hold the contract, there will be an effect in other areas. The people who subsequently hold that contract, as Dr Marshall said, will have no way to negotiate their terms and conditions of service, which is a concern.

There are certain things in which only GPs can be involved, such as issues with immunisation, so there will be problems if the contract is changed to include other health professionals. Dr Marshall will expand on that point.

Dr Marshall: Under the bill, there will still be a variety of contractual options in Scotland. We will have GMS, which is an independent contractor model. We will also have section 17C, under which boards can set up practices. That provision has not been used very much recently, for a variety of reasons—for example, the money that was previously put aside for that purpose no longer exists. As Dr Simpson said, section 17C can also be used to set up other services, such as care homes. The contractual options are available, and we are not talking about removing them, but they are not being used, because there is no longer any identified funding.

It is my understanding that the only section 17C practices that have been set up recently are on some of the remote islands, because they would not be viable for a commercial company to run. We are talking about removing the possibility of commercial companies coming into Scotland and taking over huge swathes of practices, which would cause problems, as it has done in England. However, health boards can still pursue a variety of contractual options if they want to, for example if a new building is needed.

There are problems with the GMS contract. For example, it is difficult for boards to set up new practices in new housing developments, but that comes back to the issue of money again; the problems are not to do with the contractual options. Section 17C allows locally negotiated

contracts without doing all the GMS stuff. In addition, section 2C of the 1978 act includes a salaried option, so that can be used. Boards have not taken up such contractual options in any great numbers, but there are examples around the country. Those options will remain: we are not asking for them to be removed.

Theresa Fyffe: To return to the point about developments arriving north of the border, the most recent health service changes show that that is not happening in the way that we thought it did for a number of years: we thought that if something happened in the south, it came to the north. I am part of a UK organisation, so I can see the whole health care picture. We consider various things and say, "That does not fit in Scotland." We have learned from other countries as well as England, so perhaps too much is made of that concern.

On Ross Finnie's point, the contract was negotiated UK-wide, and there is currently no means for others to be involved in it, which is quite right. I understand why the Government has said that it cannot have eligibility equity between section 17C and the GMS contract at the moment, but there is no reason why it could not reconsider in the future, because the conditions are part of the UK contract.

We are learning about devolution. Given the recent evidence that has emerged, when we examine the UK contract—which affects terms and conditions—we have to rethink what we provide. It is wrong to say that changes cannot happen, which is why we are saying that the opportunity should be left open, but we have not yet had that debate or considered the impact.

Ross Finnie: One of the difficulties—or rather, one of the challenges—in discussing the principles of the bill at stage 1 is that we need to look forward. Dr Marshall makes the point that, when negotiations take place that involve devolved Administrations but a single outcome is sought, a compromise is inevitably involved, but it is not just a compromise between the principle and the negotiator; we also have the inter-devolved-Administrations issue. Some of the comments that have been made therefore seem a little odd.

The NHS is run by a Government that is absolutely committed to the general principles of a mutual service, and that is not something that I wish to compromise. That raises a question as to whether the bill creates a framework that envisages UK negotiation on the contract with the inevitable result that the drift that has happened—whether it has been consulted upon or not—leads to a compromise that is not provided for anywhere in the legislation.

Alex MacKinnon: We can do something radically different. We did that with the pharmacy contract in Scotland: we stood it on its head and moved the focus away from the importance of prescriptions towards improving clinical outcomes for patients with new pharmaceutical care services. We now have a radically different contract from England and Wales, with patient registration and capitation. In fact, it is unique in the world. We can engage with the mutual NHS and produce something different. We are still negotiating that contract at the moment.

Dr Marshall: Next time I come to the committee, I will have to prepare to discuss any part of the contract, because a lot of what we have discussed is not in the bill. However, I am happy to discuss it, and it is great to have the opportunity to do so.

The Convener: I let the discussion run because it is useful background on the issue of public versus private. It is as simple as that.

Dr Marshall: On the UK contract and the Scottish contract, as Theresa Fyffe said, we have the benefit of having a second bite at the cherry when matters come back to Scotland. From day one, there have been differences between the contract in Scotland and the contract in the rest of the UK, and each of the devolved nations has bits that are different from the UK contract, even involving the fundamentals. For example, funding is allocated in practices in Scotland according to a Scottish allocation formula and not a UK one, so the position is different from that point of view, and the directed enhanced services in Scotland are different from those in England.

I am happy to discuss that, but on the quality and outcomes framework, which is evidence-based, clinical stuff, I have yet to be convinced that the standards in the middle of London and in the Shetlands should be different. There are some benefits from the UK contract, and we can make bits of it Scottish if we want to. We have done that quite successfully over the years.

Ross Finnie: I accept Dr Marshall's point. He has to understand that we have broadened out the discussion because we are discussing the general principles of the bill. The next difficulty will come when we discuss the wording of the bill line by line, but first we have to be clear about whether the principles that the Government is enunciating are met by what is proposed, so it is helpful to consider the contextual framework.

The Convener: Helen, is your question a short one? I want to move on.

Helen Eadie: I seek clarification of Dr McCarron-Nash's answer to Dr Simpson. She said that £1 million was injected into the primary care trusts, but that was a one-off pump-priming exercise for infrastructure, which will not

necessarily be reflected or required further down the line.

Dr McCarron-Nash: That is correct, there was pump-priming, so we are looking at satisfaction rates and access that are not comparable with existing investment in GMS. Local surgeries have not been offered the chance to extend their hours or provide other services. That is our argument.

The Convener: That is on the record. I recall the point being made. It was a one-off. Helen Eadie's question was, "Will this not be repeated?"

Helen Eadie: However, Dr McCarron-Nash inferred that the funding might be required further down the line as well.

Dr McCarron-Nash: Yes. I inferred that there could be a knock-on effect on local health economies in the future. Obviously, if investment is made in something, there will be less money for other things. Difficult choices might have to be made.

Helen Eadie: I find it difficult to reconcile the fact that the funding was a one-off and the fact that it will be needed further down the line. That is all.

The Convener: I was satisfied with the explanation that we got the first time; nevertheless, that is on the record.

Ian McKee: I will please Dr Marshall by returning to the bill, but my question is for Theresa Fyffe and Alex MacKinnon. Section 30, which is in part 2, on primary medical services, will insert proposed new section 17CA into the 1978 act. The proposed new section concerns "Primary medical services: persons with whom agreements can be made" and says:

"A Health Board may … make an agreement … with …

(b) a health care professional (other than a medical practitioner),

(c) a qualifying partnership".

It further defines the latter as a partnership in which:

"(i) at least one partner is a medical practitioner or other health care professional,

(ii) all other partners are individuals".

In previous evidence, "other health care professional" has been defined as nurses, pharmacists or practice administrators, so it is possible to have an agreement to provide primary medical services between nurses, administrators or pharmacists as long as all the other partners are individuals.

My reading of that is that it would allow the sort of initiatives that Theresa Fyffe suggested, because nurses could get together to ask for a primary medical services contract. I appreciate that there would be more difficulties with pharmacists but, by my reading, the bill would allow an independent pharmacist to offer a service with a salaried GP. However, I accept that it would not allow a multiple to do that, because a multiple is a commercial organisation. It seems to me that the bill is a lot more flexible than Theresa Fyffe and Alex MacKinnon have implied. I ask both of them to comment on that. Perhaps I have misunderstood the bill and they have a different understanding.

Theresa Fyffe: You are absolutely right that, at the moment, under section 17C of the 1978 act, health boards can contract with health care professionals on the list that you read out to provide primary medical services. The Government proposed equality of eligibility criteria between primary medical services and the GMS contract but stepped back from that. You are right that eligibility equality is possible in one aspect of primary medical services, but we say that it should be opened up across the board. The Government stepped back from proposing equality of eligibility criteria because there was a view that it was a step too far at this stage. We say that there should be consultation and debate about the very thing that you are exploring: what would the difference be between providing primary medical services under section 17C or the GMS contract? What difference would that make? We have not debated that question. My point is that we never got into that debate and understood what such a proposal would look like.

The Convener: That was a very clear explanation of all the different contractual arrangements that even I understood.

Alex MacKinnon: We were unclear about the intention of that bit of proposed new section 17CA. It needs a wee bit further scrutiny.

Ian McKee: It seems quite clear.

The Convener: Michael Matheson wishes to ask a question about part 1 of the bill, which the witnesses may or may not wish to answer.

Michael Matheson: It is only right that the witnesses have the opportunity to comment on part 1, which is another significant part of the bill. I suspect that they will largely agree with one another on what the Government is trying to do on the control of tobacco advertising.

The tobacco companies and associated organisations in the tobacco lobby questioned in some detail the evidential basis for the proposal to ban the display of tobacco products in shops. They said that there was no evidence that it would have any impact on the numbers of smokers. It is clear from your written evidence that all three of your organisations support the proposal. It would be helpful if you explained a bit more why your

organisations believe that it is important that the display of tobacco products in shops is banned and on what evidence you made that decision.

11:15

Alex MacKinnon: As practitioners in primary care, we are all committed to getting people off smoking through smoking cessation schemes and so on. A ban on smoking in public places was introduced by the Smoking, Health and Social Care (Scotland) Act 2005. It is logical to take that a bit further now by going down the route of prohibition of the display of tobacco products and making tobacco products less easy for youngsters to obtain. The statistics speak for themselves with regard to the number of 15-year-olds who smoke, which we think is unacceptable. However, there must also be more education to link in with the prohibition that is being planned.

Theresa Fyffe: We are members of the Scottish coalition on tobacco and we absolutely support the action that is proposed. The facts and figures show that an increasing number of 15-year-olds and other children are smoking, and we think that the proposals send a clear message that that needs to be stopped. That is a good health message.

Michael Matheson: Both of you have referred to the figures on young people smoking. However, the tobacco companies led us to believe that the banning of tobacco displays in other countries did not appear to have any impact on reducing the number of young people who smoked.

Theresa Fyffe: The solution involves a raft of measures. If you introduce a prohibition on the display of tobacco products without also introducing all the other necessary measures, such as smoking cessation clinics, of course it will not have the desired effect. I would be surprised if you could get evidence that any one measure had had an impact. Rather, what will have an impact is the raft of measures, as that will send a clear message to the Scottish population that the problem must be addressed. A cultural change is needed. If you are saying that it is okay to display cigarettes in the way that they currently are, you will not get across a message that will bring about a cultural change.

It is important to focus on young people, because what that generation does now will have a great public health impact at a point in time when many of us around this table are no longer in our jobs. I have got young people and I am concerned about the public health issues that they are going to face when I am no longer in the job that I am doing.

Alex MacKinnon: You will find that, in countries that have introduced an apparent total ban on the display of tobacco products, the tobacco companies have found ways of doing more direct advertising.

The Convener: Such as?

Alex MacKinnon: Sending out direct mailshots and so on.

Theresa Fyffe: Texting.

Dr Marshall: If the tobacco retailers do not think that banning tobacco displays has any effect, why are they against banning them, and why are they spending such a huge amount of money on advertising?

Our written submission gives some evidence on studies that have been done which show that advertising in local shops gives schoolchildren and adolescents brand awareness and increases their interest in trying certain brands. We have evidence that the gantries in shops affect children and bring about greater brand recognition, which I imagine is why tobacco retailers have them.

There are many issues around advertising to children. In the United States of America, a significant number of retailers have their cigarettes beside their sweets, because they know that that has an effect on increasing brand awareness and also because it normalises cigarettes—if children see cigarettes on sale beside bread, milk and sweets, they will think of them as a normal product.

The Convener: You keep using the word “advertising” in a broad way. Tobacco advertising has been banned, of course. When you talk about cigarettes being advertised to children, what are you talking about, in practical terms?

Dr Marshall: Having the brands in front of children in shops is a form of advertising, as far as I am concerned. Perhaps my definition is different from that of others. I am talking about point-of-sale advertising, which normalises cigarettes. I know that people have said, “What about alcohol?” However, that is a different case, because we believe that there is probably a safe level of alcohol intake, but there is not a safe level of tobacco use. That is why we support the Government’s proposals.

The Convener: I hope that the committee does not mind, but I would like to draw this evidence session to a close, as we have rather a lot to get through today.

I thank our witnesses for their evidence.

Subordinate Legislation

Personal Injuries (NHS Charges) (Scotland) Amendment Regulations 2009 (SSI 2009/193)

11:20

The Convener: Item 2 is consideration of subordinate legislation—I can see that Dr Simpson is riveted by the subject.

The purpose of the regulations is to amend the Personal Injuries (NHS Charges) (Amounts) (Scotland) Regulations 2006, which make provision about the charges that are payable under the scheme for the recovery of national health service charges in cases in which an injured person who receives a compensation payment in respect of injury has received NHS treatment or ambulance services.

No comments have been received from members and no motion to annul has been lodged. The Subordinate Legislation Committee considered the instrument at its meeting on 26 May and wishes to draw no issues to our attention, so do we agree that we do not wish to make any recommendations on the instrument?

Members *indicated agreement.*

The Convener: As previously agreed, we will now move into private session for item 3, which is consideration of a draft report on the committee's inquiry into child and adolescent mental health services.

11:21

Meeting continued in private until 12:32.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, Scottish Parliament, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Monday 15 June 2009

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

Single copies: £5.00
Meetings of the Parliament annual subscriptions: £350.00

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committees will be published on CD-ROM.

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at Document Supply.

Published in Edinburgh by RR Donnelley and available from:

Blackwell's Bookshop

53 South Bridge
Edinburgh EH1 1YS
0131 622 8222

Blackwell's Bookshops:
243-244 High Holborn
London WC1 7DZ
Tel 020 7831 9501

All trade orders for Scottish Parliament documents should be placed through Blackwell's Edinburgh.

Blackwell's Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0131 622 8283 or
0131 622 8258

Fax orders
0131 557 8149

E-mail orders
business.edinburgh@blackwell.co.uk

Subscriptions & Standing Orders
business.edinburgh@blackwell.co.uk

Scottish Parliament

RNID Typetalk calls welcome on
18001 0131 348 5000
Textphone 0845 270 0152

sp.info@scottish.parliament.uk

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by RR Donnelley