HEALTH COMMITTEE

Tuesday 1 November 2005

Session 2

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HEALTH COMMITTEE
26th Meeting 2005, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

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

COMMITTEE SUBSTITUTES

Paul Martin (Glasgow Springburn) (Lab)
Mr Kenneth Macintosh (Eastwood) (Lab)
Euan Robson (Roxburgh and Berwickshire) (LD)
Mary Scanlon (Highlands and Islands) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Colin Fox (Lothians) (SSP)
Lewis Macdonald (Deputy Minister for Health and Community Care)
John Swinburne (Central Scotland) (SSCUP)
Chester Wood (Food Standards Agency Scotland)

THE FOLLOWING GAVE EVIDENCE:

Elspeth Atkinson (Macmillan Cancer Relief)
Stuart Bain (NHS National Services Scotland)
Dr Jennifer Bennison (Royal College of General Practitioners Scotland)
Scott Bryson (NHS Greater Glasgow)
Suzanne Clark (Patient Partnership in Practice)
Glyn Hawker (Unison)
Lindsay Isaacs (Citizens Advice Scotland)
Alison MacRobbie (Highland Area Pharmaceutical Committee and Scottish Palliative Care Pharmacists Association)
May McCreaddie (Royal College of Nursing Scotland)
Jim Milne (Dundee Anti-Poverty Forum and Scottish Campaign to Remove All Prescription Charges)
Dr Philip Rutledge (NHS Lothian)
James Semple (Scottish Pharmaceutical Federation)
Angela Timoney (Royal Pharmaceutical Society of Great Britain)
Chris White (Scottish Association for Mental Health)

Clerks to the committee

Lynn Tullis
Simon Watkins

Senior assistant clerk

Tracey White

Assistant clerks

Merrin Thompson
Roz Wheeler

Location

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 1 November 2005

[THE CONVENER *opened the meeting at 14:02*]

Items in Private

The Convener (Roseanna Cunningham): Welcome to the committee. First, we must agree to take agenda items 4 to 7 in private. Item 4 relates to a discussion of the evidence that we will hear today; item 5 relates to our consideration of options for our on-going care inquiry; item 6 concerns an update on our outstanding hepatitis C evidence session; and item 7 relates to our consideration of a second draft report on the Scottish Executive's 2006-07 draft budget. Do we agree to take those items in private?

Members *indicated agreement.*

The Convener: I also ask the committee to agree to deal in private with our draft stage 1 report on the Human Tissue (Scotland) Bill at our next meeting. Do members agree to do that?

Members *indicated agreement.*

Abolition of NHS Prescription Charges (Scotland) Bill: Stage 1

The Convener: Item 2 concerns the Abolition of NHS Prescription Charges (Scotland) Bill. This is our first opportunity to take evidence on the bill, which is a member's bill proposed by Colin Fox, whom I welcome to the meeting. I remind him that he will be able to ask questions towards the end of the session. The session is designed to enable us to engender round-table debate, which means that witnesses are encouraged to ask questions of one another rather than waiting for MSPs to ask questions.

All members have a copy of the bill, the Scottish Parliament information centre briefing and a pack of written submissions. Members' questions will not always be directed to a particular witness, so I will need to be given some indication if people wish to comment on a question, unless that question is specifically addressed to one person. If a witness wants to comment on a particular question, they should clearly raise their hand.

Once I have introduced the witnesses, I will ask each of them to indicate briefly their position on the bill. I want "Support" or "Do not support" and a single sentence outlining the major reason for that position. If the statements are any longer, it will be half an hour before we ask the first question, which is not what the round-table session is meant to be about.

May McCreaddie is board member for the acute and supportive division at the Royal College of Nursing Scotland; Glyn Hawker is the Scottish organiser for health at Unison; Jim Milne is from the Dundee Anti-Poverty Forum and the Scottish campaign to remove all prescription charges, or SCRAP—I do not know whether that is an indication of his style of debating, but we will see; Lindsay Isaacs is the policy and public affairs co-ordinator at Citizens Advice Scotland; Suzanne Clark is the chair of Patient Partnership in Practice; Elspeth Atkinson is the director of Macmillan Cancer Relief; Chris White is the benefits officer at the Scottish Association for Mental Health; Stuart Bain is the chief executive of NHS National Services Scotland; and Dr Jenny Bennison is the deputy chair for policy at the Royal College of General Practitioners Scotland.

I have just seen my colleague John Swinburne—welcome to the meeting. Dr Philip Rutledge is a consultant in medicines management, public health and health policy at NHS Lothian; Scott Bryson is the pharmaceutical adviser at NHS Greater Glasgow; James Semple is the chairman of the Scottish Pharmaceutical Federation; Angela Timoney is the chairman of the Scottish executive of the Royal Pharmaceutical

Society of Great Britain; and Alison MacRobbie is a palliative community care pharmacist with the Highland area pharmaceutical committee and the Scottish Palliative Care Pharmacists Association.

May McCreaddie (Royal College of Nursing Scotland): We wholly support the bill. The reason for that is simple: 93 per cent of delegates at congress this year supported the bill. We can see the benefits for patients of the proposal and the inequities that are perpetuated in the current system, which we therefore wish to be scrapped.

Glyn Hawker (Unison): Unison fully supports the bill, because the current arrangements are unfair, inconsistent and have a bad effect on already poor health.

Jim Milne (Dundee Anti-Poverty Forum and Scottish Campaign to Remove All Prescription Charges): We support the bill fully. We believe that there are sound medical and financial grounds for the abolition of prescription charges.

Lindsay Isaacs (Citizens Advice Scotland): Citizens Advice Scotland supports the bill because client evidence from bureaux throughout Scotland shows that people on low incomes or with serious chronic illnesses are struggling to meet prescription costs. Abolition of charges would help to improve access to health care for a significant number of vulnerable Scots.

Suzanne Clark (Patient Partnership in Practice): Long term we support the bill, but in the meantime we would support a review of exemptions.

The Convener: I will put you down as neutral.

Elspeth Atkinson (Macmillan Cancer Relief): Macmillan Cancer Relief supports the bill because it would exempt cancer patients from charges—now that more people are being treated at home, charges are a major financial worry for some people. However, we, too, believe that the same result could be achieved by considering exemptions or through other measures.

The Convener: If I put you down as neutral, is that an accurate reflection of your views?

Elspeth Atkinson: We are in favour of people who are receiving long-term cancer care at home not having to pay; we would not want to comment on other illnesses at this stage.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I thought that you said that you supported the bill.

The Convener: I know, but then, like Suzanne Clark, she said that she was neutral.

Chris White (Scottish Association for Mental Health): The Scottish Association for Mental Health fully supports the bill. The current system is unfair and bureaucratic and the exemption criteria follow no clear rationale.

Stuart Bain (NHS National Services Scotland): NHS National Services Scotland is neutral on the issue. We are responsible for administering the payment process and pre-payment certificates. I am here to give evidence on the facts and to invite the committee to consider the implications of any changes to the payment process, particularly in the light of new pharmaceutical contracts.

Dr Jennifer Bennison (Royal College of General Practitioners Scotland): The Royal College of General Practitioners Scotland is neutral on the bill. We see several inequities in the current system, but we feel that the abolition of charges would have a considerable impact on general practitioners and other professionals such as pharmacists. We do not believe that such a move should be considered without further inquiry into the full consequences for patients and professionals.

Dr Philip Rutledge (NHS Lothian): Lothian NHS Board does not have an official view on the matter, because it has not carried out an official consultation. I am here wearing my professional advisory hat. In that respect, the answer is yes and no: yes in principle and no because we need to sort out the finances before we say yes.

Scott Bryson (NHS Greater Glasgow): NHS Greater Glasgow supports reform of prescription charges, but we do not support the bill for the simple reason that we are not convinced that the full repercussions have been quantified.

James Semple (Scottish Pharmaceutical Federation): We oppose the bill. The current system is a mess, but abolition would be using a sledgehammer to crack a nut.

Angela Timoney (Royal Pharmaceutical Society of Great Britain): The Scottish executive of the Royal Pharmaceutical Society of Great Britain believes that the current system is unfair, but we are neutral on the bill at present. The national health service is a complex system, so changing one part of it may have unintended consequences on other parts. For example, as many have said, workloads might increase under the bill. We are concerned that the increase in workloads would mean that people whom we particularly wish to help, such as those who suffer from health inequalities and the poor, may find it even more difficult to access health care.

Alison MacRobbie (Highland Area Pharmaceutical Committee and Scottish Palliative Care Pharmacists Association): I am wearing two hats. The Highland area pharmaceutical committee is neutral on the bill, because it feels that the impacts have not been

explored fully. I am here to contribute to the debate to ensure that that matter is explored fully. The committee supports the principle of altering the current system, which is unfair. The Scottish Palliative Care Pharmacists Association supports the bill in relation to cancer patients, but understands that it is a bit like using a sledgehammer to crack a nut and that alternative processes may be possible.

The Convener: Unless any of the witnesses is keen to start off by asking a question of any other witness, I will go straight to Mike Rumbles.

Mike Rumbles: I will start by asking a question of the witness who said that his organisation opposes the bill. The Scottish Pharmaceutical Federation's written submission states:

"It is a fact of life that people are inclined to place little value on what they receive for nothing".

It goes on to say:

"NHS prescription charges are an essential barrier to frivolous use of NHS resources".

In Scotland, the only gatekeepers of the prescription of drugs are clinicians who are on the list. I am surprised by your federation's written submission. You do not seem to be giving us your professional evidence; instead, you are giving what seem to be weighted—I hesitate to say "loaded"—political statements. Will you expand on what you mean by the comment that prescription charges are

"an essential barrier to frivolous use"?

James Semple: We were speaking from experience as pharmacists. I mentioned the fact that, every year, we collect huge amounts of unused pharmaceuticals that have been prescribed. It is all very well talking about clinicians being the gatekeepers, but they can do only so much. They cannot go to people's houses to check that they take their medicine. We can do a huge amount to try to ensure that people are informed and that they take the medication that they should take and do not get stuff that they do not need, but it is an unfortunate fact of life that, if people do not have financial input into stuff that they get, they will tend to stockpile. When pensioners die and we go to their houses and collect all the stuff that is left over, we do not tend to find cupboards full of tins of peaches; we find bottles of lactulose, for example, because people stockpile that.

14:15

Mike Rumbles: Are GPs prescribing frivolously?

James Semple: No, I do not necessarily mean that GPs are prescribing frivolously. There is a lot that we can do to educate the public and to encourage compliance with medicine regimes. However, although I would never say that pensioners should pay for their prescriptions, we do not want a system in which we gather tonnes of waste every year from prescriptions that have not been taken for no great reason.

Mike Rumbles: You are making a leap of logic. If you accept that clinicians are responsible gatekeepers who ensure that people do not get prescriptions that they do not need, how can you argue that people not paying for a prescription would encourage frivolous use? I do not see the logic.

James Semple: Not everybody who obtains a free prescription will use the service frivolously. In fact, only a small proportion will. However, as we know, 91 per cent of prescriptions are dispensed for free. A reasonably high number of prescriptions are dispensed to people who do not use the prescriptions that they receive. We know that because we have clear figures for the tonnes of waste that are returned to pharmacies. We are the guys on the front line who collect all that stuff in huge yellow bins. We usually collect enough waste to fill two or three bins before somebody comes to pick them up. It is an unfortunate fact of life that, in order to maintain the current system in which people can have free prescriptions, we have to teach the public not to get prescriptions that they do not need. However, clinicians can go only so far. Let us not say to the other 50 per cent of the population, "Join the club."

Mike Rumbles: If 91 per cent of prescriptions are free, you are worried that there will be an increase in cost for the other 9 per cent that people have to pay for. You believe that people will not value a service that they do not have to pay for and will take prescriptions from clinicians with the result that there will be a huge increase in the frivolous use of drugs.

James Semple: The fact that only 9 per cent of prescriptions are paid for signals that people who have to pay will get a prescription only when they need it. In an environment where nobody pays—there would no longer be 9 per cent of people who pay—the number of prescriptions would be much bigger. Correspondingly, a much larger proportion of those prescriptions would end up as waste. That is only one of a list of reasons why we think that the bill is a bad idea, but it is an important part of our argument.

Mike Rumbles: I pay my prescription charges under the law, quite rightly, but when I go to the doctor—he sometimes writes me a prescription, although not always—there is no thought in my mind that whether I will use that prescription will depend on whether I have paid for it. Do you see what I am getting at? I just do not understand your argument.

James Semple: The argument is quite simple—if an office gives away free pens, lots of people will take home lots of pens even though they do not necessarily need them.

Mike Rumbles: We should have a good gatekeeper for pens.

Lindsay Issacs: In response to James Semple's argument, I would say that the evidence from bureaux clients is that, if charging acts as a barrier to unnecessary demand, it also acts as a barrier to necessary demand for people on lower incomes or for those who have chronic conditions that require multiple prescriptions. People need to get prescriptions filled, but some simply cannot meet the costs.

James Semple: The fundamental point is that anybody who cannot afford to pay for prescriptions should not have to. We totally agree with that. However, there can be no one around the table who disagrees that the system needs complete reform. Our argument is not that prescriptions should be paid for by people who cannot afford them; it is that prescriptions should be paid for by people such as me who can afford them. That is a different argument.

Chris White: James Semple makes the point that people will get prescriptions only when they need them. However, a sufficient body of anecdotal evidence, including Citizens Advice Scotland's "Unhealthy Charges" report, suggests that people will get prescriptions only when they can afford them. With multiple prescriptions, there is a worry from a mental health point of view that, if someone can afford either a drug that will save their life because of a physical condition or a drug that will treat their depression, that person will take the drug for the physical condition, which means that their mental health is not being treated.

James Semple: As far as I am aware, all the evidence of groups of people stopping taking their medicine because they cannot afford it comes from America, where low-income groups have to pay for their prescriptions. Nobody here is arguing that low-income groups should have to pay for their prescriptions, so I do not think that that evidence is particularly relevant.

The Convener: Is that the evidence to which you were referring, Chris? Are we all speaking about the same evidence?

Lindsay Isaacs: I should just clarify that the "Unhealthy Charges" report to which Chris White referred was conducted by Citizens Advice, our sister organisation in England and Wales, not by Citizens Advice Scotland.

The Convener: Could you forward that report to the committee, please? It would be useful for us to see the evidential basis for that statement.

Jim Milne: People are well aware that the biggest increase in poverty in this country has been among the working poor and people who suffer from sickness and disability, to whom a charge of £6.50 is a significant sum of money. The 2003 figures showed that 75,000 people in Scotland did not go to the pharmacy and get their prescription delivered. We are told that people may be stockpiling drugs, but significant evidence exists to show that people are not getting the drugs that they are being prescribed.

James Semple: I do not know where the figure of 75,000 people not getting their prescriptions dispensed comes from. There is absolutely no evidence for that, as it is impossible to find out who gets their prescription dispensed and who does not.

The Convener: Okay. I ask Jim Milne to forward to the committee any information that he has about the figures. It would be useful for us to know the basis on which some of these evidentiary claims are being made.

Shona Robison (Dundee East) (SNP): I am a bit confused about James Semple's conclusions. He states in his written submission that there is a link between stockpiling drugs and paying for prescriptions. However, his conclusion is not that more people should pay; there would have been some logic to that, but that is not what he is saying. Surely we are talking about different issues. He is saying that measures need to be introduced to avoid stockpiling. I would have thought that that related more to the electronic patient record and better ways of monitoring prescriptions than to anything to do with paying or not paying. He seems to have introduced an argument that does not really relate to the abolition of charges; it is about other things, which he does not relate to paying or not paying.

James Semple: The point that we are making about the additional cost of having the other 50 per cent of the population, which does not currently face a barrier—[*Interruption.*]

The Convener: Excuse me for a second. Will anybody who has a mobile phone please switch it off? It is not very courteous to have mobile phones going off in the middle of a committee meeting.

James Semple: Exempting from prescription charges the 50 per cent of the population who currently pay for prescriptions would add to the cost through frivolous use. That is just one of several reasons why we think that abolishing prescription charges is a bad idea. Currently, 50 per cent of the population have to think about whether they really need to go to the doctor and get a prescription or whether they would be all right going to the chemist and buying a packet of paracetamol. If those people are given free

prescriptions, they may be more likely to say, "Och, I'll just get it for nothing." They might then get a couple of packets, in case they need the medication the following week, when they are on holiday. That is what I call frivolous use and it incurs an additional cost.

There are two sides to the issue: there would be costs and benefits. If we provide everyone with free prescriptions, a benefit would be that everybody would gain easy access to medicines that they need. However, there would be an undeniable cost, in that people will ask for frivolous and unnecessary prescriptions for medicine that will just be put in a cupboard until it goes out of date, so that they will need the same prescription again.

The Convener: What is the current position? Do 9 per cent pay for their prescriptions and the other 91 per cent pay nothing?

James Semple: No. At the moment, 50 per cent of people pay for their prescriptions and 50 per cent do not pay. The anomaly that confuses many people is that 91 per cent of prescriptions are exempt from charges. However, that is because the 50 per cent of people who receive an exemption are responsible for the vast bulk of prescriptions that are dispensed. Only 9 per cent of prescriptions are paid for because—let us face it—the 50 per cent of people who are required to pay for their prescriptions are not that ill anyway.

The Convener: Given that only 9 per cent of prescriptions are currently paid for and 91 per cent are not paid for, if the proportion of prescriptions that are not paid for was increased to 100 per cent, what percentage of that increase—the difference is less than 10 per cent—might be accounted for by what you call frivolous use?

James Semple: But there will be no frivolous use at the moment among that 9 per cent, because those prescriptions are paid for. If all prescriptions were free, the rate of frivolous use would balloon. If 100 per cent of prescriptions were free, that total will represent a much bigger whole.

The Convener: I am puzzled by that. Are we to assume that general practitioners will suddenly start prescribing like crazy? I do not see how that will happen. I will let Jean Turner ask her question and then Jenny Bennison.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I declare my previous job as a GP, which people probably already know about. Because of that experience, I tend to favour the abolition of prescription charges.

Mr Semple, how many prescriptions are left on your shelf and not picked up? How many of those who come into your pharmacy who are required to pay for their prescription—they may have asthma or other chronic diseases—have difficulty in paying? Also, how many of those people who come into your surgery with asthma choose the Ventolin inhaler over the steroid inhaler? Anecdotal evidence suggests that most of them will opt for the Ventolin inhaler.

James Semple: In all honesty, no patient has ever asked me which of a list of medicines they should choose. The simple reason for that is that, if any pharmacist in any of my pharmacies sees that someone has a prescription for two items of the kind that people normally receive every month—for example, a salbutamol inhaler and a beclomethasone inhaler—the first question that they are asked is, "Have you ever thought of getting a pre-payment certificate?" If the answer is no, we tell them, "Well, it is cheaper than two prescriptions a month, as it works out at about £8 or £9 a month."

In my opinion, only a small number of people are what Jim Milne referred to as the working poor, who cannot afford £8 a month. I believe that such people should be looked after and should not have to pay £8 a month. However, the vast majority of people on chronic medication can afford £8 a month. We tell people, "Here is the form. Fill it in and the prescriptions will cost about £30 for four months."

Dr Turner: So you have never had any difficulty with people in any area paying the full price. I have found that many people find it difficult to pay the full amount up front. They can even have difficulty with the monthly or quarterly payments.

James Semple: Personally, I have never come across anyone who has been unable to pay the £33 for a pre-payment certificate, but I accept that some people will be unable to pay £33 in a lump sum. The simple solution is to introduce some sort of direct debit system that allows them to pay £8 a month while we reform the system to make it fairer. Reforming the system should be about targeting those who cannot afford to pay. It should not be about allowing guys such as me to get their prescriptions for free. I am quite happy to pay £6.50 when I need to do so, because it is not that much.

The Convener: You said that the vast majority of those who pay for their prescriptions each month—cancer patients and the rest—can afford to pay for them. On what basis do you say that?

James Semple: Ask yourself how much of the Scottish working population who are not already exempt on grounds of income cannot afford £8 a month.

The Convener: But that is not evidence. That is just your view.

James Semple: It might not be evidence, but we are talking about only £8 a month. If people cannot afford £8 a month, they should be exempt.

The Convener: The problem is that many of those people are not exempt.

Lindsay Isaacs: James Semple mentioned that the working poor among the Scottish working population should be exempt. However, many people on benefits are not automatically exempt from prescription charges. I just wanted to clarify that.

James Semple: I reiterate that my position is that anyone who cannot afford prescription charges should not be required to pay them. That is why the whole system needs reformed. I agree with all the other speakers that we need to reform the system to ensure that prescriptions are affordable to everyone.

14:30

Dr Bennison: I have a couple of points to make. Somebody said that GPs might suddenly start prescribing like mad where we do not do so already. We would not do that for our current patients, but one of our difficulties with the bill is that many people might start coming to see us to get free what they currently buy over the counter.

Lots of outpatients use paracetamol, ibuprofen or cimetidine—products that they can and do buy easily over the counter. Our worry is that we could become overwhelmed by patients who, instead of buying those products out of their own pockets, decide to come to us for a prescription to get the products free. Pharmacists in the minor ailments service will soon be able to hand over some of those products to people who cannot afford to buy them. I understand that they, too, are worried about becoming overwhelmed if that service were made available to everybody.

The other point about the pre-payment certificate is that not all pharmacists do what Mr Semple does to inform people about it. Many of our patients complain about prescription charges and ask us, as GPs, which items to get. That is not made up; it is absolutely true. Patients ask us whether they should get the blue inhaler that will make them feel better now or the brown one that will stop them feeling unwell in the longer term. The pre-payment certificate is a difficult issue. For many people, £30 is a lot of money to have to produce up front. The charge is only £8 a month, but it is neither well publicised nor easily available to people who do not have capital.

The Convener: I will bring in Stuart Bain and then return to Mike Rumbles. If James Semple has other comments to make, he can come in at that point.

Stuart Bain: It might be helpful for the committee if I set out some recent figures on the rising number of prescriptions. The figures will give us some sense of the trend—

The Convener: Steady now.

Stuart Bain: In 2002-03, some 69.5 million prescriptions were issued. In 2003-04, the figure rose by 2.7 million to 72.2 million and it rose again last year by 2.4 million to 74.6 million. We are seeing an increase of about 2.5 million per year in the number of prescriptions that are going through the system.

Free—in other words, not charged for—prescriptions represented just under 91 per cent in 2002-03, under 92 per cent in 2003-04 and 92.5 per cent in 2004-05. My organisation tracks a lot of information on prescriptions through the practitioner services division and a lot of information about activities and so on through the information and statistics division Scotland. I do not wish to make a specific point on the figures, but it is extremely difficult to track evidentially what is prescribed by a doctor, what is dispensed by a pharmacist and what is used by a patient. Until we get the single patient records and integrated information technology systems, it will be difficult to do so.

I ask the committee to reflect on likely future trends. We can see that a rising number of prescriptions are being issued and, as we have seen in the Kerr report, for example, we have a rising number of elderly people. Not only is the percentage of the population that is elderly rising but increasing numbers of people have co-morbidities—in other words, they have multiple illnesses and need to get many prescriptions. The trend seems to us to be one that is established and likely to continue. The issue for me is not to say whether we are for or against the proposal but to say that the current patterns of exemptions and usage do not seem to meet the objectives that were originally set for prescription charges.

Before making any sudden changes in any particular direction, we need to make sense of all the evidence. As others have suggested, we need to be clear that we do not want to produce perverse incentives—I am not referring to James Semple's point, because I do not necessarily support it. New systems are being introduced for remuneration of pharmacists in terms of minor injuries and chronic medication services. The way in which people will access the service and whether they will want to be registered with a pharmacist may be skewed by whether there is an exemption system and whether they will have to pay for prescriptions.

We have not had the opportunity to explore or to model what the different systems might look like

and where they might place the cost, be it on the patient, the local health system or the health service nationally. We need to be mindful that, although we do things for good reasons, they can lead to unforeseen consequences because we did not model them.

Mike Rumbles: I want to follow up what Jennifer Bennison said—she made some good evidence-based comments. However, in speaking on behalf of the Royal College of General Practitioners Scotland, she gave the impression that it would be a negative result if more people went to see their GPs because of the bill. We are all interested in people in Scotland leading healthier lives and in illness prevention, so surely it would be a good thing if abolishing prescription charges resulted in more people going to see their GPs.

Dr Bennison: You should understand the pressures that we are under in trying to deal with the people who already come to us. If we had to see for a 10-minute appointment everybody who has a bit of a sore ankle after spraining it at the weekend, there would be a limit to how much we could offer. If we want to offer a quality service to our patients, we have to offer each patient a reasonable length of time.

Mike Rumbles: But we are encouraging patients to visit you and other health professionals, are we not?

Dr Bennison: Are you?

Mike Rumbles: Yes, we are.

Dr Bennison: We provide preventive care. The latest figures for the new GP contract show an enormous improvement in management of chronic disease—we see such patients anyway. The patients whom we do not necessarily need or want to see are people who are actually well and look as if they will remain well, but who maybe have a cold and need some symptomatic relief. They know that they can go to their chemist and buy paracetamol or Lemsip and that they will feel better. We do not want our waiting rooms to be filled with people like that, because we would not have space or time to see people for whom we can make more of a difference.

Shona Robison: I have a quick question for Stuart Bain. Given the trends, are you not talking about more effective management of prescribing and information gathering on how prescriptions are issued, which should be happening anyway? It does not necessarily relate to who pays and who does not pay. You could still do away with inherent unfairness in the system by introducing mechanisms that better manage a situation that is not being managed as effectively as it could be, given the trends that you are talking about.

Stuart Bain: I agree with much of that, although not necessarily the analysis that abolition of prescription charges per se will deal with all the issues. We have talked about poverty, the ability to pay and the incentivisation or otherwise of people to access general practitioners, but a whole raft of issues sit behind those, such as who is within the exemption classes. A number of exemption classes relate to people who have chronic lifelong conditions, but we all know that there are many people with chronic lifelong conditions who do not fit within the exemption classes and for whom there is no equity. That is not to say that everybody should be in or out.

We should examine whether the original purpose of prescription charges is being achieved, and whether they are inherently unfair to any groups according to income, ability to pay or chronic condition. We need to examine the issue in a more rounded way. If the conclusion is that prescription charges can meet none of the objectives, abolition may be right. However, some other reform might better meet those objectives and the objectives of the health service, which is why my organisation takes a neutral position. As I said, we gather many statistics about disease and trends in health, as well as being responsible for paying pharmacists for prescriptions.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): My question relates to Dr Bennison's exchange with Mike Rumbles. Is it the case that poor sick people already struggle to get a GP's attention, while healthier people are more likely to access their doctor and drugs? Does the present system serve poor and sick people well? I regularly use antihistamines during the summer and ibuprofen for my aches and pains, and I can afford to pay for them over the counter, although they are not cheap. Would I have an incentive to go to my GP if they were prescribed free? There is an argument that people like me would be encouraged to go to the doctor as a consequence.

The Convener: That is more a statement than a question.

Mr McNeil: I asked whether the bill would serve poor people. Would it restrict further their access to GPs, given that healthy people like me would be in surgeries taking some of GP's time? Does the present situation serve poor people and ill people well? Are we dealing with a problem on the margins? We hear a lot of self-interested nonsense about the idea that by giving something to everyone we serve the poor. Are we already serving the poor and ill?

The Convener: Was that question directed at an individual or is it a general question?

Mr McNeil: I am happy for anyone to respond.

The Convener: There are other issues that we need to cover, and I am worried that we could end up going over the same ground. We are spending a long time on this.

Glyn Hawker wanted to come in—perhaps Glyn could respond to Duncan McNeil's question. I ask others to respond to the question as well as to raise points of their own.

Glyn Hawker: It is certainly my view, and that of Unison, that we are not currently serving the poor well, in that it is the poor who are disadvantaged by the current system. They tend to have chronic illnesses and multiple conditions that cost a lot in prescription charges, and they are the ones who have to make choices as to whether they can or cannot redeem prescriptions. Although I cannot give you chapter and verse by way of figures, I certainly know from talking to colleagues who work in the health service that there is a great deal of anecdotal evidence. The information from Citizens Advice Scotland also refers to people having to make choices about having one or other of their medications, or sometimes nothing at all.

On the back of that, there is the point that I started out by making, which leads very neatly to other points that have been made in response to Stuart Bain's information about the increase in the number of prescriptions. It seems to me that that reinforces the situation that we are in; our population is growing older and living longer, but it is no healthier and is, in fact, getting sicker. We will therefore have an increasing number of prescriptions prescribed, if not actually taken up, over the next few years as that situation continues. If prescriptions were free to everybody, that would benefit the poor more immediately, but it might also put us in the position of having to reinforce other measures to do with inequalities in health so that our population will get older but also healthier. If we can take a more preventive approach and use medicines in that fashion, we might bring about changes in other areas. Members have referred to the Kerr report, and it is clear that we will be in the situation it describes.

I accept Jenny Bennison's point about people visiting their doctors more often, but there is an issue there just as there is in many areas of medicine with regard to ensuring that people are aware of what GP services are available for. We hear in a number of forums and at different times about people turning up at accident and emergency units with a sprained ankle. We need to educate people about what services are for. We hear all sorts of nonsense about people making 999 calls because their cat is stuck in the larder, or whatever. Similarly, we must teach people the right approach to making use of health services.

Of course, there will always be people who will take advantage, who will have cupboards full of medicines and who will turn up at the GP's surgery with very little excuse, but I think that we can achieve an enormous amount with the bill by making prescriptions free to those who need that, in order to remove from them the stress about whether they can afford to redeem them and to provide them with the medicines that they need. That would increase generally the health of the population of Scotland, which should be a priority for us all.

Angela Timoney: You asked us to respond to Duncan McNeil's point. There have been a lot of comments from people around the table, some ad hoc reports and some personal views, and I think that that reflects the lack of good evidence that we have about the consequences of the bill's implementation.

Mr McNeil asked specifically whether there was evidence that the poor are less likely to get access to health services. We know that people in deprived communities go to see their GPs later and are less likely to demand referrals, so they may be referred later. If we place more demands on GPs' time, the problems for general practitioners in helping the poor and deprived will be exacerbated.

Mike Rumbles said that we are trying to encourage more people to go and see GPs, but that is not true in the modern health service. We are trying to ensure that people access the right health care. Where it is appropriate to self-manage, we want people to self-manage. Where it is appropriate to see a community pharmacist or other allied health professional, we want people to do that. My concern is that if we make all prescriptions free, we may end up with everyone going to see a general practitioner inappropriately, because of free access to prescription.

14:45

Mike Rumbles: I did not say what you attributed to me. I said that people should visit their GPs and other health professionals.

May McCreaddie: I take issue with the notion that patients are frivolous and would be more likely to visit their GPs. Most patients are responsible and value the health service. Recently, I was unwell and had to wait 10 days for an appointment with my GP. In the interim, I went to the supermarket—not to the chemist—to buy medications, after which I went to my GP for a prescription. Most people behave in that way. When they can manage a condition themselves, they will do so. We could facilitate patients to manage themselves in more innovative ways, through education about adherence to medications and access to nurses as a first port of call, for example.

One issue that we have not considered is the impact when people do not take their medications. A serious problem is that people do not take medications because they cannot afford them. What are we doing about that? That problem has been ignored because of the extent to which people have medications but do not use them. Some people do not buy medications and therefore do not use them.

James Semple: The bottom line is that the proposal would cost a lot of money. The beneficiaries would be well-off people and the people who would lose out would be those who most need NHS health services. It is a bad idea to take from the poor and give to the rich.

The Convener: I suggest that we move on to a slightly different subject. I know that Colin Fox is twitching, but he was advised that he would be called to sweep up issues at the end. Do not worry—you will have your day. I am trying to ensure that all committee members and witnesses have the opportunity to speak.

We need to move on. The next topic is reform of the system short of abolition of charges, to which several witnesses referred.

Kate Maclean (Dundee West) (Lab): My question is aimed more at people who are neutral on, or opposed to, the bill, although I am interested to hear what anybody has to say. If I had a choice between the status quo and abolition, I would go for abolition. From hearing everybody's brief comments at the start, I think that I am right in saying that no one is in favour of the status quo, although I am sure that I will be corrected if I am wrong.

It is ridiculous to have a system that requires somebody to pay for medicine when they have a mental illness and are compelled by compulsory order to take medicine, or when a person has cancer. An anomaly, however, is that if one condition exempts a person from paying for a prescription, every other medicine that they receive is also exempted. There are many anomalies.

Will the people who favour reform say realistically what criteria could be used to decide on exemptions? Could we exempt so many conditions that the number of people who pay for prescriptions becomes so small that abolition would be better because the cost of administration for that small number of people would outweigh the amount that was collected?

Helen Eadie (Dunfermline East) (Lab): I will build on what Kate Maclean said. I emphasise the point about people qualifying for exemptions. If someone has an exemption because they have a particularly serious condition, when they go to the chemist, that exemption applies to everything else they receive, whether for influenza or whatever.

As I understand it, there is a more fundamental issue in the debate around exemptions. A major report—the Wanless report of 2002—criticised the exemptions as being illogical because they do not take account of people's ability to pay; rather, the main criteria are age, receipt of income-related benefits and specific medical conditions. We need to consider what we are trying to achieve. Are we trying to achieve a system in which exemptions are based primarily on people's ability to pay, or are we basing it on the number of illnesses and medical conditions that people have?

I do a lot of work with people who suffer from skin diseases, ranging from the extreme—skin cancer—to dermatitis, eczema and so on. An issue that came up in Ken Macintosh's member's business debate was that a person with cancer who loses all their hair quite rightly gets a replacement wig—that comes under appliances—no matter what age they are, but young patients who have skin conditions and lose all their hair must pay for wigs throughout their lives. Even when they get to 60, they still have to pay for the prescriptions, which can amount to £200, £300 or £400. We are not just talking about a £6.50 prescription. Should that be a priority area of reform, which we should be considering? Skin disease is a chronic condition that no one has addressed for years.

Chris White: Kate Maclean mentioned community treatment orders, which introduces a new dimension to the prescription argument, particularly in Scotland. Under the Mental Health (Care and Treatment) (Scotland) Act 2003, people can be subject to community treatment orders, which means that they have to comply with the conditions of the act. Part of that could be compulsion to take medication; there would be legal and personal consequences of not doing so. At the moment people have some choice, but people on incapacity benefit, who would not qualify for free prescriptions, would be forced into paying for prescriptions. We said earlier that there appears to be no clear rationale regarding chronic conditions. We risk adding to the unfairness of the situation if we consider exemptions on chronic conditions.

Jim Milne: The latest Government figures show that there are 319,000 people in Scotland on incapacity benefit who are not exempt from prescription charges. If we are serious about tackling health inequalities in Glasgow and Dundee—the main black spots, where up to 20 per cent of people are on incapacity benefit—we will have to deal with that issue.

Elspeth Atkinson: On chronic illness, people who have cancer are living longer, and are living

longer at home. In the light of all the facts, the side-effects and the consequences, the general consensus seems to be that the present system should be reviewed. Considering the number of people with cancer who are being treated at home, it is important that the many worries that they have—one of which, after the cancer itself, is finance—be addressed. Younger people who are unable to work have great difficulty paying for prescriptions. We ask the committee to consider that carefully because we do not want people to have to pay for long-term drugs when they are being treated for cancer at home.

Lindsay Isaacs: People who are on incapacity benefit or disability living allowance or statutory sick pay, are not automatically entitled to free prescriptions. By virtue of the very fact of their being on such benefits, those people can be expected to have higher costs for prescription charges, which they cannot meet. In addition, many people genuinely believe that they are entitled to free prescriptions and because the system is opaque, not very accessible, complex and confusing, they incur costs and find themselves paying punitive penalty charges. Those people are already very vulnerable because they are on low incomes and have chronic health conditions.

Kate Maclean: I would like some of the witnesses to address more medical criteria. To a certain extent, income-based criteria are simpler to define and address. For example, we could just say that everybody on incapacity benefit should get a free prescription. I am more concerned that it will be impossible to define medical-based criteria and have a hierarchy of criteria that would allow us to say, for example, that one condition will be eligible but another will not. Therefore, it would be useful if some witnesses could address medical criteria.

Suzanne Clark: I have to agree with most of what Lindsay Isaacs said. A large increase in the number of people receiving free treatment for long-term conditions would help significantly to decrease cases of hardship. However, it is unreasonable that payment exemption for one condition brings with it exemption for all other treatments—that does not make sense.

Glyn Hawker: Unison supports the bill, but we said in our written evidence that we would prefer reform of the status quo. There does not seem to be a great deal of difficulty about that. However, how would we achieve a defined list of further exemptions based on chronic conditions, on which I take Kate Maclean's point? I do not know how that could be done. Would so many people be exempt that the revenue that was generated became more trouble than it was worth? On that basis, and having considered the options, Unison comes back full circle to the abolition of prescription charges being the fairest and most straightforward option.

James Semple: It seems to me that there is actually a very simple solution to the problem. Kate Maclean made a good point; it is absolutely true that we cannot keep adding on different chronic conditions because we would get arguments about whose chronic condition was more chronic than everybody else's. At the end of the day, the only thing we care about is that people are not disadvantaged because they cannot pay for prescriptions. It strikes me, therefore, that the simplest solution is to have a well publicised and easily affordable season-ticket system and to ensure, as we currently do, that anybody who is not exempt on the ground of cost can access it and that no chronic conditions are exempt. If anyone cannot afford the season ticket, they get it for nothing. That would solve all the problems in one simple step.

Dr Rutledge: I want to come back to Kate Maclean's point about how we can change the current system, which most people seem to think is unfair, especially regarding medical exemptions. The issue is whether we should change them or reform them. The current list was produced in 1968 and there have been various meetings throughout the years on how we should change it. The most recent meeting for England and Wales that considered the issue failed to reach a conclusion.

Stuart Bain told us about the statistics. The number of prescriptions that are written is rising at a great rate; the health bill is constantly rising at about 13 per cent a year; and about 80 new drugs come in each year. If we were to have an exemptions list, we would have to change it every three months. By the time we had done that and included all the chronic medical conditions that we thought were valid for an elderly population, we would be exempting about 98 per cent of prescriptions.

One of the things that I like about the bill is that in principle it is simple; it takes an all-or-nothing, 100 per cent position. However—to switch the discussion slightly—I think that Helen Eadie asked what we are trying to achieve. If we are trying to achieve more funds for the NHS, which is what the current system originally came in with a long time ago, there are other ways to do that. We could shift the onus for funding from the individual and their status—whether age, medical condition or whatever—to considering the drugs that are prescribed.

15:00

I analyse drugs to establish whether they are of high or low benefit to the NHS. We could bring in a

system similar to that which operates in Australia, France and Italy, which unfortunately has not featured in the papers or in the discussion. Their systems are based on the effectiveness of drugs. Essential, effective, cost-effective drugs would be free to everybody, regardless of who they are. Patients would make a co-payment for drugs that are of similar effectiveness but which are more expensive and there would be a full charge for drugs that are of dubious benefit. Such drugs are currently being prescribed all the time. We should be very proud of the Scottish Medicines Consortium, because it evaluates all new drugs and makes such assessments. We are therefore in a unique situation to consider such an approach. That is what makes the discussion very interesting. I put forward that idea for consideration.

The Convener: I remind witnesses that we have to take evidence on the bill that is before us.

May McCreaddie: I would like to make two brief points. First, benefits can be gained from prescribing for certain conditions. For example, as Greater Glasgow NHS Board has shown, if we prescribe for HIV, we will, as a consequence, reduce opportunistic infections and subsequent infections. Secondly, there is an anomaly for some medical conditions. If someone is diagnosed as having a sexually transmitted infection at a genito-urinary medicine—GUM—service, they will get free prescriptions, but if they are diagnosed by their GP, they will not. By the way, that is not why I was at my GP. There should be consistency, which is why I think it would be better to go for the complete abolition of prescription charges.

Dr Turner: There is no difficulty with prescribing within a hospital—hospital patients get their drugs. However, nowadays there is a great tendency for everyone to come out of hospital very quickly. That includes people with cancer who, because of the age group that they tend to be in and the income that they have, cannot cope with the price of some of the drugs—one drug might cost £100 per month. The other group that might find it difficult involves people who take immunosuppressant drugs after they have transplants. When they come out of hospital, they have to find the money for their drugs. If they do not keep on taking their drugs because of the expense, that might have a detrimental effect on their health and on their quality of life; it might also lead to an increase in GPs' workload, as many of those patients are now looked after in primary care settings rather than in hospital. Would anyone like to comment on that?

Dr Bennison: I suppose that, as a GP, I have to comment. A lot of early discharges take place, and there is a grey area about which drugs are prescribed by hospitals and whether patients should get a week's supply or a month's supply when they come out of hospital. In my experience, antiviral drugs for HIV are prescribed by the hospital clinics, so patients do not pay for them. As May McCreaddie said, there is an anomaly whereby people get free prescriptions at the GUM clinic but not from their GP. One of the reasons why people sometimes go inappropriately to accident and emergency is that they are given drugs free there; if they get a prescription from their GP, they have to pay for it. The system must be reformed.

Janis Hughes (Glasgow Rutherglen) (Lab): My question relates to a point that May McCreaddie made. Some of the submissions that we received—particularly those from health boards—state that the abolition of prescription charges might lead to a loss of revenue, which might affect front-line health services in the longer term. The converse argument is that some research indicates that patients who cannot afford to pay prescription charges and are therefore non-compliant with prescribed medication may require more acute care in the longer term and therefore may be more of a cost to the NHS—particularly the acute sector. Can any of the witnesses say whether they think that there would be a longer-term cost benefit from abolishing prescription charges?

Dr Rutledge: I am happy to comment on the matter, but I do not think that what I say will be that helpful as I have found very little evidence on it. Colin Fox's paper certainly contains some information, but it is really only speculation. What has been suggested is simply an unknown.

When co-payments were introduced in other countries, the number of people who got prescriptions decreased. However, I realise that that is not really your point; you want to know whether abolishing prescription charges would prevent people from being admitted to hospital. We simply do not know the answer to that very difficult question. I have seen no data on it, and I am not sure whether Stuart Bain has any such data.

Stuart Bain: I do not have any evidence that is good enough to put before the committee.

On the narrow point about the cost of collection, several witnesses have pointed out that because one collects money from fewer and fewer people, the administration costs of collection become less cost effective. With new pharmacy contracts and new e-enabled ways of working, automatic payment systems are increasingly replacing manual systems. I do not think that the committee should run away with the idea that by abolishing prescription charges there is a pot of gold to be had out of administration costs. Increasingly, we are using systems that pay automatically;

therefore, the costs involved are at the margins of our administrative costs.

The Convener: This is probably an appropriate time to bring in Nanette Milne.

Mrs Nanette Milne (North East Scotland) (Con): My question is directed at Dr Bennison and Mr Semple. We have already touched on the possibility that introducing free prescriptions for everyone could overwhelm primary care and pharmaceutical services. What changes would need to be made to the existing systems to deal with the influx of extra prescriptions?

Dr Bennison: I am not familiar with the details of the minor ailments service in the new pharmacy contract, but we certainly need such changes. The idea is that patients who are entitled to free prescriptions but who need over-the-counter medication such as head lice treatment for children can obtain such items free from the chemist without having to get a prescription from their GP. If prescriptions became free for everyone, we would need to extend pharmacists' ability to hand out medication that does not really require a prescription to save on the unnecessary administration and paperwork involved in getting a prescription from a GP.

Mrs Milne: Will the new pharmacy contract take care of such situations?

James Semple: The minor ailments scheme, which forms part of the new pharmacy contract, is an excellent way of reducing inequalities because it gives people who are exempt from prescription charges the same fast access that the rest of us have to a pharmacist if they need over-the-counter medicines for minor ailments. Under the terms of the scheme, they will not have to phone their doctor and make an appointment to get a prescription.

Conversely, if we remove means testing, anyone will be able to walk into a pharmacy and get any medication they want for nothing. The over-the-counter market in this country is worth £127 million. Who in their right mind is going to buy something in a pharmacy if they can get it for free? If means testing is removed, the minor ailments scheme will be finished, because it will be unworkable. The barrier to excess consumption would therefore be that people would have to make an appointment with their doctor, but that would swamp those services. As Duncan McNeil pointed out, people who need those services will not get near them because there will be too many people in the surgeries suffering from sore throats.

Stuart Bain: My point is more general—and, I hope, slightly more neutral. The new pharmacy contract splits what is currently done into three different categories: the minor ailments service; the chronic medication service; and the acute prescribing service. Those services are not fully embedded at the moment but, as someone else pointed out, such an approach will mean that people will go to the right person for their condition at the right time.

The services, which are being rolled out, might relieve GPs of the high volume of people with chronic illnesses who seek repeat prescriptions. However, we need to carry out some modelling and to think about how any reform of the prescription charges regime will affect the changes that are already planned. We need to think about what perversities might be introduced into the system, either financial or to do with access to GPs and pharmacists. I strongly support reform, but we need to think the issues through. We might not have fully understood the consequences if we simply leap into the changes.

May McCreaddie: I return to Janis Hughes's point about the abolition of prescription charges possibly meaning a reduction in hospital admissions. There does not appear to be direct evidence for that. A report that is cited in our submission suggested that hospital admissions might be reduced. However, there is perhaps some indirect evidence. For example, in the nurse-led heart failure service in Glasgow, work has been done with patients on their medication, with the result that there is increased adherence and a subsequent reduction in admissions to hospital. That might not be directly related to the fact that people do not pay for their medication—those concerned probably do not pay for it because they are generally in the over-60 age group—but there is evidence that patients are more likely to adhere and therefore less likely to be admitted.

Alison MacRobbie: I endorse much of what Stuart Bain has said. I would like to add another layer to this. We have been talking mainly about situations in urban areas. Putting my remote and rural hat on, I point out that there are areas where we do not have any community pharmacy services and there is unequal access to medicines. Some of the issues that we are discussing are mainly relevant to urban areas. Different aspects that apply to remote and rural areas need to be taken into account.

Kate Maclean: I listened to Colin Fox and James Semple on the radio this morning and I was a bit puzzled to hear that the Scottish Pharmaceutical Federation opposes the bill. I could not see anything in it to which the federation and the profession would be opposed.

I am interested in James Semple's remark that people will not buy medicines from pharmacies if they can get them for free. Is it a concern that the delivery of pharmaceuticals will be different if people do not go into chemists to buy things? Quite a lot of things, such as cold treatments and

antihistamines, are available on free prescriptions at the moment, although people might not go to the bother of going to their doctor for such items now. However, if they were to get them on a free prescription, they would go to their doctor and then to the pharmacy. Is the concern a pecuniary or business concern, rather than a medical concern?

James Semple: There is a simple answer to that. The gut reaction of all pharmacists would be that prescription charges are a pest to collect and are a waste of their time—it is not their money—so pharmacists would be in favour of abolishing them. It is only when we consider the matter in more depth that we might conclude that abolishing prescription charges would not be the best thing for the health service. As far as the loss of the OTC market is concerned, I would say that, unfortunately, we lost it to Tesco and others years ago, so we will not be affected that much in that respect.

The Convener: We can now move on to a slightly different issue.

Shona Robison: There are a number of concerns about the system, should there be a swift implementation of the abolition of charges. Specifically, the issues of excessive consumption and the impact on primary care have been raised. Could some of the potential difficulties be dealt with through a phased abolition of charges, so that the system and the population can be prepared in a way that addresses some of the other aspects that we have been discussing? That might include the questions about who people go to or whether there can be better monitoring of prescribing. Would some of the panellists who have expressed concern be more reassured by a phased abolition?

The Convener: James Semple clearly spoke against the proposals at the start, and he has answered a lot of questions. Scott Bryson, who has been sitting very quietly, also said that he was against. Perhaps Scott could let James off the hook for just a second or two.

15:15

Scott Bryson: We would support a phased revision of prescription charges. We would emphasise the concerns that were expressed earlier. Our experience is that a number of patients on low incomes who are just above the exemption threshold have difficulties. It is ironic that chronic diseases, such as cancer, mental illness and coronary heart disease, that have been identified as national priorities are not exempt. My take on many of the contributions is that there is uncertainty and a lack of hard evidence. Therefore, there should be a controlled, phased revision and a careful assessment and quantification of the repercussions.

For example, if we were to go with one of the national priorities, I assume that, to determine and quantify the true impact of any innovative departure from the present arrangements, we would start with information about incidence and prevalence and the data that people such as Stuart Bain can supply on prescription numbers.

Shona Robison: I am not sure that phased revision and phased abolition are quite the same thing.

James Semple: Free prescriptions will cause a shift from self-care and people putting their hands in their own pockets to the NHS paying. Everyone may want that, but it will have to be paid for. There is no magic formula for doing it on the cheap; it will cost money and, in my opinion, that money will have to come from other parts of the health service, and those most in need will suffer.

Angela Timoney: My difficulty with the concept of phased implementation is the assumption that the abolition will be implemented. I would like to endorse what Stuart Bain said: we need to model the consequences of what we do before we make decisions on phasing the various stages. Should we, following the modelling, decide that that is the way forward, a phased implementation would be appropriate for different parts of the sector so that they can respond appropriately.

Stuart Bain: We are talking as though there were a closed system and that we either abolish the charges in it or not. One of the points that is emerging is that we may change what is in the system and that people may seek to have prescribed for them things that at the moment they cannot get prescribed for them. Therefore, the cost burdens may fall in different places. That is why I speak about modelling the proposal through to understand how people's behaviour would change.

We should not assume a linear progression. We should not say, "This is what it costs now, so that is the totality of the system. If we abolish the charges, these are the costs that we would bear." Abolishing charges may not only shift costs; it may alter their boundaries.

Dr Bennison: I would like to make a similar point. A proportion of the £127 million spent on over-the-counter drugs by people digging into their own pockets would end up being spent by the NHS.

My other point is that we must surely learn from what will happen in Wales. I think that there is to be a fact-finding mission there—

The Convener: We will be going there on 21 and 22 November to speak to a wide range of people about the position there.

I want to allow the visiting members to ask some questions.

John Swinburne (Central Scotland) (SSCUP): It is not so much what I want to ask; it is what I want to say. I do not know where the idea comes from that if we were to get something for nothing from the NHS, people would be queuing up to avail themselves of it. My circle of acquaintance and friends shy away from going to doctors as much as possible. I have gone decades without ever going near a general practitioner—I am content about that.

I know of no truth in the anecdotal evidence that we heard from James Semple—which, if I may say, was agist and unacceptable—about older people hoarding drugs. I can assure him that older people do not want drugs any more than younger people do. I am as old as anyone in the room, and I want no medication.

The position is not new. I remember that, in 1948, prescriptions were free for all. Unfortunately, paying for the war with Korea brought a halt to free prescriptions. The system was tried again in the 1960s, when it worked for a few years.

The system now is being tried in Wales, which is setting an example for Scotland. I would not like to think that our country would lag behind another country in the United Kingdom. If Wales can do it, we can do it.

When I hear anecdotal evidence about GPs who have to lie by making out a prescription for a person who is under 16 so that an older person can get medication that the GP knows the household cannot afford—

The Convener: That is fraud, and we have to be careful where we go with that.

John Swinburne: I know that it is fraud, but I know it to be fact. When we have such evidence, we should get back to basics and make prescriptions free.

This has been a very enjoyable afternoon.

The Convener: I ask Colin Fox whether there is anything left that he believes that we have not yet covered.

Colin Fox (Lothians) (SSP): John Swinburne said that this was an enjoyable afternoon, but it has been like a form of torture; it should be outlawed under the United Nations charter on human rights. I feel as if I need a prescription myself.

It seems to me—and there now seems to be a wider consensus—that no one now defends the status quo; I include the Executive and those who are present. The status quo is no longer an option, and this meeting has served to illustrate that. The question for this meeting and those who consider the bill is whether we should stick with a thoroughly discredited exemption scheme or whether we should abolish it. That is the choice in front of us.

It is unfortunate that James Semple has been put in the dock but it is inevitable that the discussion has centred around his remarks. It is the first time that I have heard a representative of the Scottish Pharmaceutical Federation saying the things that he has said today. He made the point that the majority of his colleagues believe that prescription charges are a pest and a waste of time and that their gut reaction would be to abolish them. Their day-to-day experience is that they come across patients who ask them, "Which one of these four items can I skip this week?" I thought that it was curious that that evidence should be dismissed.

I have a question about the frivolous use of the health service—I thought that James Semple's argument was frivolous, so it is a good word. He seems to be saying that the 50 per cent of the population who do not need medicines will, upon the abolition of prescription charges, rush off to see their GP and ask for free medicines. Is that accurate and is it likely?

James Semple: I said that the 50 per cent of the population who are not currently exempt will be more likely to access medicines from their GP than go into Tesco and buy a packet of paracetamol. I consider that to be a frivolous use of the NHS.

Colin Fox: I will press you on that because it is very important that everyone gets the facts and figures that you and I know. Fifty per cent of the population qualify for free prescriptions but 92 per cent of all prescriptions go to people who get them for nothing. That leaves 7 or 8 per cent. That is what we are talking about; the disparity is explained because the overwhelming majority of prescriptions are repeat prescriptions. Is it not the case that 75 to 80 per cent of all prescriptions go to people who get them week in, week out?

James Semple: The overwhelming majority of those prescriptions are for people who are over the age of 60.

Colin Fox: Let us focus on the question. As the colleague from the RCN said, you are saying to the committee that, rather than go to a pharmacist as the 8 per cent do at the moment—

James Semple: It is 50 per cent.

Colin Fox: Okay. You are saying that the 50 per cent of the population who are not currently exempt and who go to the pharmacist for over-the-counter medicines will instead make an appointment with their GP, which might mean that they have to wait with their condition for up to 10

days. They will sit in the surgery and wait to see the GP, rather than pay £3 at Boots. Is that your contention?

James Semple: First, no one I know waits 10 days these days to see a GP. You can see a GP very quickly. That is certainly true where I practise.

Colin Fox: How many days? One? Two? My point is not about the number of days.

James Semple: It is an important point. If someone is told they will have to wait for 10 days, they will not bother waiting. If they are told that they can have an appointment the next day, they are more likely to say, "I will go and see my GP tomorrow." It is obvious that a lot of GPs will deal with the pressure by writing a script line for 100 paracetamol or 48 ibuprofen for the patient to pick up at the surgery or the pharmacy. A large part of that 50 per cent may well think of drugs as something that they get from the doctor rather than as something that they get from the supermarket or the chemist.

Colin Fox: I do not want to get bogged down in whether it takes 10 days or one day to get an appointment. That is not important.

James Semple: I never mentioned 10 days.

Colin Fox: A period of 10 days was mentioned in evidence. You suggest to the committee that people will take time off work to see a GP rather than go to Boots to spend £3. That is your opinion. I have to say that we are probably not going to agree.

I turn to Dr Rutledge from NHS Lothian, whose evidence answers the question definitively, if I may be so bold.

Dr Rutledge, you state:

"Unnecessary demand can be managed by good prescribing practice and robust medicines management policies by Health Boards and their prescribers."

That is surely the way to discourage frivolous use. Do you want to expand on that?

Dr Rutledge: Yes. I stand by what I put down in black and white in our submission. In prescribing and medicines management there is a continual effort to ensure that we get patients the medicines that they need and that those are the best medicines for them. We have a barrage of policies and processes to try to make that happen and we do it quite well. All health boards follow prescribing indicators; we have lots of policies; we have formularies of drugs; and we have shown that we are getting better and better at that work. We need to make sure that we do that because we must spend NHS money efficiently.

Colin Fox: What evidence is there that the 50 per cent of people who already get free prescriptions are frivolous users of the national health service?

Dr Rutledge: There is no evidence of that. The 50 per cent figure is confusing; 90 per cent of those people do not get prescriptions because they feel well and do not need them. They might occasionally go to their pharmacist or a supermarket for paracetamol. The idea that all those people would suddenly rush off to the doctor is nonsense. They would not, because they do not need medicine.

Colin Fox: Exactly—they are not ill.

I turn to the substance of the matter, which is whether we should extend the current exemption system or opt for abolition. I address my question to Helen Eadie, who does a lot of good work with the Skin Care Campaign Scotland, and to the patients' representatives, Suzanne Clarke, Elspeth Atkinson and Chris White, who have not had much of a chance to contribute to the discussion. How would your organisations be affected if the exemptions were extended and there was a sick Dutch auction, in which the Skin Care Campaign Scotland, the Scottish Association for Mental Health, Macmillan Cancer Relief and Patient Partnership in Practice had to contend that certain conditions were more worthy than others? If you were in those circumstances, what would be your reaction?

Elspeth Atkinson: We would like everyone who is affected by cancer, regardless of their age, to get their drugs free. In the past, most people got their drugs in hospital—and perhaps they lived and died there. Now, luckily, most people do not do that. I take the point that we need to review the matter carefully and consider the NHS's budget because we are well aware of other priorities and the pressing need for the money. It has been suggested that we need a scale that shows which illnesses are more severe or more chronic than others. That is particularly important in relation to cancer because people with certain cancers can be quite well while they are being treated but people with other cancers can be very ill. However, it would be difficult to have a sliding scale whereby people with certain cancers got their drugs free but a line was drawn at a certain point. That could become an enormous problem. My comments also apply to other illnesses and long-term conditions such as asthma.

Suzanne Clark: The conditions that spring to mind are cancer and mental health. It is in everyone's interest that people with mental health problems get free treatment.

I suggest to John Swinburne that it is not a disgrace to be following Wales, but a learning opportunity. We will be able to find out what happens in Wales and take our ideas from there.

15:30

The Convener: In fairness to John Swinburne, he was not saying that it was a disgrace to be following Wales; he was saying—

Suzanne Clark: I am sorry; he said that it was a disgrace to lag behind Wales. I think that we should take what happens in Wales as an example and learn from it.

The Convener: Does Helen Eadie want to respond?

Helen Eadie: It would be difficult to give a quick response today, but I would be happy to give a more considered response in writing and to copy it to the clerk and to Colin Fox.

The Convener: That is reasonable.

The minister is waiting outside the room for the next item on the agenda, so I do not want our discussion to drift on regardless. Does Colin Fox have another specific question?

Colin Fox: I just wanted the other patient representative, Chris White, to have a chance to reply.

The Convener: I remind everyone that if they want to make a point, they can put their hand up at any time. I emphasised that right at the start.

Chris White: In response to Colin Fox's question, I am not sure that we would want to enter into a Dutch auction, especially in relation to mental health. As we said at the start, there does not seem to be a clear rationale behind the current list of exemptions. Page 12 of the SPICe report refers to a study in which a cap on free prescriptions was imposed on people who had schizophrenia. The result was that some of those people did not cash in their prescriptions and there was a rise in the rate of in-patient admissions. I repeat that we do not want to enter into a Dutch auction and that we must consider the effects of doing so on people's mental health problems.

Colin Fox: I am conscious that the committee is short of time because the minister is waiting outside, but I have one final question. It seems to me that none of the patient groups would feel particularly happy if patients in the other three groups were among those who were exempt from prescription charges whereas patients in their group were not.

My question relates to Stuart Bain's evidence and is to do with the money. He said:

"The system as it currently operates does not cost the Health Service anything to administer".

Stuart Bain: I would like to clarify that. It is not that the exemption system does not cost anything to administer, but that it does not cost anything more than the wider administration of payments costs. We must collect and process some 70 million paper prescriptions, which involves working out the various complex charging mechanisms that enable us to remunerate pharmacists. That is a huge undertaking that costs many millions of pounds a year. The element that relates to the tick in the box on the back of the prescription, which relates to whether someone is exempt from the charge or not, is just one part of the process. Moving to electronic methods of payment, electronic capture of data and electronic transfer of remuneration to pharmacists under the three new streams of the contract will significantly reduce the cost of that process.

To be fair, I think that what I said in the submission is inaccurate. It is not that the exemption system does not cost anything to administer, but that the cost is buried in the cost of administering the totality of the system. Removing the element of charge would not alter the cost significantly. There are proposals on the pharmacy contract, such as information technology management solutions, that will significantly reduce costs. That is how we aim to reduce the system's cost burden on the NHS.

Colin Fox: I am grateful for that clarification because the minister has already told us that the cost of administering the exemption system is £1.54 million. That covers the anti-fraud work and the cost of advertising the system and promoting pre-payment certificates, which, as the GP representative said, are not as well known as the pharmacists organisation would like them to be.

I am grateful for your clarification of the cost of the system, but I want to press you on something else that you say in your evidence. You say that pre-payment certificates bring in another £8 million to the NHS on top of the £43 million. That is a curious figure. Throughout the past two years, the Executive has been asked repeatedly about what its income would be if prescription charges were abolished, and it has said that the figure would be £43 million. In your evidence, you suggest that there is another £8 million on top of that. Perhaps you meant that that £8 million was included in the £43 million. Will you clarify that for us?

Stuart Bain: I would rather clarify that in writing to the committee after today's meeting.

Colin Fox: I am grateful for that.

I am sure that everyone present, including Stuart Bain from NHS National Services Scotland, would accept that a fundamental principle is at stake. When the NHS started out, that principle was that if someone was ill, they got treatment. Of course, prescription charges fly in the face of that fundamental principle. Do you accept that that is the case?

Stuart Bain: Frankly, that is outside my remit. I

am here to deal with the facts and figures of the matter. I have said that it is clear that inequities exist in the way in which the system is administered. Those inequities have been highlighted by people around the table. The system applies unequally to people with chronic conditions and as regards people's income. I started off by saying that we were neutral on the issue, but believed that prescription charges were an area that should be subject to reform.

The Convener: Thank you. I thank everyone for their attendance this afternoon. We have got through a significant amount of information. I hope that you did not find it all too difficult to endure, notwithstanding Colin Fox's comments. I suspend the meeting while we reset the table to allow us to move on to agenda item 3.

15:36

Meeting suspended.

15:40

On resuming—

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 12) (Scotland) Order 2005 (SSI 2005/497)

Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (Orkney) (Scotland) Order 2005 (SSI 2005/506)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (Scotland) Order 2005 (SSI 2005/498)

The Convener: Item 3 is subordinate legislation. I apologise to the Deputy Minister for Health and Community Care for the delay in bringing him in; he will understand the reason for that.

The Deputy Minister for Health and Community Care (Lewis Macdonald): Indeed.

The Convener: We are asked to consider three affirmative instruments relating to amnesic and paralytic shellfish poisoning. The minister is accompanied by Chester Wood.

The Subordinate Legislation Committee has already considered the orders and has no comment to make. Does any member wish to seek clarification from the minister and his official on any of the orders?

Mrs Milne: I have a question about the Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (Orkney) (Scotland) Order 2005 (SSI 2005/506). I notice that the notes on the purpose of the order refer to amnesic shellfish poisoning. I presume that that is a misprint.

Chester Wood (Food Standards Agency Scotland): Yes. I apologise.

Mike Rumbles: That answers my question.

The Convener: Does any member wish to debate the orders?

Members: No.

The Convener: Does any member object to a single question being put on the motions?

Members: No.

Motions moved,

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No. 12) (Scotland) Order 2005 (SSI 2005/497) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (Orkney) (Scotland) Order 2005 (SSI 2005/506) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (Scotland) Order 2005 (SSI 2005/498) be approved.—[*Lewis Macdonald.*]

Motions agreed to.

The Convener: That is the end of the minister's onerous duties and concludes our public business.

15:42

Meeting continued in private until 16:13.

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