HEALTH COMMITTEE

Tuesday 28 October 2003
(*Afternoon*)

Session 2

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HEALTH COMMITTEE
10th Meeting 2003, Session 2

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Mr David Davidson (North East Scotland) (Con)
*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

*attended

COMMITTEE SUBSTITUTES

Robert Brown (Glasgow) (LD)
Paul Martin (Glasgow Springburn) (Lab)
Mrs Nanette Milne (North East Scotland) (Con)
Ms Sandra White (Glasgow) (SNP)

THE FOLLOWING ALSO ATTENDED:

Dr Andrew Walker (Adviser)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Graeme Elliot

ASSISTANT CLERK

Hannah Reeve

LOCATION

The Chamber

Scottish Parliament

Health Committee

Tuesday 28 October 2003

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:05*]

Item in Private

The Convener (Christine Grahame): Good afternoon. I welcome committee members back from what I know was a busy recess. Most people were working—I put that on the record for all of us. Welcome to the 10th meeting in session 2 of the Health Committee. I ask members to ensure that mobile phones and pagers are switched off.

Item 1 is consideration of whether to take item 4 in private. I ask the committee because the item deals with the draft report on the budget response to the Finance Committee, and it has been the practice in committees to discuss draft reports in private. Mike Rumbles has kindly advised me that he wants to make a point. The floor is yours, Mike.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): You quite rightly say that that has been the practice of this committee, and of many other committees in the Parliament, so it is an issue not just for the Health Committee. A general trend of taking items in private has developed over time. Although you say that it has been the general practice of the committee to take such items in private, it is not presumed that they should be taken in private. In fact, rule 12.3.4 of the standing orders states that

"Committee meetings shall be held in public except as mentioned in paragraph 5",

which gives the committee the right to move into private session. There is a presumption of openness and transparency, which is a founding principle of the Parliament.

I mention this today because if we do not take item 4 in private, the whole of this meeting will be in public. As you know, the Parliament records many statistics, and we regularly see how many meetings are held in public and how many are held in private; it helps if we hold meetings in public.

We discussed the draft report on our budget response to the Finance Committee in private session at the previous committee meeting. It lasted five minutes. Nothing controversial was discussed. In my view, there was no need for privacy at the last meeting, yet we discussed the report in private session.

I would like committee members to think this through. I know that privacy might be convenient, because there will be rambling suggestions about changing sentences or words, but we should be operating in public. I do not see the need for us to move into private session. I hope to ask the committee to take the item in public session. Let us just try it.

The Convener: Are there any other comments? For clarification, Mike, is it your submission that you wish this particular draft report to be taken in public, but that there might be instances where certain reports of a different nature would be taken on their merits?

Mike Rumbles: I agree. We should take them on their merits. We should try to avoid the practice of saying that we will take all draft reports in private session.

Shona Robison (Dundee East) (SNP): I have sympathy with what Mike Rumbles is saying. I think that, on balance, the Health and Community Care Committee considered far too many draft reports in private during session 1 and that that was not always required. There is an important principle here. There is also a perception among the public about all these reports' being discussed in private, which is perhaps not the image that this new Health Committee wishes to give out. I am quite happy to hold item 4 in public today. I do not think that that sets a precedent in any way. It is about common sense. I think that we should hold item 4 in public.

Mr David Davidson (North East Scotland) (Con): I think that the committee should continue with the practice of asking at each meeting at which a report is being discussed whether that item should be taken in private. On the previous such occasion, I suggested that, given the range of views on how we were going to approach the report, we should not have that discussion in the public domain until we had reached a later stage and had thrashed out the fine print of the report. I have no difficulty with taking our consideration of the budget report today in public, but we have to be wary that there will be not just political issues at stake, but other situations where people do not have a full understanding of what is meant in the draft of a report that comes out. It would be better to deal with such situations in private.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I am happy to proceed on that basis—without setting a precedent. It might be necessary for the committee to have a debate on how and when to consider draft reports in public. Nothing has been said about the merits and strengths of the committee discussing its reports in private.

The committee framework has so far been served well by the process overall, right through to when a report is debated in the chamber. There are balances to be struck and debates that can take place on such decisions.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I agree with the previous speakers. If we wish the Executive to be transparent, we have ourselves not only to be transparent, but to be seen to be transparent. As soon as we discuss agenda items in private, people automatically assume that we do not want them to hear about what we are discussing. From what I have heard so far, I do not think that there has been any need to discuss those matters in private. It is a good thing, however, to have to consider whether something should be taken in private under certain circumstances.

The Convener: I have just taken some advice on the technicalities. It would be useful for Andrew Walker, our adviser, to take us through the report. The paper itself is not in the public domain, although it can be put in the public domain if the committee agrees to discuss it in public today. I have no difficulties with that myself, as it does not set a precedent, with such decisions' being decided on a case-by-case basis. I share the view of other members that there might be occasions when, for a variety of reasons, it would be appropriate to discuss reports in private. When we come to our discussion—if we decide to take it in public—I will invite Andrew Walker to speak to the draft report and lead us through it. The draft report could then be added to the committee's public papers following the meeting. Are members content that we do that? Does anyone not wish us to proceed in that way?

Mr McNeil: I would just point out that there is an immediate impact on the committee's work. Our discussion on the draft report will now be on the public record. The management and delivery of the report has already been compromised, as it were. It will now be out there. Normally, we would present a completed piece of work to the public in a more managed way. That is of immediate consequence.

The Convener: If we choose to discuss a draft report in public again, we need to take a view on our approach to that report beforehand.

Kate Maclean (Dundee West) (Lab): I am aware that we are reporting to another committee, so the draft report will be in the public domain before the committee to which we are reporting will have had sight of it. I am not saying that that is a reason not to proceed with the item in public, but we should be aware that that might create certain difficulties with some reports.

Mr Davidson: On this occasion, the Finance Committee will deal with its report in private, sifting through all the information from the various committees. What is before us now will not be what comes out through the Finance Committee's report.

The Convener: I take Kate Maclean's point.

Kate Maclean: It would not be courteous of us to discuss a report in public before the lead committee had sight of it.

The Convener: It is right that we should give the lead committee notice.

Kate Maclean: I am not talking about the present circumstances; I am just saying that that is an issue that we should be aware of.

The Convener: That point is well made.

Do members agree to proceed with our consideration of the draft report on the budget process in public?

Members *indicated agreement*.

Subordinate Legislation

National Health Service (Optical Charges and Payments) (Scotland) Amendment (No 3) Regulations 2003 (SSI 2003/431)

National Health Service (General Ophthalmic Services) (Scotland) Amendment (No 2) Regulations 2003 (SSI 2003/432)

Food (Star Anise from Third Countries) (Emergency Control) (Scotland) Revocation Order 2003 (SSI 2003/437)

National Health Service (General Medical Services) (Scotland) Amendment (No 3) Regulations 2003 (SSI 2003/443)

14:14

The Convener: We move on to item 2 on the agenda—subordinate legislation. Members have before them four instruments for consideration under the negative procedure. The Subordinate Legislation Committee made no comment on the Food (Star Anise from Third Countries) (Emergency Control) (Scotland) Revocation Order 2003 (SSI 2003/437), but it did comment on the other instruments. As no member of this committee has any comments, I will make an observation on paper HC/S2/03/10/1 before I ask what the committee wishes to do. In relation to the National Health Service (Optical Charges and Payments) (Scotland) Amendment (No 3) Regulations 2003 (SSI 2003/431) and the National Health Service (General Ophthalmic Services) (Scotland) Amendment (No 2) Regulations 2003 (SSI 2003/432), the Subordinate Legislation Committee noted in its report:

> "the principal 1998 Regulations … have now been amended on numerous occasions. The Executive is asked to indicate whether it has any plans to consolidate these instruments bearing in mind that in the past it has appeared to accept that consolidation on the fifth substantive amendment is reasonable practice."

There seems to be a habit of continual amendment. We have indicated concerns about going down that route with recent legislation on previous occasions. That point was well made by the Subordinate Legislation Committee and I wanted to draw attention to it.

As no members' comments have been received and no motions to annul have been lodged, can I take it that the committee does not wish to make any recommendation on the four aforementioned statutory instruments? Members have to say something—such as "Yes" or "No"—for the record, because nods and grimaces are not included in the *Official Report*.

Members *indicated agreement*.

The Convener: That is fine—thank you.

Mainstreaming Equality (Correspondence)

14:16

The Convener: We move on to consider paper HC/S2/03/10/2 under item 3 on the agenda, which is on mainstreaming equality. The committee is asked for an opinion so that a response can be submitted to the Equal Opportunities Committee by the deadline of 21 November. We have a number of options. One of the recommendations that the Equal Opportunities Committee made in its report was that we should adopt the equality guidelines that are given in annex B of that report and should agree to use them in drawing up our work programme for the 2003-07 parliamentary session. It was also recommended that the committee should use the equalities checklist during stage 1 consideration of legislation, should detail how it has mainstreamed equality in its annual report and should highlight specific practices.

Helen Eadie (Dunfermline East) (Lab): We warmly welcome the initiative, because it is an aspect of the Scottish Parliament's work that will have a positive impact on the Scottish Executive's work. I hope that we proceed with such an approach throughout the Parliament so that it permeates everything that we do.

Mr Davidson: I believe that all parties in the Parliament that attend meetings of the Equal Opportunities Committee signed up to the recommendations on mainstreaming. However, in relation to the Health Committee, I would not like any individuals in Scotland to be treated differently from other individuals. That is a personal comment about not wanting to go down the positive discrimination route.

Janis Hughes (Glasgow Rutherglen) (Lab): I, too, warmly welcome the Equal Opportunities Committee's report. There is a mixture of issues, for some of which committees would be responsible—for example, the need to ensure, when considering from whom to take evidence, that there is a balanced view and that everyone has an opportunity to contribute. There are also issues for which the Parliament is responsible through the clerks, such as accessibility and ensuring that people who come to give evidence have any aids that they might need.

We learned from a recent evidence session that we must ensure that people who come to give evidence have enough information to enable them to know that they can make a positive contribution. Members of the Health Committee—and of all other committees—are beholden to witnesses to ensure that that information is given to them. That would go some way towards ensuring that everyone comes along on an equal basis.

Mike Rumbles: I am sorry, but I am still not quite clear about what we are being asked to do. I welcome all the work that is being done on equal opportunities, which is a fundamental principle of the Parliament.

The introduction to the implementation notes states:

"It is widely recognised that mainstreaming involves a process of cultural change."

I hope that it does not mean that for the Scottish Parliament. I hope that mainstreaming is already embedded deeply in the grain, as it were. I am a little concerned about the language there.

Under equality guideline 1, on primary legislation, paragraph 6 of the notes states:

"In order to have taken account of equalities issues, the sponsor must have assessed the impact of the legislation on specific groups who can be identified in terms of the grounds or categories listed in Schedule 5 of the Scotland Act".

However, I am not so sure that that is the case. The text that is then quoted in the notes, from schedule 5 to the Scotland Act 1998, is:

"the prevention, elimination or regulation of discrimination between persons on grounds of sex or marital status, on racial ground, or on grounds of disability, age, sexual orientation, language or social origin,"

and so on. I hope that I have not misinterpreted the Equal Opportunities Committee's intention, but it seems to be focusing on groups, rather than on what the act specifies, which is persons or individuals. I am a little concerned—in the context of David Davidson's comments—that individuals should not be left out. I would not want to think that, in our ingrained equal opportunities policies, we would focus on groups in society rather than individuals. A society is made up of individuals, and people are often left out of groups. I have read through the document and I have concerns about it. The equalities checklist in paragraph 14 states:

"The Equal Opportunities Committee recommends that lead committees, as a useful starting point, utilise the equalities checklist during stage 1 consideration of legislation."

Correct me if I am wrong, but I think that that is talking about groups rather than individuals.

Helen Eadie: One of the issues that we always confront when we talk about equality of opportunity is the language that we use. It is not about positive discrimination; it is about taking positive action to remove barriers to people's participation. If there is a barrier that prevents someone who is disabled from accessing this chamber, that is a barrier to equality of opportunity as well as a barrier to an individual. I hope that we

can all sign up to the general thrust of the work that the Equal Opportunities Committee is undertaking.

As always—whether in legislation or in the work that we do as a committee—we must be mindful of the fact that, sometimes, there can be cost issues that we do not really take cognisance of when legislation is passed. I point to the implementation of the Disability Discrimination Act 1995, which has major cost implications for enabling people to access all kinds of services. This lunchtime, I raised with some of my colleagues the issue of accessing railway stations. It is not possible, within the cost situation at the moment, to resolve that issue. That is the kind of thinking that we have to do. We must think about the cost when we are thinking about how we can remove barriers through legislation, and we must ensure that we do not pass legislation without giving full consideration to such issues.

I hope that that takes care of the individuals as well as taking care of the global situation, regarding the removal of barriers. Whether someone has a disability or whatever, it is about our putting barriers in place and society's not providing solutions. It is not about the individual's presenting problems; it is about our not providing solutions to their difficulties.

The Convener: The financial memorandum that accompanies any bill would have to include the cost to the public purse of its implementation, although not the cost to private companies. Some of the costs that the legislation would involve would therefore have to be in the documents accompanying a bill. Nevertheless, I take Helen Eadie's point, as costs to private companies are a different matter.

Dr Turner: While I was reading through the document, I began to wonder whether, given the speed with which we have to process bills, it would take us longer to consider in this context all the legislation that we pass. Paragraph 19 of the notes states:

"If an amendment at stage 2 introduces new policy, committees will wish to ascertain if there is an impact on equalities issues."

It will take time to do that.

I would think that we would all inherently be as equal as we possibly can be and try to take in every person from every group, not only groups. The report is good reading and it is good practice, but I did not really understand how committees were going to do more than they do at present to fulfil all that it suggests.

The Convener: I am looking at what is required of the committee on equal opportunities in any event. We have to make a statement regarding whether policies are discriminatory. We are already required to do that. I think that a statement accompanies every Executive bill, but the committee also takes a view on those matters.

Dr Turner: That is what I thought: it seemed as if we were doing that anyway. If we are thinking about postcode prescribing, for example, inequalities exist. Equality is a great subject to think about. We could go on applying it for ever. I am in favour of it.

The Convener: I am glad to hear it.

Kate Maclean: Things such as postcode prescribing would not really come into equality unless specific individuals within groups that are identified in schedule 5 to the Scotland Act 1998 were being discriminated against. If a particular area that had a high level of black and ethnic-minority people was not getting access to particular services, that would be a cause for concern.

Some members seem to be missing the point about mainstreaming. The committee has always had a responsibility to have regard to equal opportunities. All the subject committees have that responsibility. The fact is that the reason that the Equal Opportunities Committee decided to conduct research into and do a major piece of work on mainstreaming was that none of the committees was mainstreaming. The Equal Opportunities Committee was left with a kind of policing role for equal opportunities throughout the Parliament. Mainstreaming, which seemed to be broadly accepted just before the October recess, means that everybody has responsibility for equal opportunities. That includes all the subject committees, the Executive and the Parliament staff. That takes a bit more time and work. It is far easier to bash on and not have regard to such matters.

I could not understand Mike Rumbles's point. I know that schedule 5 to the Scotland Act 1998 refers to "persons", but there are groups of people who have broadly similar attributes that cause them to be discriminated against. That is what the Equal Opportunities Committee refers to in its report. Groups that are discriminated against are what is always referred to. Those are groups of individuals who have broadly similar attributes that cause them to be discriminated against.

As well as welcoming the report, we should commit ourselves to doing what the Equal Opportunities Committee asks of us. It will take a bit more time and will sometimes cause a lot more discussion in certain areas, but if we are welcoming the report, we should commit ourselves to its recommendations. All the committees should do that. Every member of the Scottish Parliament should commit themselves to mainstreaming in every aspect of their work, not only their

committee work. We should consider it in the way in which we deal with constituents and with organisations in our constituencies. We should ensure that everybody has equal access to the services that we offer.

Mr Davidson: Has the Scottish Executive said that it will adopt the report lock, stock and barrel? Is that a fact or not?

The Convener: We will have to check that.

Mr Davidson: In annex A, which is fairly far back in the document, a responsibility for bill sponsors at stage 1 is laid out. Consider the bill with which we will be dealing with tomorrow afternoon. Annex A asks:

"what consultation has been carried out with the stakeholders"?

Well, for the Primary Medical Services (Scotland) Bill, there has been virtually no consultation with the recipients of health care. The next bullet point in the annex asks:

"have the intended effects of the Bill been set out in accompanying documentation"?

The Convener: Sorry, where are those bullet points?

Mr Davidson: They are in annex A.

The Convener: I am looking at annex A.

Mr Davidson: It is three or four sheets back from the end of the paper.

Dr Turner: They are under the heading "Primary Legislation—Stage 1".

Mr Davidson: My point is about the third and fourth bullet points, which are halfway down the page, under the heading "Bill Sponsor" in the section headed "Primary Legislation—stage 1". I want to give an example, not a statement of position. All members mentioned the small amount of consultation and few opportunities to give views on the Primary Medical Services (Scotland) Bill, as did those who gave evidence on the bill. The fourth bullet point mentions setting out the intended effects of bills in the accompanying documentation. However, the accompanying documentation for that bill did not cover at all the bill's potential effect on the delivery of services in rural and remote areas. I use that only as an example.

How far are we prepared to take consultation and how far does the Executive go? It is all very well for committees to run round saying that we will do this and that, but we work in parallel with the Scottish Executive at all times. Before we come to a view, I would like to know what the Scottish Executive's view is. We must come to a common view with the Executive about how the Parliament should work.

14:30

The Convener: I take your point. On the technicalities, perhaps we should write to the Executive on the issues you have raised about consultation with stakeholders and about policy memoranda. The policy memorandum to the Primary Medical Services (Scotland) Bill covers some issues, but I cannot remember whether it says who was consulted. Policy memoranda usually list who has been consulted.

Mr Davidson: On this occasion, the consultation did not go as far as the committee would want. That is why we need a view from the Executive about mainstreaming equalities.

Mike Rumbles: What Kate Maclean said prompted me to speak again. The nub of the issue is about individuals and groups. Although I understand what Kate said about people who have broadly similar attributes getting together in groups and questioning whether they are being discriminated against, the danger of compartmentalising people and not treating them as individuals is that, in attempting to make the process non-discriminatory, we risk being discriminatory.

I did not want to get this far into the debate, but I will use as an example the issue of domestic abuse, which the Parliament has discussed, although it is not specifically a health issue. All Executive and Parliament documents claim that domestic abuse is an extremely important issue. In debate we often hear from members who try genuinely to treat people equally, but who argue that because most domestic abuse occurs against women we must focus on that group. I do not disagree with that, but the danger of focusing on that group is that we might ignore other groups, such as the group of men who suffer from domestic abuse. That is far less of an issue, but it is still an issue to those individuals.

I use that example to try to get across the reason why I am reluctant to support the notes as they are written. I agree fundamentally that equal opportunities must be ingrained in our work—I think that it is—but I am not happy about the language used because it puts us in danger of grouping people and of discriminating against them, which is not helpful.

The Convener: On a point of information, Mike Rumbles focuses on the word "persons", which, in the statutory or legal sense, means a person or persons. The word can be read as singular and can be interpreted to mean not only campaigning groups, but individuals.

Mike Rumbles: That is exactly my point. That is what the legislation says, but it is not what the Equal Opportunities Committee says.

The Convener: The Equal Opportunities Committee refers to schedule 5 to the Scotland Act 1998.

Mike Rumbles: That is exactly what I am referring to. In paragraph 6 of the implementation notes, the Equal Opportunities Committee talks about specific groups, not about persons, although the quote from the legislation mentions persons.

The Convener: We will ask the Equal Opportunities Committee for clarification on the point that Mike Rumbles has raised. Duncan McNeil and Kate Maclean wish to speak. If it is okay with Duncan McNeil, I will call Kate Maclean first, because she was a member of the Equal Opportunities Committee.

Kate Maclean: Mike Rumbles gave a poor example. Gypsy Travellers have an average life expectancy of 55 years and are discriminated against in access to medical services. They form a group of people. Although that group of people has the culture of Gypsy Travellers, which therefore defines their access to medical services, the group contains individuals who might be black and ethnic minority people who do not have access to interpretation and translation when receiving medical services, or disabled people who might not have access to facilities or to information. Those are groups of people that are made up of individuals, and that is what the Equal Opportunities Committee is referring to. I would never accuse Mike Rumbles of it, but I think that he is being intentionally obtuse.

Mike Rumbles: That is not on.

Kate Maclean: The issue has not been raised by anybody else. People who share specific attributes do not mind being referred to as groups of individuals with those attributes. There is nothing wrong with the word "groups". We would waste time if we tried to clarify it.

The Convener: I was going to draw the discussion to a close and ask for clarification, but some members want to speak again.

Mr McNeil: I do not think that I have spoken on the subject yet—I have forgotten as the discussion has gone on.

The Convener: I am sorry.

Mr McNeil: I am being discriminated against.

The Convener: Are you a group or an individual?

Mr McNeil: I do not know whether it is the committee's role to open up the debate again. We have legislation, guidelines and several reference points, which include the Scottish Parliament's operation as an open and accessible organisation and how we treat our employees, our clerks and witnesses. We have the legislation that other parliamentarians and legislators have discussed at great length, so we should not open up the debate again.

The committee must work out how to live up to those expectations. Every time that any committee discusses the matter, the first line is that mainstreaming equality is too difficult and that we will never be able to do it. We need to consider how the guidelines apply to us and how to conform practically with the guidelines. For example, we might revisit care homes issues. We know that people in care homes may have eyesight or hearing difficulties, so any materials that we produced for them would need to be adapted to that. The committee needs to adopt a practical approach, rather than have a philosophical argument about the rights and wrongs of one line of legislation against another.

Shona Robison: We could open an interesting, if long, discussion about what we all mean by equality. Given some of the comments that have been made, that might be dangerous, because we have fundamental disagreements. We must bear it in mind that the Parliament has debated the subject on the Equal Opportunities Committee's initiative and a position was reached to which I thought that everybody was signed up. The wording to which Mike Rumbles referred could be read to mean "persons" or "person". Whether discrimination is against an individual or groups of individuals is neither here nor there.

The place in which to make those views known was the debate that the Equal Opportunities Committee initiated. We have had the debate and the position has been taken. It is time to focus on the committee's responsibility to fulfil its role. I do not know whether much can be gained by having a long, albeit interesting, philosophical debate about the issues that have been thrashed out.

The Convener: I will draw the discussion to a close. We will issue to all committee members a possible letter to the Equal Opportunities Committee and members can tell us whether they have objections, which I have no doubt that they will.

I have a note that the Executive responded positively to the report when it was debated in the chamber. I confirm that when we ask people to be witnesses, it is standard practice to ensure that we mainstream equalities and that people have equal opportunities.

Janis Hughes mentioned guidance to witnesses, which would be very helpful. Recently we threw someone in at the deep end, which was rather unfair. It is one thing to hear from professionals who give evidence regularly, but another to hear from ordinary people. For me, providing guidance is an example of equal opportunities. At a later

date, the committee may decide to allow witnesses who are not used to giving evidence advance notice of the kind of questions that they will be asked. That would help to balance the situation. We must consider the practical suggestions that Duncan McNeil has made.

Thank you for your contributions. We will bring together in a letter the points that have been made. Is that agreed?

Members *indicated agreement*.

Budget Process 2004-05

14:39

The Convener: Item 4 on our agenda is the budget process. Dr Andrew Walker, our expert adviser, will take us through this. I am grateful to him for guiding us through the quagmire that is known as the budget—at least, it is a quagmire for me. I will leave Andrew to deal with it as he thinks appropriate. Members of the committee may comment on parts of the paper that they want to amend. We will go through the paper paragraph by paragraph. Andrew, you do not have to read it out—you need only highlight the main issues.

Dr Andrew Walker (Adviser): In effect, members have two papers in front of them. One is a reply to the seven questions that the Finance Committee asked us to answer. The other started life as the introduction to the first paper and became something slightly longer and more involved as it progressed.

The Convener: Andrew Walker is referring to paper HC/S2/03/10/3. The two documents have been amalgamated in one. There are not two separately enumerated papers.

Dr Walker: The replies to the seven questions that we discussed previously appear from paragraph 14 on page 7 of the paper. The preceding part of the paper started as an attempt to explain to the Finance Committee some of the frustrations that the Health Committee has felt when trying to understand how the £5.5 billion that goes to national health service boards has been used, but developed into an attempt to explore the issue further.

On my way to the meeting, members asked me whether we wanted to include the whole introduction in our reply to the Finance Committee. The answer to that question is almost certainly no. However, because we are now focused on the budget this would be a good time to think about whether we want to proceed in the same way next year. Do members want to deal with the seven questions before discussing the introduction?

The Convener: Members are indicating that they would like to deal with the seven questions first.

Dr Walker: The section on the seven questions, which starts at paragraph 14, should be relatively straightforward, as it reflects our previous discussion. The paper works through the recommendations that the Health and Community Care Committee made in the first session and seeks to ascertain whether those have been addressed. The first recommendation appears on page 7. I will not read out all the

recommendations, but members may comment on individual parts of them. Should we move straight to the recommendations that I am making this year?

Members *indicated agreement*.

Dr Walker: I recommend that we repeat some of the recommendations that were made last year, so that action may be taken on them this time. The first recommendation, in paragraph 27, is that we again ask the Executive to respond to previous recommendations 1, 2, 3 and 8, which are about making more accessible information on how health boards spend their money, on postcode prescribing and on public involvement. We all recognise that the Minister for Health and Community Care is committed to public involvement, but something more specific is required. I could have asked the committee to repeat all 10 recommendations, but I judged that recommendations 1, 2, 3 and 8 were the most important.

The Convener: Do paragraphs 28, 29 and 30 accompany your first recommendation?

Dr Walker: Those paragraphs are about the Arbuthnott formula. I stopped at the first recommendation so that we could deal with that. I suggest that we repeat recommendations 1, 2, 3 and 8. I then make some specific points about the Arbuthnott formula.

The Convener: Is the first recommendation agreed to?

Members *indicated agreement*.

Dr Walker: As the convener points out, in paragraphs 28, 29 and 30 I tried to pick up on the comments that we made about the Arbuthnott process. The recommendations are in paragraph 30 on page 11—I hope that I have captured the flavour of what members wanted to say. In the third recommendation, about specifying how much each NHS board gains or loses as a result of its demography, deprivation and rurality, we need to make it clear that we want separate figures for each of those factors in each board, because the Executive could construe that as one figure.

14:45

The Convener: We need to amend that.

Dr Walker: Just an amendment. There are a number of small typos through it—

The Convener: What do you suggest that it should say?

Dr Walker: We should be asking the Executive to supply data on the financial allocation to each NHS board, showing how much each board gains or loses as a result of first, socioeconomic deprivation; secondly, rurality; and thirdly, demographic structure. That is to make it clear that we want to know each bit of information for each board.

Kate Maclean: In order to know what losses and gains there are, there has to be a baseline. What would you use as a baseline?

Dr Walker: It has to be relative to Scotland. We would be saying, for example, that although the Scottish population has a given demography, some areas, such as the Borders, have more elderly people. How much more does the Borders receive as a result of having more elderly people than the Scottish average? Is that what you mean?

Kate Maclean: I assumed from the way in which that last recommendation was written that you were talking about gains or losses in relation to NHS boards' financial allocation at a given point in time. What would the baseline be for that?

Dr Walker: I see what you mean. So, perhaps for the current financial year, 2003-04—

Kate Maclean: We are talking about trying to work out, from the period before Arbuthnott, what percentage each board had. In order to find out the actual effect presumably you would need to have very specific figures. A bit more information is needed in that recommendation or we will not get the answers that I thought the committee wanted.

Dr Walker: I understand what you mean, Kate. Sorry, I had thought that you wanted to know how much more Grampian, say, received as a result of its geography compared to what it would receive if it had the Scottish average geography. [*Laughter.*] Sorry, I was just testing to see whether members were still listening.

The Convener: You just mention Grampian and you go all Pavlov.

Mr Davidson: On the back of what Kate Maclean was saying, we receive information on outcomes and outputs so late that it is difficult to assess them annually. I suspect that it will have to be done on budget rounds of three years or so because that will be the only way in which we can analyse trends. Do you see what I mean?

Dr Walker: Yes, I think so.

Mr Davidson: We must compare with outcomes—in other words, not just what was spent in cash terms but what actually happened. I thought that we were going to have some comment on the Arbuthnott effect on core service provision. Does the fact that health boards have to meet targets relating to socioeconomic deprivation, rurality, demography and so on have any effect on their ability to deliver core services?

How does it compare with that ability in the past? That may get support from those who come from the north-east. The point is that if we are going to ask for information, we have to do so in a meaningful way and our request should refer to something.

Dr Walker: Sure. Sorry, I had not picked up on your point about core service provision, which also raises a question. To stick to what it says in that last recommendation at the moment, however, are we asking for information about the current financial year—which is what I had envisaged—or, as Kate Maclean suggests, information about before and after the Arbuthnott formula was introduced?

Kate Maclean: Sorry, it is not clear.

Dr Walker: You are right—it is not clear.

Kate Maclean: Are we are looking at what percentage each health board area receives for those factors, or are we looking at how much health boards have gained or lost since money was distributed, or partially distributed, under the Arbuthnott formula?

The Convener: Rather than deal with this on the spot we could come back to it next week. Are you available?

Dr Walker: I was just checking whether the report is supposed to be at the Finance Committee for next week.

The Convener: We have another week.

Dr Walker: Just to clarify, there are two views on this. One is that we should use this financial year and the other is that we should use before and after Arbuthnott. What would members like?

Kate Maclean: I do not mind.

Mr McNeil: Do we have a political problem here? Everybody gains with increased investment, but the report says that there are gains and losses. The Arbuthnott formula builds in something to take account of a particular area of need so that more money is made available for that area of need. Money is not necessarily taken from somewhere else. The alternative to such an approach would be that a rich and healthy area would want to take money from a poor and deprived area in which people are dying.

Kate Maclean: How funds were previously distributed should be known. We can get information for the previous financial year or the previous couple of financial years, but I presume that other indicators or methods have been used for distributing money to health boards. If we do not know how money was previously distributed and whether the Arbuthnott formula has helped or hindered specific areas, it is difficult to see what the point would be in having information only about funding percentages over the past year or couple of years.

Dr Walker: In any given financial year, some boards will lose. A particularly affluent area will have less money than it would have if allocations were based simply on a population split. That is what I meant by gains or losses. There will be a different allocation if the population in an area is young to middle-aged or if the area is a concentrated urban area, as a result of the factor of rurality. In that sense, there will be some losses. I suggest that the solution is that we ask both for information on the current financial year, which will show us something, and for a before-and-after picture. Perhaps I am trying to cram too much into one recommendation.

Mike Rumbles: It is important that we ask for such information and I hope that we will do so. I assure Duncan McNeil that, regardless of our personal views, if any MSP from the north-east goes to Grampian NHS Board briefings, the view of most health professionals in the north-east will be made absolutely clear. They see that the Arbuthnott formula has clawed back from Grampian money that would otherwise go to Grampian and they talk about cuts in services, albeit that the Scottish Executive has given a funding increase over and above inflation. The issue relates to perceptions.

The Convener: I do not want every member's constituency to be discussed and pitched against one another. However, we are trying to get comparisons and a framework.

Mr Davidson: The issue does not relate to any one board. There is a perception difficulty with the Arbuthnott formula throughout Scotland and not just in the north-east. I have heard things that have been said in other parts of the country, too. We should do anything that we can to bring clarity to the process. If money is allocated through Arbuthnott for specific areas, such allocation should be seen to be delivering additional benefits and not to be at the expense of core service delivery. There is a perception that such allocations are at the expense of core service delivery.

The Convener: Andrew Walker will round off the discussion once Shona Robison has said something.

Shona Robison: I do not know whether I am the only person in the room who is confused.

The Convener: No, you are not.

Shona Robison: For the adviser's sake, we need to be clear about what we are asking. The starting point should be what the committee is trying to find out. I thought that we were simply trying to find out whether the factors that are listed

are being properly taken into account in the allocation of funds. To return to what Kate Maclean said, what is the best way of determining that they are? If that is what we are trying to find out—which I take it that we are—what advice can the adviser give us about the best questions to pose to get such information?

Andrew Walker: I was trying to say that the answer to this question would give us the information that health board X gets £400 million, gains £10 million on the deprivation part of the index, loses £5 million on the rurality part of the index and gains £2 million on the demographic part of the index. We could then see how each part of the index played in. I was going to do that for the current financial year because I thought that that was what the committee wanted.

Shona Robison: I would find that helpful.

The Convener: Do members agree with that?

Mr McNeil: It gives more clarity.

The Convener: For the current financial year.

Dr Walker: On David Davidson's comment about the effect on core service provision, could I add to the report that the committee is concerned about that and seeks reassurance? I am not quite sure how to phrase that, but it has been raised.

Mr Davidson: We are seeking clarity rather than just reassurance.

Dr Walker: I predict that the Executive will say that it is up to local health boards how they spend their funds.

Mr McNeil: Is the issue not much wider than core service provision? It is not just about money. We are still discussing where we put planning and the availability of staff into our work programme.

Mr Davidson: You are looking at me, convener.

The Convener: I am just wondering whether we should leave it as it is at the moment and you could raise the issue again next week. We could then move on because this is not the final shot at the report.

Mr Davidson: That is fine.

Kate Maclean: The point that I was making and that created that discussion was that the wording is not clear about what we are asking for. We did not really have to have that discussion; we just had to clarify the wording.

The Convener: We have got that and will clarify that it is for the current financial year. If we are going to deal with core service provision, we can talk about it at next week's meeting. Let us move on.

Dr Walker: Question 2 was about the partnership agreement and whether the committee was content with the additional funding proposals. In paragraph 31, I have quoted from the minister's letter and paragraph 32 lists from the *Official Report* the reasons given as to why the information is not in the draft budget. Paragraph 33 refers to column 231 of the *Official Report* and says that we are aware that few details are available, but the recommendation says that we would like those details to be made available as soon as possible. The final sentence of the recommendation states:

"The Executive is requested to write to the committee stating an anticipated date"

by which all those details will be made available.

The Convener: We have all ticked that.

Members *indicated agreement*.

Dr Walker: Question 3 is the shortest one on the list because it is about end-year funding and, as has already been pointed out, the *Official Report* shows that the £24 million of EYF has gone into the boards' allocation and been carried forward. It has not been earmarked for a specific purpose. It seemed to me that the committee would be content with that. Is that okay?

Members *indicated agreement*.

Dr Walker: Question 4 is about the programme budgets and whether we want to change them. I have made a point about the lack of information on outcomes and I quoted different examples, such as research and cancer services. The minister made the point that his life was quite difficult because he had to make such judgments, but if he had some information on outcomes, it would be easier to make such judgments, although I accept that there can be problems with that.

Last year, we asked the Executive to look into providing information on outcomes and to set out a timetable. The recommendation that I have made this year is that the Executive should respond to those requests.

The Convener: I have ticked that.

Dr Walker: It might not be possible to do that, I accept.

The Convener: The Executive should at least try.

Dr Walker: It would be nice if it explored the possibility because the £7.5 billion is supposed to be making people better and, at the moment, we do not know that it is.

Question 5 asks:

"Does the Committee feel that the portfolio priorities are appropriate and are reflected in the budget proposals?"

David Davidson asked the minister a question about that and the minister replied that he would be very surprised if the two lists were not the same. I have done a new table and found that the lists are almost, but not completely, the same. There are some surprises; for example, waiting times appear in one list but in not the other. Although there is a good core of overlap with service redesign, cancer services, heart disease and mental health being on both lists, there are some differences. However, I was not sure whether the committee wanted to make any recommendation other than to say that it is a bit surprised. Would members like to suggest a specific recommendation or are they happy with it?

The Convener: You are not looking at the recommendation on page 16. What does that relate to?

Dr Walker: The next recommendation relates specifically to target setting. I did not make a specific recommendation on the difference between the portfolio priorities and the national priorities. Do we want to make one? I do not think that it will change much, to be honest.

Dr Turner: It is important to draw attention to the fact that they are different.

Dr Walker: It is just that the minister said that he was surprised, as he did not think that they were different at all, but I think that they are quite different.

The Convener: This is a daft-lassie question, but will the useful little table be in our report? The minister will have that in any event, so it will be quite useful to draw his attention to things that are not matched.

Dr Walker: The paper that is before you is a draft of what will go to the Finance Committee.

The Convener: That is fine.

15:00

Dr Walker: Paragraph 41 on page 15 repeats what you saw back on 23 September, and it links the different portfolio priorities to bits of the budget. Where further evidence has become available—such as on the number of nurses recruited—I have included that, although there was not too much additional evidence.

On abolishing NHS trusts, I saw the Finance Committee trying to get out of the Executive how much it believed the cost of the reforms would be, and I noted that it was not easy to estimate. I think that there are still scorch marks around the witness seats.

The problem is that we cannot clearly link the priorities and the budget together because, according to the Health Department, the priorities overlap so much. It is difficult to see how we can say that we are getting best value out of the budget if we cannot see exactly what is going on. I was surprised to read in the *Official Report* that the chief executive of the NHS was saying that he could not tell how much the waiting time initiative cost; that seems an extraordinary state of affairs.

The main problem, on a pragmatic budget-monitoring level, is about the idea of setting SMART targets. If you do not have a SMART target, you cannot easily monitor whether anything much is being done.

The Convener: For the record, could you say what a SMART target is?

Dr Walker: I apologise. SMART stands for a set of principles—targets should be specific, measurable, achievable, relevant and time-limited. Those should be the characteristics of a target, so that it is a precise, quantified, measurable target and so that you can say at some point in time whether or not you have achieved it. There is a tendency not to set targets in that way. The recommendation of that rather long section is that all future targets should be in that form.

The Convener: Are members content with that?

Members *indicated agreement*.

Dr Walker: Question 6 is whether the committee is satisfied with the performance information contained in the chapter and whether it feels that the links between aims, budgets and targets are properly integrated. I do not think that there is an awful lot that is new here, although this is where the bit about the nurses came in. I wondered about mentioning the new delayed discharge figures, but have just said that we have noted that they are up a bit and are not quite as good as they used to be. After that, I have said more about SMART targets, which is a fundamental point. That is where the point about cancer waiting times came in.

The minister's response to that, if you recall, was that, first, the Executive knew that the data were not perfect and, secondly, officials had spoken to clinicians, who thought that the targets were probably achievable. Well, a basic requirement of setting a target is that the people involved think that it is achievable, but the Parliament will want to monitor progress on that target, so we really need some data to get that together. The first recommendation is therefore that

"The Executive take urgent steps to review and improve the data available for monitoring the cancer waiting times targets."

The second recommendation reiterates the point about SMART targets. Is that okay?

Members *indicated agreement*.

Dr Walker: Paragraphs 51 and 52 talk about integration and the problems with ring fencing. The recommendation states:

"For accountability purposes, the Executive is urged to find ways to at least estimate the cost of its policies."

I do not think that we can go on saying, "We don't know what the waiting times targets cost." It could be that a quarter of the NHS budget has gone on that; we just do not know. I have suggested that the committee ask for evidence of progress in that direction in the next budget document. We recognise that the Executive cannot crack it immediately, but we cannot go on like this.

Helen Eadie: I am slightly hesitant about that because demand cannot always be known in advance. In any demand-led service throughout Scotland, whether education, housing or health, for which there is an unknown public demand, it is extremely difficult for the Executive to respond and to set a precise budget. However, the Executive does its best to respond to all demands that are presented to it.

Dr Walker: I recognise that, which is why I would never assume that more than an estimate was being made. We cannot even know precisely in retrospect. Trevor Jones's point was about how far a hospital bed is accounted for by waiting times. I recognise that that is a problem and that we have no idea about the answer just now.

The Convener: Are ministers in other legislatures able to find a way of estimating and monitoring the cost of their policies?

Dr Walker: I welcome others' views on this, but my understanding is that, compared with what happens in Westminster, we get more information in the Scottish Parliament, which makes us hungrier for more.

The Convener: I was thinking of Europe rather than Westminster.

Dr Walker: In that case, I do not know the answer.

The Convener: If you cannot answer the question, you cannot answer it.

Kate Maclean: My understanding is that there is far more information in the Scottish Executive budget than there is in the National Assembly for Wales or Northern Ireland Assembly budgets. That is also the case in comparison with Westminster, as Dr Walker said.

Shona Robison: I have a quick comment in response to Helen Eadie. We must bear it in mind that the Executive set its own targets. I assume that in doing so the Executive took into account the fact that pressures can materialise in different ways at various times. Nevertheless, the Executive set the targets and we are obliged to measure the progress made towards those targets. However, the problem is, as the adviser outlined, that the data are inadequate. The Executive must surely address that issue.

Mike Rumbles: That is a fundamental question for any management system or process, whether it is a government one or not. We referred earlier to another part of the budget document that dealt with costings for the partnership agreement for the next four years. The costings have not all been published yet, but they have been done. I am sure that the Executive has information on that and on other issues that are running, but such information is not yet in the public domain. I do not believe that there is any conspiracy to keep such information from the public. It is important to know what any management tool costs and it should not be difficult for the Executive to present information about costs.

Mr Davidson: The first sentence of our recommendation ends with "cost of its policies." To clarify what is being sought over time, I suggest that we add "and targets within the budget document."

The Convener: We are just asking for an estimate. We do not want to pin anything down in accountancy terms. We are asking the Executive only for evidence of progress rather than for a solution or a straight answer. We just want to see that progress is being made.

Kate Maclean: There are targets in the budget. I suggest that there is more—

The Convener: We are concerned with costs.

Kate Maclean: David Davidson referred to targets in the budget document.

The Convener: No, the phrase that he quoted was "cost of its policies."

Mr Davidson: I want to add to that "and targets within the budget document." I know that that cannot happen overnight, but I am asking the Executive to consider it for the future.

The Convener: We will return to that point. We will not return to what we have agreed on, but we will underline and highlight the parts of the document to which we must return.

Dr Walker: The final question is number 7. Does the committee have any comment on the sections that cover the cross-cutting issues of closing the opportunity gap, sustainable development and equality? I have separated out sustainable development and equality as being generally helpful. I suggest that we recommend that the Executive do a bit more next time in those areas, although our recommendation might open up a

philosophical debate about what we mean by equality. However, perhaps the Executive should try to come up with something for those areas that is linked more coherently to the budget than it was this time.

The Convener: I think that it involves equality for Grampian somewhere.

Dr Walker: No comment.

In contrast, I felt that it was good that someone was looking at sustainable development, but I did not think that we would want to spend a lot of time on it. Are members happy with that?

Members *indicated agreement.*

Dr Walker: I take members back to the beginning of the report, where I start to explain to the Finance Committee and to people who do not know much about NHS finances why it is so difficult to get into the £5.5 billion that goes to NHS boards. I have tried to explain the data that are available, going through the performance assessment framework, local health plans and the Scottish health service cost returns. I spell that out on page 2.

At the bottom of page 2 and the top of page 3 I have included a wee table. It does not work very well, because it has been split in two, but I was trying to say that in six months' time we will be sitting in a committee room somewhere—or members will, at least—trying to scrutinise the next draft budget. So, at the start of 2004-05, the year that will be of interest and which we will be examining for the budget will be 2005-06. The performance assessment framework will have data from the previous two years and health service cost returns will have data from the previous two years. Local health plans will have some data for some health boards, but probably only on growth moneys for the next year. I see that as a problem that just moves on from year to year. We will never get the data that we want. Matters are not the way that we assume they will be.

In paragraph 7, I pick out two examples from the oral evidence. The first is about the cancer budget. The Minister for Health and Community Care said he was really pleased because, unlike in England, we can track how all the money has been used. The convener pushed him a little bit harder and asked what outcome we are getting, and from reading the *Official Report*—I was not present—it appeared that the minister became slightly more uncomfortable when it came to saying what the money had actually achieved. The second example is the waiting times budget, where I picked up on the chief executive of NHS Scotland's comment.

Paragraphs 8 and 9 are my personal interpretation, which is that we seem to use the money to set up an infrastructure for care that includes staff, equipment and buildings, then we rely on clinicians to do the best things for their patients within that. However, as a committee scrutinising the budget, we tend to assume that there is a plan somewhere that says, for example, that Fife NHS Board will spend X million pounds on cancer services in two years' time. My impression from having worked in a health board is that at that level planning simply does not exist. It is not quite as chaotic as I might be implying, but it is the product of lots of individual decisions that add up to a cancer service. It is a bottom-up system, but we are assuming that it is a top-down system.

I started thinking that if that is the case, we are always going to be frustrated in trying to get people to reveal what their plans are, so what are our options for doing something about that? In paragraph 10 I set out five different options that we could adopt. Option 1 is to continue as we are, which is to keep trying to get information out of the Executive. There is so far no evidence that we can find anything terribly useful to ask, and no evidence so far that the Executive will go further than to say that it is up to health boards how they spend their money. We are all going to be quite frustrated.

Option 2 is to try to bring the performance assessment framework into the process and to look at the broad direction of travel over time to judge what health boards are doing and whether the various indicators—I think that there are about 100—in the PAF are moving in the right directions over time. That would not give us micromanaged information and it would not give us fine-tuned information, but it would give us broad directions of travel, which might be all that we should have.

The third option is that the easiest way to engage with the health service—because it is the way that it thinks most naturally—is in terms of the inputs, such as the numbers of doctors, nurses and other staff, the number of beds, the number of buildings and so on. We could try to monitor that at local level and ask which direction it is moving in. That would have some advantages, because everyone feels quite comfortable talking about more doctors and more nurses and many targets are set in such ways. The downside is that using inputs is not specifically about how many people are getting healthier. We might assume that more doctors leads to better health, but the equation is not simple.

Option 4 is to examine historic spend, which we can do from the hospital cost returns from two years ago. We can then assume vaguely, given time trends, how things are going to be in two years' time. That involves a bit of extra work, but it gives us some quite fine-detailed information.

Members might remember that I had an A3 sheet with me on 23 September, which showed some more information from Greater Glasgow NHS Board. We could drive that on a lot further for all the health boards, but the information would essentially be about what happened two years ago and we would be using that information to make assumptions about what will happen in a year's time.

15:15

The final option concerns proxy outcomes, whereby we identify the health services that give high levels of health gain for the amount of money that is spent on them and then identify another group that give quite low value for the amount of money that is spent on them and try to monitor where the health boards are moving into the first group and out of the second group.

In paragraph 11, I have included a wee table that tries to summarise all that information. The options are listed along the top and I ask various questions about them. The first question is whether the option would allow us to comment on NHS board allocations, to which the answer is no or yes. The second question is whether health gain is central—I am assuming that health gain is fundamental to what we would do under each of the options. The third question is whether the option relies on retrospective data, which I take to be undesirable. The fourth question is whether additional effort is involved in preparing the information and bringing it together, which is generally undesirable. The fifth question is whether the option would encourage dialogue between the Executive and the NHS, which I am assuming would be desirable for present purposes. I have set out how I perceived that each of the options performed against each of those questions.

I am sorry that that has been slightly long-winded. I regard the document more as a discussion document than as something that might be sent to the Finance Committee. The Health Committee might want to take this opportunity to think about where we want to be in six and 12 months' time and whether we will be frustrated because we still will not have any information on how we could do better next time. I will now pause for breath.

Shona Robison: This is beginning to get to the crux of some of the debates that the committee has had time and again. Dr Walker has put a lot of work into the document, which is extremely complex. There would be nothing to stop us from recommending a combination of the options. I am quite taken by option 3—the inputs option—along with the proxy outcomes option.

The inputs option relates closely to the committee's inquiry into the impact of the centralisation of services and the driving forces behind that. It would allow us to see, for example, where moneys that were supposed to be allocated for new services were not being used for those services, but were having to be used to address some of the pressures on staffing costs. Would it allow us some transparency in having a look at that? Anecdotal evidence from around Scotland suggests that that is what is happening because of pressures on budgets. Would that option give us evidence of the degree to which that is happening?

The proxy outcomes option would also allow us to compare good practice and bad practice in determining the best use of available moneys for specific services—cancer services, or whatever. The comparison need not necessarily be made across the board. It would be interesting to see how health boards had used the money to get specific outcomes and where health benefit could be measured to a greater degree.

My preference would be for us to recommend a combination of options 3 and 5. I think that the document is a good piece of work.

Dr Walker: Thank you.

Helen Eadie: I agree. This is a complex piece of work and it is helpful for us all to have it. We are always being critical of the Executive and others for not consulting people, but the issue for us is how we can consult the wider public about some matters as well. Clearly, we are trying to improve things for the future. The question is; what can we do as a committee to consult the wider public? We always consult the clinicians and medical people, but we do not always consult the users of the services and others. That is a key point.

According to the way in which you have presented this—you have included a box at the end, with lots of ticks—the proxy outcomes option seems to be a particularly attractive option. Obviously that view might change with further consideration and on hearing other members' comments.

Dr Walker: I warn Helen Eadie that the proxy outcomes reflect my personal prejudices. As a result, members should exercise suitable discretion.

Helen Eadie: I guessed that.

The Convener: That is on the record now, Andrew—you are being far too honest.

Mike Rumbles: I agree with Shona Robison and Helen Eadie that the inputs and proxy outcomes options are good ideas. I am very happy to agree to them.

However, given that this is a draft report, I am a little bit confused about how we are going to present it. Do we intend to issue it as an introduction to the seven questions? Moreover, Dr Walker, are you asking us in paragraphs 12 and 13 to firm up a preference? I am not quite sure about what you are trying to get us to do.

Dr Walker: That is a fair question. After all, the document kind of evolved. The report from paragraph 14 onwards will go to the Finance Committee. However, the discursive part of the report—which we are now discussing and which perhaps includes paragraphs 8 and 9 and the various options that are outlined in paragraph 10—will probably not go into the final report to that committee. As a result, the report could include up to paragraph 7 and conclude that although the committee felt a certain amount of frustration about the level of detail, it acknowledged that there were difficulties. I propose that the report to the Finance Committee exclude paragraphs 8 and 9, which are based on my interpretation of the matter. It should also exclude paragraph 10 until the committee is sure what it wants to do.

Shona Robison: I think that that part of the report is very good. If we were going to send the report to the Finance Committee, we would have to state our recommendation in it. That section gives food for thought, because it clearly suggests a way forward that is not currently being explored, and which would provide us with some—if not all—of the information that we feel we been lacking and which would enable us to track where the money goes, how it is spent and the health benefits that derive from it. Although such an approach is not perfect, we could suggest to the Finance Committee that it form a starting point for discussion. I do not want that part to be lost from the report, because it is very good.

Mr McNeil: Like Mike Rumbles, I am attracted to the inputs and proxy outcomes options set out in the paper. However, I sense that the committee does not feel confident about making a decision, although I might be wrong about that. We have got a cut on the issue and I agree with Shona Robison that we have reached the crux of the matter. If such an approach is successful, we will be in a better position to examine the value that we are getting from the money that we are putting into the health service. We should consider taking a cut today and addressing that particular point the next time around.

The Convener: Unless I hear to the contrary from the next two members, I think that the committee is in favour of the inputs and proxy outcomes options. I have not heard any member speak against them yet.

Mike Rumbles: I think that we are in favour of those options. However, I agree with Duncan McNeil—I have not had a great amount of time to look at this part of the report, which is why I asked whether it was also going into the report to the Finance Committee. I am not sure that that should happen.

The Convener: That is not a problem, because we will have another opportunity to go through the report and redraft parts next week. The report will take on a different shape after we remove the questions and so on. Like you, I was not quite clear what was going to happen in that respect. However, we have taken decisions in principle on certain issues such as the inputs and proxy outcomes options. We have still to hear from two other members. The presentation of the report and other information that should be included are still open to discussion.

Mr Davidson: As we have pointed out previously in the committee, an awful lot of extra money has gone into the health service over the past few years, but no one seems to know where it has gone and what we have received for it. The public are asking questions about outcomes. We should focus on inputs and outcomes, as opposed to outputs, and see whether we can get something from that.

I cannot comment on the Finance Committee in this session, but certainly during the previous four years it was concerned with considering what outcomes had been achieved across the budget in all areas. Information was a problem. If we are trying to sing from the same hymn sheet today I believe that we should take options 3 and 5, or a combination of them.

Dr Turner: I would hate to see the report being lost, because the information in it is tremendous; I was particularly glad to see the table. I also marked the inputs and proxy outcomes options.

We owe it to the people whom we serve to find out more. Before the away day, I presented figures that had been gathered by another doctor. The figures proved that from 1999, for all the extra money that was put into the health service, activity was falling off. In such a situation, a business would not plough money in. It is easy to say that more money has been spent in the health service, but we are confronted with an increase in the number of people lying around on trolleys and wondering where the beds are because they have no beds to go to. At the weekend, someone told me that because there was no money for it, he could not have an operation, which I would have thought was required urgently because he has such a miserable condition.

We owe it to the population that we serve to try to find out more about how our money is spent. That is not a criticism in a nasty sense; I think that everybody in the Executive is trying to do what is

best. They cut up the money and hand it out to the health boards, but we do not know how the money is then spent. We have to work on outcomes. I wholeheartedly support the proposals and we should try to hand on as much of the document as possible because it is thought provoking.

The Convener: We all want to try to track the funding.

Dr Turner: Yes. If we examined that carefully it might save us money in the long run—if that is possible.

Mr McNeil: What is spent on an input or an outcome is a small amount of money in the total budget. We know where 70 per cent or 80 per cent of the budget goes; it goes to pay salaries.

The Convener: That is another issue for later.

Mr McNeil: It is not only a general point. We have had the debate before about what we could affect in terms of the overall budget. There is no point in our doing a lot of work on certain matters—for example, if we did not agree the consultant contract and this contract we would make more money available, but we would also disaffect staff and so on. I do not know what part of the budget we are focusing on: is it the whole budget?

Dr Walker: I think so. We are considering, for example, the number of consultants that a particular health board employs per head of population or the number of GPs or nurse specialists of a particular type that it employs.

I am mindful of Shona Robison's question about whether the information will show us whether money for new services is diverted to plugging gaps. I am not sure about that; I must consider exactly what this means. My slight wariness about the whole exercise is that we now have a statement of direction and intention, but we need to see more detailed information about what that will look like in case it becomes all things to everyone.

Mr McNeil: At the end of the day, that is where we are going.

Dr Walker: It will give us more to debate than we have now.

Shona Robison: We are talking about the whole budget. The proxy outcomes option would measure the health outcomes from money spent on staff. It would not measure the outcomes from only 20 per cent of the budget—it would relate to the whole budget. If the proxy outcomes option was adopted as a way of looking at the budget, there would be a way of measuring the outcomes.

I suggest that Dr Walker come back with something next week to show how the information would be presented. We could have another look at it then.

The Convener: I ask Dr Walker to provide the information in a digestible form that will almost be what will—subject to any amendments that we make—go to the Finance Committee. We could see clearly what is going into the report, so next week we would only tweak it. I think that Duncan McNeil wants to say something.

Mr McNeil: The adviser has been given a clear steer, so do we need to go on?

The Convener: Fine.

I feel like the Presiding Officers, because we intended to stop at 15:30 and I could almost do what they do when they talk until decision time; however, that now brings today's meeting to a conclusion.

Meeting closed at 15:29.

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