# HEALTH COMMITTEE

Tuesday 29 November 2005

Session 2

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# HEALTH COMMITTEE
## 29th 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**

Mr Kenneth Macintosh (Eastwood) (Lab)
Mr Stewart Maxwell (West of Scotland) (SNP)
Euan Robson (Roxburgh and Berwickshire) (LD)
Mary Scanlon (Highlands and Islands) (Con)

*attended

**THE FOLLOWING GAVE EVIDENCE:**

Colin Fox (Lothians) (SSP)
Dr Nadine Harrison (Scottish Executive Health Department)
Lewis Macdonald (Deputy Minister for Health and Community Care)

**CLERKS TO THE COMMITTEE**

Lynn Tullis
Simon Watkins

**SENIOR ASSISTANT CLERK**

Tracey White

**ASSISTANT CLERK**

Roz Wheeler

**LOCATION**

Committee Room 2

# Scottish Parliament

## Health Committee

*Tuesday 29 November 2005*

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

## Items in Private

**The Convener (Roseanna Cunningham):** Good afternoon. Item 1 is to ask the committee to consider whether to take item 7 in private to allow us to consider the main themes arising from the evidence that we will be taking, which will inform the drafting of our stage 1 report on the Abolition of NHS Prescription Charges (Scotland) Bill. The committee is also asked to consider whether to take in private consideration of its work programme next week. Is it agreed that we should take those items in private?

**Members** *indicated agreement*.

## Subordinate Legislation

### Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 15) (Scotland) Order 2005 (SSI 2005/575)

### Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 16) (Scotland) Order 2005 (SSI 2005/579)

### Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 17) (Scotland) Order 2005 (SSI 2005/585)

**The Convener:** Item 2 is subordinate legislation. The committee is asked to consider three affirmative instruments relating to amnesic and paralytic shellfish poisoning. I welcome the Deputy Minister for Health and Community Care and Chester Wood.

As indicated in the papers, the Subordinate Legislation Committee previously considered the orders and has no comments on the first two. It considered the third order this morning and I am advised by the clerk that it had no comment to make on that, either. Does any member wish to seek clarification on the instruments from the deputy minister?

**Members:** No.

**The Convener:** Does any member wish to debate the instruments?

**Members:** No.

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

**Members:** No.

**The Convener:** I invite the minister to move motions S2M-3587, S2M-3588 and S2M-3621 en bloc.

*Motions moved,*

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No. 15) (Scotland) Order 2005 (SSI 2005/575) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No. 16) (Scotland) Order 2005 (SSI 2005/579) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No. 17) (Scotland) Order 2005 (SSI 2005/585) be approved.—[*Lewis Macdonald*.]

*Motions agreed to.*

### Food Labelling Amendment (No 3) (Scotland) Regulations 2005 (SSI 2005/542)

### National Health Service (Superannuation Scheme, Injury Benefits, Additional Voluntary Contributions and Compensation for Premature Retirement) (Civil Partnership) (Scotland) Amendment Regulations 2005 (SSI 2005/544)

### Common Services Agency (Membership and Procedure) Amendment (Scotland) Regulations 2005 (SSI 2005/550)

**The Convener:** We come to item 3. The committee is asked to consider three negative instruments as listed on the agenda. The Subordinate Legislation Committee has considered all the regulations and has comments to make on SS1 2005/542 but not on SSI 2005/544 and SSI 2005/550. No comments from members have been received and no motions to annul have been lodged in relation to any of the regulations. Are we agreed that the committee does not wish to make any recommendation in relation to SSI 2005/542, SSI 2005/544 and SSI 2005/550?

**Members** *indicated agreement*.

**The Convener:** Thank you, minister. That bit of your duties is completed.

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

14:04

**The Convener:** Item 4 on the agenda is further stage 1 consideration of the Abolition of NHS Prescription Charges (Scotland) Bill. Last Monday afternoon and Tuesday, Jean Turner, Mike Rumbles, Janis Hughes and I, accompanied by a clerk, visited Cardiff to look at the phased abolition of prescription charges in Wales. I invite those members to highlight briefly the impressions that they took away with them, after which we will have a short discussion of the visit.

**Mike Rumbles (West Aberdeenshire and Kincardine) (LD):** It was clear that the abolition of charges was a political decision that had been not so much made after consideration of a great deal of evidence as motivated by the election results and the Welsh Assembly Government's mandate. However, one piece of useful and concrete evidence that we received came from Citizens Advice, which said that 28 per cent of its clients failed to get all or part of their prescriptions dispensed because they found the cost prohibitive.

**Dr Jean Turner (Strathkelvin and Bearsden) (Ind):** I was surprised to find that the decision had not been based on any evidence—it seemed to be more of a walk in the dark. The difference is that the Welsh Assembly Government is phasing in the measure. I agree with Mike Rumbles that the only real evidence that we received came from Citizens Advice. Indeed, the chair of the Health and Social Services Committee said that he had evidence from his general practice days, but he did not seem to know where he could find it. As a result, we were left with no evidence at all.

**Janis Hughes (Glasgow Rutherglen) (Lab):** The report speaks for itself. As other members have said, it was difficult to find any evidence. That said, I was interested to discover that the legislation to abolish all prescription charges was introduced after a member's legislative proposal to abolish prescription charges for people with chronic illnesses had been debated at great length in 2003. People who supported the member's proposal felt that it would possible to produce a clinical definition of chronic illnesses, but it was then decided that charges should be abolished totally.

**The Convener:** That is a fair, if brief, summation of what we discovered. For stage 1 consideration of any legislation, the committee is enjoined to look for evidence. Given that the Assembly is in the process of phased abolition and intends to abolish charges completely by 2007, it seemed only sensible to go to Wales. The alternative

would have been to invite a number of Welsh witnesses to come up here and give evidence.

It quickly became clear that we were not going to get the cast-iron evidence that we were looking for and—to be fair—expected. Although our discussions were interesting, they were couched in the same language as we have heard used in Scotland. People could relate anecdotal evidence of one kind or another—they could tell us what they believed, thought or felt was going to happen—but very little of the negative or positive impacts that they identified could be backed up by hard evidence.

We got a couple of things out of the visit. First, as Mike Rumbles pointed out, Citizens Advice told us about its very specific survey and gave us some information about the situation in Italy, where prescription charges have been abolished. However, we ought to be careful in reading across to what might be a very different health culture. More to the point was the reminder, for those of us who are too young to remember such things, about the previous abolition of prescription charges in the United Kingdom. We think, from what we can see, that that might be the source of the feeling that there would be a 30 per cent increase in the number of prescriptions, as there was a 30 per cent drop-off after the charges were reintroduced. One might say that that is a small piece of concrete evidence, although it arose from something that happened a long time ago in very different circumstances.

We are back at square one. As has rightly been pointed out, the decision that was made in Wales was purely political. The decision was made, it was driven forward and some monitoring is now being undertaken of the impact of the phased abolition on over-the-counter sales. If the number of over-the-counter sales decreases, the assumption will be made that the number of prescriptions for those products has increased. A couple of studies are being undertaken, but they will not be completed in time for our stage 1 report; indeed, we will not know the results of those surveys for a couple of years.

**Shona Robison (Dundee East) (SNP):** I seek some clarification. On page 4 of the report, under the heading "Impact of phased abolition", we are told:

"there did not appear to have been a noticeable rise in the number of prescriptions due to the reduction in price."

Are there any figures available for that? I assume that there must have been some evidence, however limited, leading to that conclusion.

**The Convener:** There was not. The pharmacists told us that they had not picked up any impact thus far. In 2003, the Welsh Assembly Government froze prescription charges at £6; last year, it brought them down to £5. The charge is currently £4 and will be £3 next year. The pharmacists told us that they anticipate that the £3 charge will be the trigger for some of the impacts to begin to be felt. They said that, thus far, they had not detected any impact on their workload, but they insisted that they would. The evidence is all still anecdotal.

**Kate Maclean (Dundee West) (Lab):** On page 3 of the report, under the heading "Simplicity of approach", we are told that the National Assembly for Wales concluded that it would be easier to have a phased abolition of prescription charges than to put together a list of chronic conditions, which would be overcomplex. The report states:

"It is worth noting that a number of Assembly Members suggested that, in their view, it would be possible to produce a clinical definition of 'chronic'."

Was that a large number of members, or just one or two?

**The Convener:** One or two members of the Assembly committee who were general practitioners felt that the word "chronic" would be self-evident to most doctors, who would be used to describing chronic illness. However, I would argue that there is a big difference between the medical definition of "chronic" and what the population thinks of as chronic. That might be one of the difficulties that the Welsh Assembly Government considered.

**Mike Rumbles:** Kirsty Williams, the Welsh Assembly member who introduced the original proposal, went down the route of defining chronic conditions and some Assembly members are still convinced that that is the way to go. However, we heard evidence from others that, by the time a list of chronic conditions had been compiled, it would not be worth going down that route, because there might as well be a total abolition of charges. That influenced the thinking of the Welsh Administration.

**The Convener:** There was definitely an indication that such an approach would be quite complex. That is what drove the Assembly down one road rather than another.

14:15

**Janis Hughes:** Correct me if I am wrong, but I understood that the member's legislative proposal to abolish charges for certain chronic conditions was passed and that, prior to the dissolution of the Assembly, a working group was set up to look at taking it forward. Obviously, the majority of members at the time supported the move, but it did not happen because the Assembly was dissolved subsequently.

**The Convener:** The proposal to abolish charges then appeared in the manifesto of at least one party—the Labour Party—which, after winning the election, began the process of abolition and dropped the provisions relating to chronic illness.

**Dr Turner:** Everyone was in agreement that the present system is extremely unfair. Every person to whom we spoke thought that the present state of affairs was so unfair that the issue had to be approached in another way. That was positive.

**Mr Duncan McNeil (Greenock and Inverclyde) (Lab):** Unfair to whom?

**Dr Turner:** It is unfair to those who have to pay.

**The Convener:** Jean Turner is saying that nearly all the witnesses to whom we have spoken have said that they do not think that the status quo is ideal, although they may have different views on how it could be improved. There was the same perception in Wales. No one felt that the pre-existing situation was good, although they had different ideas about how it should be changed.

**Mr McNeil:** Did they propose any changes? Many people have sat around this table or have written to us saying that the system is unfair, but they have not identified the issues that need to be addressed.

**The Convener:** The biggest change that has been suggested is a change to the chronic diseases list. With one or two members, I canvassed the possibility of changing the qualifying criteria, on a socioeconomic rather than a medical basis, but we did not get much feedback on that. It is possible that something could be done in that area, because the evidence from Citizens Advice is that there are people on incapacity benefit who cannot get free prescriptions. Many people find that a little strange.

We may need to address the situation of the narrow band of people who are on low incomes but do not qualify for free prescriptions. There may be other ways of doing that. However, there was not a strong sense in Wales of what those other ways might be. Duncan McNeil is right to say that the witnesses from whom we have heard have not yet given us a strong sense of what the alternatives to abolition might be.

We are trying to give members a flavour of the extent to which all the discussions that we had in Wales were as anecdotal and hypothetical as some of the discussions that we have had here. We are no further forward in terms of evidence.

**Mr McNeil:** Was the trip a waste of time?

**The Convener:** I do not think that it could be said to be a waste of time. We had a number of discussions in which it would have been interesting for you to have participated. We heard a spirited defence of the abolition of prescription charges from the Welsh Minister for Health and Social Services. That defence was couched in exactly the same words and sentiments as your spirited objection to abolition.

**Mr McNeil:** He was wrong, of course.

**The Convener:** It would have been an interesting and dynamic conversation. The visit was not a waste of time. We came away with the clear indication that the Welsh Assembly Government had made a political decision about the policies that it wanted to pursue and that the evidence on the positive or negative impact of abolition was not going to change its view. It felt that there was a good to be had from abolition and wanted to pursue that. The alternative would have been for us to have had a host of Welsh representatives flown up here, at vastly greater expense, to give much the same evidence. In view of what we are doing, we would have needed to take evidence from them.

I think that we have exhausted the subject. As no members seem to wish to ask any further questions or to make any further comments, we will move to item 5 on our agenda, which is our final evidence-taking session on the Abolition of NHS Prescription Charges (Scotland) Bill. We will take evidence from the Deputy Minister for Health and Community Care and, subsequently, from Colin Fox.

Members have a copy of the report from the Finance Committee on the financial memorandum that accompanies the bill; they also have a copy of a paper containing supplementary submissions. It would be helpful if Colin Fox would come to the table; I expect that he will want to ask the minister questions after committee members have done so. I invite Lewis Macdonald to make a brief opening statement.

**The Deputy Minister for Health and Community Care (Lewis Macdonald):** I begin by introducing Chris Naldrett from the policy side of primary care, and Dr Nadine Harrison, who is a medical adviser in primary care.

In my brief opening statement, I will reinforce the message in the memorandum that we sent to the committee earlier this year: the Abolition of NHS Prescription Charges (Scotland) Bill should not proceed. The evidence that the committee has heard since that time does not appear to me to alter the balance of the argument.

One thing that is generally agreed in Scotland, as in Wales, is that the current system of prescription charges is no longer fit for purpose in the 21st century. That is why the Executive parties agreed two years ago to undertake a review specifically in relation to people between the ages

of 16 and 60 with chronic conditions and in relation to young people in full-time education or training. We have not yet published the terms of the consultation as part of that review, but it is likely to consider some fundamental points. It will of course be informed by evidence that this committee has taken.

When Andy Kerr launched "Delivering for Health" a month ago—and I think that everyone here spoke in the debate in the chamber—we made it clear that we wanted to see some pretty important changes in the way in which health care is delivered. We said that it was time to acknowledge the prevalence of chronic conditions and to adjust our approach to the national health service accordingly; we talked of developing a team approach to primary care that focused on promoting good health rather than simply on treating illness; and we emphasised the priority that we would give to tackling health inequalities. All those priorities attracted pretty broad cross-party support. I contend that none of those priorities can best be delivered by the abolition of all prescription charges.

Addressing the kind of chronic conditions from which people suffer will include ensuring that prescriptions are affordable. The way in which we support people with chronic conditions will reflect the reality of people's health as it is now, rather than as it was in 1968. It does not follow from that that all prescriptions for all people with chronic conditions should be free of charge. We need to address the anomaly whereby a person with one chronic condition receives special help not only for their chronic condition but for all other prescriptions, whereas a person with another chronic condition does not receive special help at all.

Promoting better health will at times include therapeutic interventions, but more often it will mean changing people's lifestyles, offering them more choices and giving them more knowledge to inform those choices. If we are serious about moving the focus towards promoting better health and preventing illness, we should not start by reducing the cost of prescriptions and encouraging, to whatever degree, an increased uptake of prescribed medicines; instead, we should continue to focus on containing the growth of the drugs budget, without compromising patient care, in order to free up resources for other purposes.

Abolishing prescription charges is not where we would ever start if we were seeking to address health inequalities. At the moment, the population split is roughly 50:50—roughly half the population are exempt from paying prescription charges and roughly half are not. The exemptions include everybody under the age of 16, everybody under the age of 19 who is in full-time education, everybody over the age of 60, pregnant mums and so on. They also include people with one or more of a certain list of chronic conditions—in those cases, the exemptions pay no attention to social or economic circumstances.

The exemptions acknowledge the special needs of the old, the young and people with certain conditions, regardless of income. However, they also include all those who receive or whose partner receives income support, pension credit guarantee credit, income-based jobseekers allowance and all those who qualify for help on the basis of tax credit or under the NHS low income scheme.

As has been said, there may be people at the margins. Evidence from Citizens Advice has suggested that tens of thousands of people may be involved. That is by no means proven, but it is possible. Abolishing prescription charges for those on average, above-average or high incomes is not the way to deal with anomalies that affect the low paid. That is not where one would start if one wanted to tackle disadvantage or inequality; it would simply exempt many people who can afford to pay the charges.

As you said in your introduction, convener, we need to consider whether we can do more to address health inequalities by considering NHS prescriptions. That will be an underlying purpose of the review that we will work on in the new year. However, we need to proceed on the basis of evidence. The report from Wales reinforces what the committee has found, which is that there is not yet a solid base of evidence for making fundamental changes. Certainly, that is one of the key things that we will want to address in our review next year.

**Mrs Nanette Milne (North East Scotland) (Con):** You have just clarified some of what I was going to ask, minister. However, it is clear that everyone agrees that there are anomalies in the present system and that that situation cannot go on for ever. What are the Executive's views on the purpose of prescription charges?

**Lewis Macdonald:** The fundamental principle that underlies our opposition to Colin Fox's bill is that we believe that there should be co-payment and that those for whom prescription charges are not a financial burden should share the cost. That is a means by which those who can afford to do so pay the charges, which clearly benefits everybody, particularly those who cannot afford to pay. That is essentially the purpose of the current structure of prescription charges. The system has become out of date and needs to be brought up to date, but it is right to continue to charge so that patients are engaged with the process.

**Mrs Milne:** It has been suggested to me that a flat rate for everyone might address some of the anomalies. Will that sort of thinking come into your review? Will that be a possible option?

**Lewis Macdonald:** I do not want to prejudge the consultation paper in any of its detail. However, my Cabinet colleagues will not object if I say that it is unlikely that we will consult on flat-rate charges. I have said that we want to see whether we could do better in redressing health inequalities. Flat-rate charges would move us in the wrong direction.

**Kate Maclean:** You say that people should contribute if they can afford to, but why was that logic not applied to eye tests?

**Lewis Macdonald:** Eye tests raised a different set of issues; prescription charges are a separate subject. However, one of the guiding principles in relation to eye tests was to re-engage the ophthalmic profession with the NHS. Clearly, that engagement had lessened in the past 15 to 20 years, but the optical testing that we announced two or three weeks ago restored it. The tests are not simply to see whether someone needs glasses; it is a wider health test. It is about encouraging people to come back to the optician so that any issues that arise, such as sight or other optical health problems, can be addressed in that context.

**Dr Turner:** My point is similar to Kate Maclean's. I was thinking about the logic behind the fact that senior citizens get free bus fares and £200 for fuel. I can see health improvements in both those, but—

**The Convener:** Can we not stray by looking at the many other comparisons that can be made? Would you like to say something on this narrow point, Duncan?

**Mr McNeil:** I agree with the minister. It is clearly anomalous that a 60-year-old who is in high-paid employment receives free medicines and drugs, whereas a low-paid person under 60 does not. I also agree with the minister that providing free medicines to even more high-paid people is not the answer to the problem.

Although the minister mentioned that people who are on other benefits or on low pay are denied the benefit of free prescriptions at this point in time, he did not say how or when—or whether—that narrow band of people will be included in any solution to the problem of anomalies. The Scottish Parliament information centre research tells us that the Executive is not considering the economic side of the question, but the minister has mentioned the issue. In the Executive's consideration of the wider issue, will it take account of that narrow band of people who are on low pay?

14:30

**Lewis Macdonald:** I think that the SPICe briefing reflects the specific partnership agreement, which is that we will consult on whether prescription charges should be paid by those who are in full-time education or training and those who have one of a list of chronic conditions. Obviously, I cannot prejudge the Cabinet's consideration of the matter, but I believe that it will be difficult to consult on those two issues without considering the whole way in which the system operates and whether it is achieving its objectives.

It seems to me that—as the convener pointed out in closing the previous discussion—a critical issue in any such consideration will be whether a way can be found around the edges of the current system to improve the position of those who are on low incomes. Although the partnership agreement has no explicit commitment on that issue in the way that it has on the other two, I think that it will be impossible to consult on those two issues without consulting on the third.

**Mike Rumbles:** The minister will be familiar with the words of the partnership agreement:

"We will set up a review of prescription charges for people with chronic health conditions and young people in full time education or training."

That agreement was made two and a half years ago, but I understand that the only progress that the Executive has made is to prepare a literature review of the issue. After two and a half years, is the Executive serious about that commitment?

**Lewis Macdonald:** Yes, absolutely. The member makes a fair point in his question, but the literature review has been completed. On the basis of that review, the Cabinet has begun its consideration of the next steps. Therefore, yes, we are serious about that commitment.

Given our recognition that, on the one hand, the status quo is not fit for purpose and, on the other hand, Colin Fox's proposal to abolish all prescription charges is not the way forward, it is clearly incumbent on us to introduce a proposal that is neither of those things. We intend to do that early next year. Our proposal will not only fulfil the partnership agreement commitment but allow us to consider how we can better use the prescription charges and exemption system to deliver the wider health objectives that I mentioned earlier.

**Mike Rumbles:** It is interesting that not one person from whom we have heard evidence—either in Edinburgh or in Wales—is content with the present system.

It strikes me that the only proposal before Parliament at the moment is Colin Fox's bill. Given that the literature review took almost two years to complete and was finished seven months ago, and

that the minister's commitment is only to launch the consultation next year, what is the Executive's timetable for its proposals? He can see what I am getting at. If Parliament has no alternative to Colin Fox's bill, I think that it may very well go down that route unless the Executive provides some specifics fairly soon.

**Lewis Macdonald:** I recognise the force of that argument and I am keen that we should bring forward our proposals quickly. I certainly undertake to convey that message to my colleagues and ensure that the Executive's proposals are brought forward as soon as the proper process of Government allows.

**Shona Robison:** My question is on how the Executive plans to reform the system. Obviously, you have said that the Executive will wait for the consultation that will start next year, but you have already given some indication of which areas the proposals will consider. For example, in response to Duncan McNeil, you said that you will look at socioeconomic issues as well. I want to return to the issue of people who are chronically sick. When I listened to your opening statement, I think that I heard two messages, so I seek some clarification. Did you say that it does not follow that all those with chronic conditions should get free prescriptions?

**Lewis Macdonald** *indicated agreement*.

**Shona Robison:** So you do not agree that all people with a chronic condition should get free prescriptions. Are you saying that some people who have a chronic condition should get free prescriptions and some should not?

**Lewis Macdonald:** What I said was that the logic of prioritising chronic conditions does not mean that all prescriptions for all those with all types of chronic condition should be free.

**Shona Robison:** So the Executive does not intend to find a definition of the term "chronic" to provide a level playing field for those who have chronic illnesses.

**Lewis Macdonald:** However we frame the consultation, it is inevitable that some of the responses will be propositions about what ought or ought not to be a qualifying chronic condition.

**Shona Robison:** Is that not tantamount to a bidding war between the chronically sick?

**Lewis Macdonald:** It might be, and that is—

**Shona Robison:** Surely that is something to be avoided.

**Lewis Macdonald:** Absolutely. That is something that we want to avoid.

**Shona Robison:** But how can you avoid it?

**Lewis Macdonald:** You are taking the words out of my mouth. We need to avoid the process becoming a bidding war, so we are framing the terms of the consultation carefully, although it is not yet at the point at which we can publish it. The Cabinet is considering the matter carefully, because it is important. That comes back to Mike Rumbles's question about how serious we are about the consultation—we are very serious about it, but we want to ensure that it does not start a bidding war. We want to consider some of the fundamental issues that are implicit in the way in which the system operates at present.

**Shona Robison:** At this stage in the process, when we have a clear proposal before us, the fact that you have so few answers to what are pertinent questions leaves us in a difficult situation. I would have thought that, given all the time that you have had, you could say whether you will come up with a definition or talk about the approach that you will take, but there seems to be a complete lack of information about what you are trying to achieve.

**Lewis Macdonald:** As I said in my opening remarks, we want to ensure that the system—including the charges that are made and the exemptions that are provided—is geared in a way that delivers our health objectives. We accept that the current list of exempt chronic conditions is not logical or coherent in today's medical circumstances and that that needs to be addressed. I can see why, from your point of view, it would be advantageous if I could say precisely how we intend to address that, but we need to get the issue right. For example, we need to consider the way in which many people with chronic conditions who are not exempt take advantage of prepayment certificates and therefore pay less for their prescriptions than people who have a one-off requirement for a prescription pay. We must consider whether we can make that system more efficient and effective so that it delivers a better deal for those who have repeat and predictable needs for prescribed medicines.

**Kate Maclean:** Leaving aside the issue of which chronic conditions are exempt and which are not, why does the Executive think that someone should be exempt as a result of having a chronic condition? What is the purpose of that?

**Lewis Macdonald:** With the exemptions from prescription charges, we should seek to avoid placing an unreasonable financial burden on those who will struggle to meet it.

**Kate Maclean:** Is the aim purely to reduce the financial burden on people who have a chronic condition that requires them to take medication for the rest of their life, or is there a medical reason?

**Lewis Macdonald:** There is not an either/or choice. Affordability is one of the issues that we must consider. We need to think about whether the system best achieves affordability, but we must also consider how effective it is in ensuring that people take the medicines that they need to take. That may influence the issue of chronic conditions.

**Kate Maclean:** If the purpose of exempting people who have a chronic condition is to relieve the financial burden and to ensure that their health is maintained in the best way possible, how can you possibly discriminate against some people with chronic conditions? How can you possibly say that one person who has to take medication for the rest of their life to maintain or reach their full health potential in spite of their condition should be exempt, while saying that another person in a similar situation should not be?

**Lewis Macdonald:** You rather oversimplified my answer. The aim may be financial or therapeutic, or it may be both. There is no absolute rule that says that it is one or the other.

**Kate Maclean:** But how can you then discriminate against conditions?

**Lewis Macdonald:** That is precisely why we need to review the position in relation to conditions, as we committed to do in the agreement that was reached by the Executive parties two years ago. We need to have the consultation and consider the best way of addressing the issue, which is what we intend to do.

**The Convener:** I will bring Mike Rumbles back in, as he opened up the issue.

**Mike Rumbles:** On that point, minister, it was interesting that, in informal evidence, your counterpart in Wales said that there people could not discriminate between chronic conditions. He made the point strongly that in Wales they examined the issue, and said that in drawing up a list of chronic conditions it would be completely illogical to exclude some chronic conditions and not others, which is why in Wales they went for abolition. We are waiting with bated breath for the consultation. Will you include the chronic conditions that you believe should be consulted on, or are you throwing it open to every condition?

**Lewis Macdonald:** You and Kate Maclean make a cardinal point. We are wrestling with how we address the issue. We gave a commitment two years ago to consider the list of chronic conditions. As you both said, there are lots of chronic conditions other than those that are defined at the moment. The criteria that were set nearly 40 years ago in 1968 were to do with lifelong, life-threatening ailments. Clearly, other ailments meet those criteria today. There is an immediate difficulty when you try to distinguish between one and the other, which is why we need to consider carefully the way in which we consult—in other words, what we seek people's views on and how we design the review process. We recognise the importance of getting it right, which is why we are giving it serious consideration.

In response to the general point that has been implicit in some of the questions, the fact that it is difficult to deal with chronic conditions is not an argument against patients co-paying for their prescriptions. While there is a difficult debate to be had about and difficult judgments to be made on chronic conditions, exemption and prepayment, that is a different proposition from saying, "Ah well, if it's difficult let's not bother doing it and let's not charge anybody for everything." Clearly, that would be a false conclusion.

**The Convener:** I do not want to spend all our time discussing a proposal that is not in front of us, as opposed to dealing with the one that is. Janis Hughes has questions on a slightly different subject.

**Janis Hughes:** Minister, in evidence from Citizens Advice Scotland we heard about research that showed that 28 per cent of citizens advice bureau clients had failed to get all or part of their prescription because they found the cost prohibitive. Does the Executive believe that charges deter people from accessing necessary medication? Taking it a stage further, if that is the case, have you assessed the cost implications of the resulting effect on people's health?

14:45

**Lewis Macdonald:** Those are two important questions. On my officials' assessment of the evidence that has been advanced on those who have been deterred from taking up prescriptions, it is important to make one distinction in relation to the report from Citizens Advice in England, which cited a pretty standard MORI poll that asked 1,000 people a question and reported the answer. That is as reliable or otherwise as opinion polls in general. As politicians, we always pay attention to opinion polls, but we do not necessarily think that they give the gospel truth.

The report by Citizens Advice was probably in the right ballpark. On the basis of the returns from the MORI poll, it concluded that about 7 per cent of patients did not cash in all or part of their script. When that percentage is extrapolated, it produces a figure of 750,000 people. I am sorry—let me get this correct. The figure of 7 per cent related to the number of people who had had a script in the past year. From the MORI study, 1.7 per cent of the population of England and Wales were affected in that way. If we translate that into Scottish

numbers, we might get a figure of about 75,000 people. All the usual caveats apply to that piece of evidence, which is as credible as opinion poll evidence tends to be.

The other figures that were used in the Citizens Advice survey, such as the figure of 28 per cent, are a very different set of numbers and relate to the client population of citizens advice bureaux. As a former management committee member of a citizens advice bureau, I am acutely conscious that that client population is not typical of the population as a whole. A figure of 28 per cent of CAB clients in no way equates to a figure of 28 per cent of the general population. It is important to make that point. The MORI poll figure of 1.7 per cent that was cited in the Citizens Advice report is much more likely to be close to the reality of the situation than is the figure of 28 per cent, which related to CAB clients, who, almost by definition, face some financial difficulty.

I turn to what we believe some of the consequences of abolition might be. Committee members will be aware of the figure of about £44 million or £45 million, which is the charging income that health boards receive from prescription charges. There have been a number of studies that show what additional effects there might be in the event that prescription charges were removed. Page 14 of the SPICe report cites four studies that reflect the best academic estimates of what the increased demand for prescriptions might be. The lowest estimate of the increase in demand is 22 per cent. In Scottish terms, if we take the latest year's figures, that would represent an additional cost of £17.5 million.

That increase in demand has an implication for consultations in GPs' surgeries. If the lowest estimate is correct and there will be a 22 per cent increase in demand for medicines, there will be a 22 per cent increase in the amount of medicine that is prescribed, which will mean that GPs will have to spend additional time prescribing medicines for people who do not currently receive them. It is impossible to make any quantifiable estimate of what the cost of that might be. However, for the sake of argument, let us assume that there will be a 10 per cent increase in the number of GP consultations. The cost of that time translates into another £15 million or so.

Such figures all fall into the area that we talked about earlier—the evidence deficit. They are our best estimates, which we have based on the limited academic work that has been done. It is clear that the impact of the abolition of prescription charges would be greater than just the £44 million in prescription charge income that would be lost to NHS boards.

**Janis Hughes:** I have a slightly separate point about prepayment certificates. The same piece of research claims that the fact that we do not encourage people to use prepayment certificates could be detrimental, in that we are not encouraging them to have their prescriptions dispensed. If that research is correct, the cost of obtaining such certificates deters people from having their prescriptions dispensed. In its examination of prescription charging, what consideration has the Executive given to how we could improve that situation? The smallest prepayment prescription that one can buy covers a four-month period. That will certainly deter a number of people who cannot afford to pay a four-monthly charge up front. Have you considered reducing that to a monthly charge or using other initiatives, such as allowing people to buy stamps at a post office that would contribute to their prepayment certificate in the longer term?

**Lewis Macdonald:** We need to be imaginative and to consult people and encourage them to come forward with ideas. We might find other ways by which people can pay for certificates and another timeframe for the certificate to cover. There might also be a connection with the issue of chronic conditions. At the moment, if someone is exempt from charges because they have a chronic condition, they are exempt from paying for all medicines forever on the basis that they have an exemption form. Many of the repeat prescriptions that people in the wider population require are to treat chronic conditions. At present, we have a system that works on an ad hoc basis, and rather than ask whether we should exempt more people, perhaps we should consider whether there are ways to make repeat prescriptions more economical and whether that approach should be linked to the nature of the medicines prescribed. When we consult, we should cast the net as widely as possible to find good ideas about how to address the issues.

**Kate Maclean:** I am disappointed that we have got to this stage and the Executive is just saying, "Maybe we'll do this," or, "That sounds like a good idea." At least we know what is in the bill before us. I agree with some of it and disagree with some of it, although I realise that it could be amended so that the proposed system would be phased in. The Executive has given us nothing to compare with the bill. Ministers can say, "It would be a good idea to do this", "We'd like to look at this," and, "Proposals will be brought forward," but we have only the status quo or Colin Fox's bill to consider. I have difficulty with that.

Did the Executive consider carefully the bill and the impact that it would have? The Executive's response is negative and says that the bill is not supported by evidenced research that quantifies the potential costs, but exactly the same could be said about free personal care. It seems as though there has been a reaction against Colin Fox's bill,

and that it has not been considered as a serious possibility. To a certain extent, I do not think that there is evidence to support the bill, but there does not seem to be any evidence against it, either. I do not think that the Executive has provided us with any real evidence against it. It seems as though figures have been plucked out of the air. The response to Janis Hughes's question was that X amount more people could be going to the doctor and X amount more people could be getting prescriptions—it was like fantasy pharmaceuticals. You are not telling me anything that convinces me not to support Colin Fox's bill, minister.

**The Convener:** Can we please not go down the personal-care-for-the-elderly route?

**Kate Maclean:** The point that I was making is that some of the responses from the Executive about the bill are to a certain extent hypocritical, because the arguments used could be applied to Executive policies. I did not want to discuss free personal care or free eye tests, but the Executive's arguments against Colin Fox's bill could equally have been made against some Executive policies, so they do not really stand up.

**Lewis Macdonald:** I do not accept that the arguments do not stand up. I outlined at the beginning the fundamental argument as to why we do not think that abolishing prescription charges will help us to deliver any of our wider health priorities, which received broad support in Parliament just four or five weeks ago. Those priorities are about addressing health inequalities and promoting better health rather than only treating illness and dealing with chronic conditions. You as a committee and we as the Government have to consider the following: if we have £44 million or £100 million that we want to invest in those objectives, are they best met by abolishing prescription charges for medicines for everybody, regardless of their state of health, income or wealth? That is not the best way to invest that money. I could sit here and talk about £44 million, add the £17 million cost of increased demand and the £15 million that we estimate is the cost of GP time, and the committee would be right to be sceptical. However, I can tell you that those are the most conservative of the estimates that my officials have derived. I have been very keen not to exaggerate the impact on health service budgets. Members will see that increased demand will have an effect. The £17 million is the lowest of the figures that academics have derived; one academic has derived a figure of more than £50 million.

The estimated cost of GP time of £15 million assumes that there will be only a 10 per cent increase in the number of consultations arising from the 22 per cent increase in demand; it could be a lot more than that. I have used the most conservative figures to hand so that I am not indulging in fantasy pharmaceuticals; I am describing the situation as it really is. Health boards' income from prescription charges in 2004-05 was £44.4 million. We have to decide whether the best thing that we can do with that money is give it to people who have paid those charges, or whether there are other ways to promote our health objectives.

**The Convener:** You have talked about a number of figures and some work has obviously been done on the potential costs of the bill. It would be helpful if the committee could see some of that information so that members can make up their own minds. We are quite late on in the process, but it would be useful to know how the figures were derived and how robust they are. I do not know what you are able to let us have.

**Lewis Macdonald:** You already have the information on two of the figures. The £44.4 million is in the public domain.

**The Convener:** That is the current income from prescription charges.

**Lewis Macdonald:** The estimate of a 22 per cent, or £17.5 million, increase in costs because of the impact of abolishing prescription charges comes from the Lavers study of 1989, which is one of the four studies that were considered by Hitiris in 2000 and cited in the Scottish Parliament information centre paper. Those four peer-reviewed papers considered the impact of abolishing prescription charges in terms of the increase in the number of prescriptions. That is the most conservative figure from those four studies and it is in the public domain.

**The Convener:** You are talking about the information that we have in the SPICe briefing and you are using that as the basis for your figures.

**Lewis Macdonald:** Yes. The third figure that I quoted today—which is not in the SPICe briefing—relates to the costs of GP time. That is in Nadine Harrison's territory. We can certainly make that information available to the committee if it would be helpful.

**The Convener:** It would be most helpful. So far all that we have heard has been anecdotal and hypothetical.

**Lewis Macdonald:** That bit is; I agree.

**The Convener:** My only comment is that a study that was done in 1989 is beginning to get quite whiskery.

Should Parliament pass the bill, leaving aside the £44 million, and given the potential on-cost of GP time and so on, are there ways in which those on-costs could be mitigated?

**Lewis Macdonald:** So, for example—

**The Convener:** It is your contention that Parliament's choosing to pass the bill would be likely to result in increased use of GP time and so on. Can you therefore suggest ways in which that could be mitigated?

**Lewis Macdonald:** I am sure that you will have heard that the Welsh Assembly has been trying to encourage patients to acknowledge that the cost to the NHS has not gone down, even if the cost to patients has. In those circumstances, we would want to do the same with GPs. Nadine Harrison is a GP—she might want to say something about the position of GPs in respect of prescribing. We want to encourage GPs to be restrained about the number of prescriptions that they offer and we also want to encourage patients to be responsible.

**The Convener:** One suggestion that we heard in Wales was for a restricted formulary. I do not know whether the Executive has considered that. It was suggested that the formularies that are being used are way too wide and that much of the problem could be dealt with by using restricted formularies.

15:00

**Dr Nadine Harrison (Scottish Executive Health Department):** GPs can offer patients non-prescription therapeutic treatments, which is one way of limiting prescribing. I believe that Dr Phil Rutledge talked to the committee about managing prescribing. You are talking about having a limited list of prescribable drugs. Work on that was undertaken in 1984 and the suggestion was not entirely popular with doctors. The issue could be addressed, but the suggestion would restrict across the board drugs that are available to patients on prescription.

**The Convener:** The suggestion was made by a practising GP, who suggested having, for example, only a small number of forms of aspirin available in a restricted formulary rather than the more than 90 forms that are currently available.

**Dr Harrison:** The problem with making things absolute is that there will always be patients who can take only particular preparations. If local formularies are used—their use is common in Scotland—there will be a recommended most cost-effective preparation and drug in a class of drugs. GPs already voluntarily use such formularies throughout Scotland—their use is common practice nowadays. Prescription charges do not need be abolished for such formularies to be used—they are already used. The difficulty with restricting the number of drugs that are available on prescription is that at the margins, a patient might be denied something that he or she needs not because of its cost but because of a quirk of the system. Restricting the number of drugs is nearly as difficult as finding a correct list of chronic conditions.

**Shona Robison:** On costs, are the figures that you have come up with based on immediate rather than phased abolition? Obviously, the Welsh experience has not produced any comparable figures.

Secondly, the evidence seems to show that maximising the number of chronic conditions that are exempt would cost about two thirds of the cost of complete abolition. Would you therefore have to consider whether a system would have to be set up to administer the remaining third of the costs of prescription collection?

**Lewis Macdonald:** As I have said, I do not want to prejudge the detail of the consultation paper, but members will have gathered that there are a number of ways in which the issue of chronic conditions can be addressed. Simply to exempt all medicines for all patients who have chronic conditions does not seem to me to be the best way to go. I think that you suggested that that would account for most of the income that the health boards currently receive, which reinforces the point that it is not necessarily the way to address the problem.

It is important to emphasise what that money means—it means, for example, £3.5 million a year for Tayside NHS Board and £5 million a year for Grampian NHS Board. Those sums matter to those health boards and to the investment that they can make in other services. We should consider whether we are delivering the most effective policy to achieve our policy objectives, but the fact that there are difficult questions to answer does not mean that we should simply say that we do not need to worry about things and that we should simply exempt all patients for all conditions and everything will be fine.

**Shona Robison:** What about my first question?

**Lewis Macdonald:** What was that?

**Shona Robison:** Are the costs that you cite for immediate rather than for phased abolition?

**Lewis Macdonald:** The £44.4 million is the last full-year cost for 2004-05. The £17.5 million takes the most conservative of the four academic estimates of the impact of abolition on demand and multiplies it by the current cost of prescribing a medicine. Although, at the moment, the charge is £6.50 per prescription, the cost to the national health service is about double that. If you take a 22 per cent increase in demand and multiply it by the current cost, you reach that figure of £17.5 million. All those figures are based on the most current figures and assume that there is no prescription-charge income.

**Shona Robison:** So the costs are not based on phased abolition—

**Lewis Macdonald:** They are not based on phased abolition, but on where we would get to at whatever stage in the process.

**Mike Rumbles:** You said that you were concerned about the possibility that there would be a 10 per cent increase in GP consultations and so on. How does that concern fit with the Scottish Executive's health agenda, which is concerned with health promotion? Surely you want to encourage visits to GPs and other health professionals across the board.

**Lewis Macdonald:** That takes us back to one of the points that I made at the outset: we want to encourage a team approach and development of primary care teams. The figures that I have given are based on the direct impact of patients increasing their visits to GPs. At the moment, that is how most patients access prescriptions. Although we want to encourage nurse prescribing and pharmacist prescribing, many patients will continue to look to GPs to access a prescribed medicine.

**Mike Rumbles:** So you are saying that it is a good thing that people go to see their GP—

**Lewis Macdonald:** No—I do not think that the purpose of health promotion is to encourage people to go to their GPs to get medicines. The purpose is to encourage people to engage with the health care system in order to maintain good health. That is not the same thing.

**The Convener:** We have already had a discussion about prescribing practices in connection with the formulary questions, so we should not pursue that issue. I apologise to Jean Turner, but I want to bring in Colin Fox. He has been sitting patiently, having been advised that he would not get to ask questions until the rest of us had finished.

You can question the minister, Colin. However, bear it in mind that we have limited time.

**Colin Fox (Lothians) (SSP):** I understand, convener. I know that you are desperate to cross-examine me instead.

I am grateful to the minister for establishing that the parameters of this debate involve the fact that nobody defends the status quo, that the Executive does not take that view and that it is not part of the consultation process to defend the status quo. That backs up the evidence that was given by the first witnesses whom the committee saw a few weeks ago.

I want to ask about the thorny issue of chronic conditions, how they are described and how you can make some exempt but not others. The minister knows that that matter has been considered for 40 years and that we are in the position that we are in because of the problems that have been discovered as a result of that consideration.

I want to give you two quotes—

**The Convener:** This is your opportunity to ask the minister questions, Mr Fox. You can give evidence when we ask you questions.

**Colin Fox:** Okay. Minister, is not it the case that asking us to find a way through the chronic-conditions maze is like asking us to make a silk purse out of a sow's ear? Do you agree that that has never been done in 40 years? Do you agree that you are asking us to take a leap of faith and to accept that, in due course, the Executive might come up with a solution to a problem that has not been solved in 40 years?

**Lewis Macdonald:** It is probably fair to say that, when the chronic conditions list was prepared 37 years ago, it met the requirements of the time in terms of identifying conditions that are lifelong and life-threatening and making special provision for those. Colin Fox is right to say that this is not the first time the issue of what constitutes a qualifying chronic condition has been examined. In my answers to the committee, I have said that we do not want to open a bidding war between various chronic conditions. We want to examine fundamentally the ways in which the charging and exemption systems address and deal with chronic conditions and how the pre-payment system deals with repeat prescriptions for patients who have existing medical problems. I do not accept that that is making a silk purse from a sow's ear; it is more a case of acknowledging that there are some thorny issues. We want to ensure that the charging and exemption systems are fair, but we do not want to find ourselves saying that because difficult questions relate to medical conditions, we should not seek a contribution from people who can afford to make one.

**Colin Fox:** The other side of the question is that you said that the purpose of the charging system was to generate co-payments and that those who can afford to pay charges should pay. Can you identify anybody who could pay now, but does not?

**Lewis Macdonald:** Yes. As I said in my opening remarks, some people qualify for free prescriptions—for exemption—on the basis of age rather than what they can afford. As Duncan McNeil said, some people over 60 could readily afford to pay prescription charges but do not do so. However, that does not mean that our review will consider removing that facility. We acknowledge that age as well as medical conditions can influence people's needs.

**Colin Fox:** You do, of course, accept that tens of thousands of people can afford to pay but do not, however.

In the past two and a half years, every time I have asked the Scottish Executive what the cost of abolishing prescription charges would be, the cost has been £44 million. Today, you have come along and said that the cost would be much greater than £44 million—perhaps as much as £66 million.

**Lewis Macdonald:** No.

**Colin Fox:** The result of adding £17 million, £15 million and £44 million is £66 million, but the Executive has repeatedly made it clear that the cost would be £44 million.

**Lewis Macdonald:** The result of adding those figures is £76 million, not £66 million.

**Colin Fox:** So would the cost be £44 million or not?

**Lewis Macdonald:** I can give the precise answer that the income to health boards from charges in the past five years has ranged from £43.4 million to £46.5 million a year. If you keep receiving the answer of £44 million or something close to it as the cost to health boards of abolishing prescription charges, the direct consequence of abolition is that that figure would come off boards' budgets.

I have tried to show today—as we have said previously in response to the bill—that other costs would be incurred. We have not pretended that we know what they would be, but we are saying that the direct cost of £44 million in the latest year is quantifiable and that, although the impact on demand and on the health service in other ways is not readily quantifiable, it would be significant.

**Colin Fox:** When will we be able to see the research evidence that you have gathered? Will that be based on the 22 pieces of international evidence that are already out there?

**Lewis Macdonald:** Some of the figures that I have quoted are in the public domain and are from peer-reviewed scientific studies. As the convener said, some of them go back several years, but they are nonetheless out there. When we consult, we will indicate the basis on which we are consulting. I have said that we will make available to the committee the basis of any figures that I have used that are not in the public domain.

**The Convener:** Thank you, minister. I ask you to retire to allow Colin Fox to take your place—perhaps "retire" is not quite the right word. It is an old-fashioned way of saying, "You can leave now."

15:15

**The Convener:** Colin, we will give you the opportunity to make a very brief statement of no more than a couple of minutes, and then we will move to questions.

**Colin Fox:** Thank you, convener. I will take literally two minutes. I want to touch on two items in my introductory statement. First, on the founding principles of the health service, this time last year the then health secretary, Dr John Reid, laid out his intentions for the NHS.

**The Convener:** He was the United Kingdom's health secretary rather than Scotland's.

**Colin Fox:** Indeed, convener.

John Reid laid out his intentions for the NHS and I believe that he spoke for many of us when he said:

"I will protect the founding principle of the NHS of equal access to healthcare provided free at the point of need … I will never apologise for extending to the mass of working people the privileges that have been monopolised only by the well-heeled and well-connected since time immemorial. Why on earth would we not be proud of … that?"

Indeed.

I believe that we find the same sentiment in the Scottish Executive's policy document, "Partnership for Care", which was published in 2003. The Executive stated:

"We are committed to creating a patient-centred National Health Service—based firmly on the ideals of a public healthcare service which is accessible to all and free at the point of delivery. Those fundamental values that shaped the NHS over fifty years ago should still guide us in modernising health services today."

The trouble is that, with prescription charges, we do not have equal access to health care provided free at the point of delivery. My bill seeks to rectify that.

My second and final point is that the current system for exemptions that determines who does and does not pay, on which ample evidence has been put to the committee, often means that the "well-heeled and well-connected"—as Dr Reid described them—get privileges that working people are all too often denied. It is notable in this debate that nobody, but nobody, now defends the status quo. The clear choice is either to try to make a silk purse out of a sow's ear by trying to make a thoroughly discredited and irredeemably flawed system of exemptions less bad or, as I suggest, to opt for abolition of prescription charges, which is a fairer, clearer and medically robust alternative.

**The Convener:** Thank you. We ended the last question-and-answer session with a spirited discussion about the estimated cost of your bill. When you presented the estimated cost, did you

have in your mind at any stage at all the possibility of a potential increase in demand for prescriptions? Did you wrap that into the cost, or had you not really thought about it?

**Colin Fox:** The issue of cost is clearly central to the debate. I am grateful for the report that the Finance Committee put in front of us to help our deliberations. It is safe to say that we know some things for facts in this debate, but we clearly need to gather more evidence and studies need to be done. I approached the issue of abolishing prescription charges by seeking the relevant figures from the Executive. It has provided us with figures throughout that suggest that the cost of abolition would be £44 million. That is a falling cost, relatively speaking. When first I asked for the cost, it was 6.2 per cent of the health service drugs bill in Scotland; it is now down to 4.7 per cent, so it is a falling cost.

It is important to consider the evidence that we have gathered. The committee made a fact-finding visit to Wales. As far as I am aware, the evidence from Wales shows that abolishing prescription charges for people between 16 and 25 produced no significant extra demand on the health service during that period: that is fact rather than supposition. In all the figures that I have put in front of the committee, I have tried to keep to the facts and to keep supposition and hypothesis to a minimum. I have taken that approach throughout.

**The Convener:** Helen Eadie has a question about savings.

**Helen Eadie (Dunfermline East) (Lab):** In the financial memorandum to the bill, you anticipate savings from reduced use of other services. What evidence do you have for that?

**Colin Fox:** I was encouraged by the minister's response to the figures from Citizens Advice, which he put before the committee. He asked questions about the MORI opinion poll but he never questioned the veracity of the figures. If 75,000 people in Scotland have been prescribed medicines by GPs but, because they have not been able to afford the £6.50, £13 or £26—which would be the cost if they needed four items—they have not been able to get those medicines, it is reasonable to assume that their condition will deteriorate, otherwise we would want to sack the GPs for prescribing the medicines. The deterioration of those people's conditions will mean that they will present to the national health service somewhere else. We have clear evidence of that. I accept, however, that it is difficult to put a figure on that because we do not know how each of those 75,000 people will present to the national health service or how they will be treated.

**Helen Eadie:** You are making a value judgment rather than giving evidence—

**The Convener:** Helen, to be fair, that is not unusual in this process.

**Helen Eadie:** No, but it is a fact. I asked for evidence and—fair enough—he gave me a valued judgment. I accept that.

**Colin Fox:** David Cullum, from the non-Executive bills unit, has drawn my attention to the evidence that you suggest does not exist. Page 11 of SPICe briefing paper SB 05-33 mentions the Hitiris report to which the minister himself referred. The briefing paper states:

> "The author concludes that co-payment schemes are not an efficient policy as the revenue gained may ultimately be offset by a detrimental effect on the long-term health of the population."

That is in the Hitiris report. With respect, I am trying to steer you in the direction of evidence.

**Helen Eadie:** I am grateful to you and I will have a look at that.

My second question is whether, if the revenue from some of the charges were lost, that could result in a loss of other essential front-line services. If the health service's income were reduced, that would pose a potential threat to other essential services.

**Colin Fox:** I hope that we can focus on the costs of the bill and the savings that will be made—which nobody disputes—in administration, advertising, pre-payment certificates, anti-fraud measures, and so on, which will run to as much as £2 million. Those are real identified savings that the Executive does not dispute and has put before the committee.

As to the other potential savings, Dr Rutledge of Lothian NHS Board, who attended the committee three weeks ago, highlighted the fact that savings may be achieved through GPs considering shifting the basis of prescription from the individual patient to the cost of the drugs to the health service and the efficacy of the drugs. In its evidence to the committee, Unison talked about establishing a more effective and streamlined procurement service whereby, instead of local health boards buying from here and there, there would be a streamlined national procurement service. Many savings could be made.

I do not want the committee, in examining the figures on savings, to lose sight of the fact that the £44 million represents less than 0.5 per cent of the Scottish national health service's annual income. I want an honest debate in which we recognise that, although £44 million is a lot of money, it is not a lot of money in that context. Anybody who proposes that the health service cannot do without that money and that its loss would lead to cuts elsewhere is not entering the debate in an honest frame of mind.

I looked at the national health service's budget across Britain, which the Government has pledged to increase year on year by 7 per cent until 2008 so that it can get Britain's health spending up to the average level for European countries. I welcome and applaud that. Given that 7 per cent annual increase in the national health service's total budget, I am not convinced that there is evidence to suggest that it cannot absorb the £44 million cost of the bill.

**Helen Eadie:** What would you say to professionals in Scotland who are arguing for more resources to be given to the health service to, for example, warn about the dangers of sunbathing and using sunbeds? Despite the fact that they are desperately trying to save lives that are threatened by skin cancer, they cannot get resources for preventive action to tackle a disease that presents one of the greatest challenges to life.

**Colin Fox:** I understand those concerns thoroughly. However, for the same reason as I am not prepared to get into some sick Dutch auction over which chronic conditions should be exempt, I do not want to get into a debate on whether the abolition of prescription charges should be paid for by people who suffer from skin disorders.

**Helen Eadie:** So what are your priorities? What is the most life-threatening condition?

**Colin Fox:** With all due respect, I do not think that it is up to me to answer that question. As I have said, it is quite possible to absorb the £44 million costs in the current budget.

**Mr McNeil:** I do not accept that we are talking about £40 million-odd. From the figures that are before us, we will have to fill a £90 million black hole. I am more interested in the impact that the proposals will have on primary care, although I would expect anyone who came into Parliament quoting Trotsky, but who ends up quoting John Reid at this meeting, to say that the budget does not matter. Is it fairer for the Executive to spend precious health money on giving free medicine to, for example, an MSP who earns £50,000 or so a year or to give it to other health service priorities? If I have the opportunity, I will come back to primary care and the notion of equity of access.

**The Convener:** I call Mike Rumbles. [*Interruption.*] Pay attention, Mike.

**Mike Rumbles:** Sorry. Is it my turn to ask a question?

**The Convener:** Yes.

**Mike Rumbles:** I thought that Duncan McNeil had asked a question.

**Mr McNeil:** I thought that I was going to get an answer to my question. Is Mr Fox only taking a couple of questions?

**The Convener:** Will you reply to Mr McNeil's question, Mr Fox?

**Colin Fox:** I am happy to answer any question, but I did not realise that Mr McNeil had asked one.

**The Convener:** It was more of a statement than a question.

**Mr McNeil:** In case Mr Fox was not listening—

**The Convener:** Duncan—there is no need to be like that.

**Mr McNeil:** I asked whether it was right to spend precious health service money on providing free medicine to MSPs. Is that good use of the money?

**Colin Fox:** Your references to Trotsky and John Reid threw me, Duncan. The simple answer to your question is this: as the minister accepted not half an hour ago, the current system ensures that people on £50,000 a year who are over 60, are diabetic or have one of the other qualifying conditions—

**Mr McNeil:** Not all of them.

**Colin Fox:** If you will allow me to finish, Duncan, I will point out that the minister accepts that at the moment tens of thousands of people can pay but do not.

**Mike Rumbles:** I have one problem with the bill. On the one hand, I do not accept the ridiculous argument that people who currently pay for prescriptions but who, under the bill, will get them free will take time off work or make special appointments to see their GPs to get prescriptions. On the other hand, I feel that a practical problem emerges with the introduction of pharmacy prescribing next spring. Anyone who has a headache can walk in off the high street and pay over the counter for aspirin or paracetamol. However—please correct me if I am wrong—if the bill is passed, anyone who is unwell can walk in off the high street, ask for a prescription and get it free. Will that happen? If so, is that right and will it increase burdens?

**Colin Fox:** The evidence that we heard at the previous meeting provided a very good illustration of that. To its credit, the Executive has proposed bringing pharmacists and specialist nurses into the prescribing regime, which has advantages and represents a good step forward; indeed, I like to think that it will considerably reduce the pressure on GPs that was highlighted at last week's meeting.

However, Mike Rumbles asked about people who currently pick up paracetamol for £3 at a pharmacist or at Tesco instead of getting a prescription from a clinical professional. I have a great deal of confidence in clinicians, who seem to be forgotten about by people who claim that the 50 per cent of people who are not ill will suddenly

rush to their GPs for free medicines that they do not need. That suggestion is ridiculous. I have greater faith in the prescribing skills of clinicians.

15:30

It is worth my while to remind the committee of the most important piece of evidence, which was in the written evidence of Dr Philip Rutledge of Lothian NHS Board. His submission states:

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

I happen to think that that is exactly what will happen under the bill.

**Mike Rumbles:** I want to follow that with one quick point. I am not arguing that people will misprescribe and sign unnecessary prescriptions. I am just saying that it is possible that, if Mr Smith has a headache while he is walking down the high street, whereas a doctor might previously have advised him to go and buy some aspirin or paracetamol, the bill would mean that Mr Smith would be legally entitled to a prescription. Why would he not ask for a prescription, given that he would be entitled to it?

**Colin Fox:** It strikes me that there is little evidence of that happening in Wales. I know that prescription charges have not been abolished in Wales, but they have been significantly reduced from £6.50. In Wales, prescriptions may now cost less than a packet of Nurofen ibuprofen, but there is no evidence to support Mike Rumbles's proposition.

**Helen Eadie:** Are you aware that some prescriptions can cost £240?

**Colin Fox:** I am, but those prescriptions are for equipment rather than for medicines.

**Dr Turner:** My question is on a similar issue. As you may remember, the evidence of the Scottish Pharmaceutical Federation claimed that abolition of charges would mainly benefit well-off people, which is what we have been discussing. The witness from the Royal Pharmaceutical Society of Great Britain also stated:

"people in deprived communities go to see their GPs later … If we place more demands on GPs' time, the problems for general practitioners in helping the poor and deprived will be exacerbated."—[*Official Report, Health Committee*, 1 November 2005; c 2344.]

Will you expand on that?

**Colin Fox:** I forget who made the point previously, but I agree that we need to encourage people, especially in the working-class areas of Scotland, to visit their GPs if they are ill.

Another point that was made by the witness from the Royal Pharmaceutical Society of Great Britain—or it might have been the witness from the Royal College of General Practitioners in Scotland—is that people from the poorest and most deprived communities wait longer to see their GPs and find it more difficult to access specialist facilities in our national health service. Although that issue may fall outwith the remit of the bill, we should surely encourage people to access more health care provision in Scotland. Therefore, the question goes much wider.

**Dr Turner:** Is it confusing that we have a cost per prescription, which is a kind of tax, while we are also trying to encourage people to comply with the directions on drugs that are given when they go to their GPs?

**Colin Fox:** It was illustrative that, after our previous evidence session, the Royal Pharmaceutical Society of Great Britain provided a later submission to put some distance between it and the Scottish Pharmaceutical Federation. The royal society was anxious to emphasise that prescription charges do not selectively deter unnecessary use of medicine, but they do deter essential use of medicine. A central issue that we cannot get away from is that charges inhibit access. Every 10 per cent increase in the cost of accessing health care results in a 3.5 per cent fall in access. That fact, which is central to the debate, needs some serious attention.

**The Convener:** Duncan McNeil has a question. Can you keep it calm and courteous, please?

**Mr McNeil:** My question is on the crux of the matter.

My strong view is that healthy and wealthy people get much of the provision. For me, that issue really needs to be addressed if I am to be convinced about the bill. Demand for GP services from the poorest 10 per cent of the Scottish population, which comprises 0.5 million people, is 2.5 times greater than the most affluent 10 per cent. However, both sections of the community are served by the same number of GPs. GPs who serve deprived communities are already working to their limits—there are no margins to fill. How can we be convinced that the bill will not increase demand on GPs who are serving deprived communities? That would not bring equality for all, but would emphasise deprived communities' unequal position in accessing GP services.

**Colin Fox:** That is an important point—there is much more common ground between Duncan McNeil and me than might appear to be the case. There is no doubt that there is a close correlation between poverty and ill health; Duncan McNeil illustrated that point well. There is also no doubt that people who are on disability living allowance or incapacity benefit and people who are low paid—850,000 Scots—do not qualify for free

prescriptions. The figures make that clear. Surely we want to rectify that situation. The central question is whether there will be increased demand on GPs. There is little evidence from Wales to suggest that that will happen.

**Mr McNeil:** There is little evidence from Wales at all. If the issue is the people who are on those benefits, why not just draw a different line so that they are exempt, rather than introduce primary legislation that will give executives who are on £50,000 a year free medicines at the expense of the health service?

**Colin Fox:** That is a good question. The one thing that you can say has surely been found in Wales is that the measure is popular. Labour in Wales won an election with an absolute majority of one in a proportional representation system. Surely that in itself illustrates that there was popular support for the measure. I believe that there is the same popular support in Scotland.

**Mr McNeil:** That does not mean that it is right.

**Colin Fox:** Duncan McNeil's question is a good one. Essentially, you are saying that currently there are three exemption systems: one is based on income, one is based on age and one is based on a category that includes people with chronic conditions, pregnant women and so on. Those systems are completely contradictory and have the logic of a plate of spaghetti. Duncan McNeil is not going in a straight line; he keeps coming back on himself. No matter how he tries to cut it, he ends up by saying, "Let's scrap all the income-based exemptions and base it all on chronic conditions." That would lead to a dilemma. First, you would take away from people who already get, and none of us, including the minister, is in favour of that. [*Interruption.*]

**The Convener:** I think that Duncan McNeil might be.

**Colin Fox:** I apologise if I have spoken out of order about Duncan McNeil's opinion.

Secondly, if we say that the only criterion will be income, we will affect people with chronic conditions who access the health service 17 times a year, compared with people like you and me who access it only once or twice. No matter where we drew the line, we would be no further forward. That is why I describe that suggestion as trying to make a silk purse out of a sow's ear. It cannot be done.

**The Convener:** We will move on to a slightly different area.

**Mrs Milne:** It is a fact that even under the present system a significant amount of prescribed medicine in the community is not consumed by the people for whom it is prescribed. The Executive suggests that the value of that might be in the region of £50 million a year. The Scottish Pharmaceutical Federation said that there are great stockpiles of medicine in people's medicine cabinets—I know that that is the case. It could be argued that the present system to some extent manages demand. If all prescriptions were free, how would you manage the problem of drug wastage in communities?

**Colin Fox:** When the Minister for Health and Community Care, Andy Kerr, and I were on the radio, I thoroughly agreed with him that every penny is a prisoner in the national health service. In other words, it is to everybody's advantage that every single penny be used to maximum effect, therefore wastage can be in nobody's interest.

Secondly, in its evidence at a previous meeting, the Scottish Pharmaceutical Federation referred to frivolous use and wastage. It did not dawn on me until afterwards that, without doubt, the group in Scotland that wastes the most medicines is pharmacists, because medicines have a shelf-life and if they are not sold pharmacists have to chuck them out, never mind the federation having a go at John Swinburne's mother or pensioners who are hoarding medicines in their cupboard.

There is wastage in the NHS because pharmacists buy in stocks of medicine that they have to dispose of after a while because they are not used. That leads me to another point. Earlier, I gave the example that mentioned 75,000 people and how they would be figured into the estimates of need. GPs would say that so many residents of Greenock or Edinburgh will need antibiotics this winter, so they make sure that there is ample stock—unlike the medicine for bird flu, or whatever. If those 75,000 people do not need those prescriptions, that medicine will be wasted. That is a serious matter and it is important to put that into the context of the bill. Perhaps you could remind me of your question?

**Mrs Milne:** How would you manage increased wastage if there were more prescriptions? There is already significant wastage under the present system. If all prescriptions were free, I envisage that the amount of wastage would rise.

**Colin Fox:** That relates to the evidence that was given by Dr Rutledge about proper prescribing practices by GPs. I am also a great supporter of the idea that instead of people taking tablets, they should be encouraged to go for non-medical intervention. I know that GPs encourage people to do that; it is part of the answer. There should be better prescribing practice and better management of the stocks that we have. It is in everyone's interest to avoid the wastage that currently exists.

**Mrs Milne:** I would have thought that a lot of wastage was to do with patient compliance rather than with prescribing habits.

**Colin Fox:** Absolutely. The Royal College of Nursing and Unison made a great play of the fact that patients do what their doctors tell them. If the doctor prescribes ampicillin, the patient should go and get it. That would be compliant with the doctor's professional advice. If patients are unable to get prescriptions, they are not complying and that is when the problems manifest themselves.

**Mrs Milne:** My point is about when patients pick up prescriptions but leave the medicine sitting unused in their medicine cabinets. How would you manage that?

**Colin Fox:** I stick by my answer that I would leave it to the professionals to ensure that the patients need the medicine and that they need it in the quantities as prescribed. That is an issue for the professionals.

**Mr McNeil:** Do you believe that herbal medicines and such lotions and potions should also be available free?

**Colin Fox:** I am not Dr Fox—or Dr Reid—so I cannot comment on that.

**Mr McNeil:** I thought that you did comment on the wider medicines that should be available.

**Colin Fox:** I would certainly encourage use of such medicines, but I would not be happy to prescribe them for individuals whom I had not seen.

**Shona Robison:** You have cited a lot in evidence the Welsh Assembly, which phased in abolition. What is your view about implementation? Do you support phased introduction or immediate abolition across the board?

**Colin Fox:** My first intention is to get Parliament to agree to the general principles of the bill. I would then be happy to enter the broader debate that would ensue about how we get rid of prescriptions and whether abolition should be phased in or whatever. If you want my honest opinion, at this stage I would support abolition straight off the bat, which would be fairer, simpler and more easily understood.

I took notes about what the convener and the committee's report said about Wales. We ought not to lose sight of the fact that it was an enormously popular decision. Wales is not dissimilar to Scotland in terms of its socioeconomic background—its coal mines, heavy engineering and so on—and in terms of its having the same long-term ailments. The decision was warmly welcomed by the Welsh people and that was illustrated by the election results, although I do not want to trespass on a debate about elections.

It is also quite clear that there is in Scotland the same weight of support for the proposal. The great advantage for the bill is that the committee has accepted that you cannot make a silk purse out of a sow's ear. The bill is clear, straightforward and transparent. It does exactly what it says on the tin.

15.45

**Shona Robison:** You have said that the decision was popular in Wales, but that implementation was phased in. The method of implementation is important because we must get the structures in place and ensure that the system can cope with additional demands. We must also ensure that there is no impact on the number of prescriptions that are sought, although there is a lack of evidence about that. In Wales, there is no evidence to date that the change has had a huge impact on the number of prescriptions that are being sought. Although we need to see what happens in the next phase, we could argue that there has been no such impact partly because people have got used to gradual change rather than overnight abolition. Do you agree that that is a strong argument for a phased abolition, in that the population does not go from paying—

**The Convener:** Is there a question in there, Shona?

**Shona Robison:** I am asking whether Colin Fox agrees that phased abolition could deal with some of the concerns that the evidence has raised.

**Colin Fox:** I welcome the question; it is an interesting area. The first thing that strikes me is that the Welsh took the decision to reduce prescription charges by £1 a year to see what would happen. It is clear that there has been no significant increase in the number of prescriptions that are being written. I understand the committee's dilemma about the fact that the evidence was not presented to it—Wales took the decision to cut charges by £1 a year to see what effect it would have, but then did not proffer any evidence to show that effect. As Shona Robison says, the Assembly's decision was not evidence-based in the first place. If the committee prefers phased abolition, I am happy to consider that if the committee wishes to lodge an amendment to that effect. I do not rule it out, and I do not rule it in. However, in the interests of clarity, my preference is for abolition rather than a seven-year phasing in.

**The Convener:** Thank you. Have we exhausted our questions? I thank Colin Fox for coming along. You have obviously done the homework. It has been an entertaining session, although you might not feel entertained.

**Colin Fox:** Duncan McNeil and I are going on the stage.

# Prohibition of Smoking in Certain Premises (Scotland) Regulations 2006 (draft)

15.47

**The Convener:** We move to item 6, which concerns the draft Prohibition of Smoking in Certain Premises (Scotland) Regulations 2006. The regulations will be laid before the Parliament in December. We discussed the contents of the draft regulations at our last meeting. We now have a letter from the Deputy Minister for Health and Community Care, including follow-up information, about the basis for the decision to include private vehicles in the list of exemptions. Does the committee want to write to the minister to recommend any changes to the draft regulations?

**Kate Maclean:** I am not happy about the response concerning smoking in vehicles. It does not address the concerns that I and other committee members had about vehicles that are used to convey children and very vulnerable people. The last part of the letter states:

"best practice suggests that private vehicles being used to convey passengers on work-related activity, whether by staff or volunteers, should be smoke-free."

That does not really mean anything.

**The Convener:** We can tell the health minister that some members are unhappy that he has not addressed that key point.

Are there any final comments? I ask members not to repeat things. Obviously, we are approaching the point at which the regulations will be considered in the chamber.

**Dr Turner:** I will not repeat anything, but I would just like to mention smoking in cars. I was shocked, because a car can be saturated with smoke—

**The Convener:** Okay; I shall have to stop you. Does anyone else wish to say anything? No.

That ends the public part of the meeting.

15.49

*Meeting continued in private until 16:16.*

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