HEALTH COMMITTEE

Tuesday 10 January 2006

Session 2

£5.00

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

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HEALTH COMMITTEE
1st Meeting 2006, 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 ALSO ATTENDED:

Dr Sylvia Jackson (Stirling) (Lab)

THE FOLLOWING GAVE EVIDENCE:

Lewis Macdonald (Deputy Minister for Health and Community Care)
Kathleen Preston (Scottish Executive Legal and Parliamentary Services)
Professor Bill Scott (Scottish Executive Health Department)
Ross Scott (Scottish Executive Health Department)

CLERKS TO THE COMMITTEE

Lynn Tullis
Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 10 January 2006

[THE CONVENER *opened the meeting at 14:00*]

The Convener (Roseanna Cunningham): I welcome everybody to the first meeting of the Health Committee in 2006 and wish everybody a happy new year. I hope that we will have a productive year.

We have received apologies from Mike Rumbles. Today was originally a free day with no meeting scheduled; as a result, Mike had arranged other business in his diary, so I welcome Euan Robson, who is the Liberal Democrats' substitute on the Health Committee. Euan, will you confirm that that is the basis of your attendance today?

Euan Robson (Roxburgh and Berwickshire) (LD): Yes, it is.

Subordinate Legislation

Adults with Incapacity (Management of Residents' Finances) (Scotland) Regulations 2005 (SSI 2005/610)

Official Feed and Food Controls (Scotland) Regulations 2005 (SSI 2005/616)

14:01

The Convener: Item 1 on our agenda is subordinate legislation. The committee is asked to consider two Scottish statutory instruments—SSI 2005/610 and SSI 2005/616—under the negative procedure. The Subordinate Legislation Committee has considered the instruments and published its comments; it commented on both instruments and the comments are reproduced in paper HC/S2/06/1/1, which has been circulated to members. No comments have been received from members and no motions to annul have been lodged. Do members therefore agree that the Health Committee does not wish to make any recommendation in relation to SSI 2005/610 or SSI 2005/616?

Members *indicated agreement.*

Health Bill: Legislative Consent Memorandum

14:02

The Convener: Item 2 is the legislative consent memorandum on the UK Health Bill. We are required to consider the legislative consent memorandum and to report to Parliament. We will receive a verbal report from the convener of the Subordinate Legislation Committee, Sylvia Jackson. Thereafter, we will take evidence from the Deputy Minister for Heath and Community Care before we move into private session to consider the report that we will have to make to Parliament.

Members should have a briefing paper on the memorandum. A supplementary letter and briefing note from the minister have also been circulated to members by e-mail—hard copies are available if anybody missed it.

I welcome Sylvia Jackson to the meeting. This is a reciprocal visit: it follows my visit to her committee—although I suspect that she will have an easier time here than I did there. I invite Sylvia to present the views of the Subordinate Legislation Committee.

Dr Sylvia Jackson (Stirling) (Lab): Thank you. The Subordinate Legislation Committee considered three aspects of the legislative consent memorandum on the Health Bill. I can report on them very briefly because there was little to concern us.

The first aspect was the proposal to amend section 17S of the National Health Service (Scotland) Act 1978. The provision will confer regulation-making powers on Scottish ministers to allow persons other than registered pharmacists to dispense medicines. The second aspect was the recovery of NHS costs in cases of personal injury compensation. The third aspect was to do with the commencement order.

We had no problems with any of those three matters—the Subordinate Legislation Committee is content with the powers as drafted—but our legal advisers brought a more general issue to the committee's attention. On reading the bill, the advisers noticed that it confers a number of regulation-making powers on UK ministers. It is appreciated that the powers will be exercisable in reserved areas and that there may well be a need to make consequential amendments to acts of the Scottish Parliament.

To get more information and to keep abreast of the issues, we are writing to the Procedures Committee. We regard the issues as being procedural. We are also writing to the Scottish Executive to ask for more details.

The Convener: Thank you. I am not sure whether this is a one-off situation because of the particular circumstances of the legislative consent memorandum that we are considering. I suspect that we will in the future simply receive written reports, as per normal.

Dr Jackson: Absolutely.

The Convener: You are free to go, if you want to get away. [*Interruption.*] I was a little precipitate—before Dr Jackson leaves, I invite members to put questions to her. No member has indicated that they have a question for the member—I know them too well. I thank Dr Jackson for her attendance.

I welcome the Deputy Minister for Health and Community Care, Lewis Macdonald, to the meeting and ask him to make an opening statement.

The Deputy Minister for Health and Community Care (Lewis Macdonald): I thank you for giving me the opportunity to explain the provisions of the Westminster Health Bill for which we are seeking consent, and to explain our reasons for doing so. I start by wishing all members of the committee a happy new year, in the same spirit in which the convener opened the meeting.

As Sylvia Jackson said, the provisions of the Health Bill fall into two main areas. First, there are provisions relating to NHS community pharmacy services. Those propose to enable Scottish ministers, through regulations, to amend the supervisory requirements on community pharmacists that are laid down in the National Health Service (Scotland) Act 1978. The amendments will bring Scottish NHS legislation on supervisory requirements into line with proposed changes to the Medicines Act 1968. At present, legislation requires that medicines that are supplied on NHS prescription be dispensed by, or under the supervision of, a registered pharmacist, which means that pharmacists are tied to their business premises and cannot provide pharmaceutical care services outwith the pharmacy.

The first elements of a new NHS pharmaceutical care services contract will be introduced shortly. The contract will require community pharmacists to deliver a wider range of services directly to patients. Clearly, that will be possible only if pharmacists are able to delegate some of their tasks to other trained pharmacy staff. Delegation will not apply to the whole range of pharmacists' professional duties, but non-pharmacist staff will be trained to undertake some of the more routine tasks that are associated with dispensing, selling and supplying medicines. Pharmacists who wish to develop their clinical services to patients under the new contract will be free to do so at a pace that suits their staff and business circumstances, and in accordance with the development of local health care services.

A further amendment to the 1968 act relates to enforcement of the act in Scotland. New section 72A will place a general duty on responsible pharmacists to secure the safe and effective running of pharmacies. The duties of pharmacists will now include a duty to keep a record that will show which pharmacist is responsible for any pharmacy on any day and at any time. If the pharmacist is not on the premises, the record will show who was in charge of the pharmacy at that time, which will remove any ambiguity. Enforcement of the new record-keeping provision will be within the executive competence of Scottish ministers.

The final point in relation to pharmacy issues is that the Health Bill will allow much of the detail of the proposed changes to be written into regulation. As the convener said, yesterday I circulated an information paper that outlines how that process will operate. The paper does not aim to give an exhaustive list of the areas that might be covered, but is intended to outline current thinking on how the regulations might be developed. Any proposals for regulations that are introduced as a consequence of the bill will be consulted on in the usual way in due course. The 1968 act places on ministers a statutory requirement to consult on regulations and orders that are made under that act.

The other substantive item to which Sylvia Jackson referred is the NHS cost recovery scheme. The scheme is based on a consultation that was carried out in 2002 and on the Health and Social Care (Community Health and Standards) Act 2003. The 2003 act has resulted in the proposal for a new widened scheme for recovery of NHS costs in all cases in which personal injury compensation is paid. The Scottish Parliament's consent is being sought for two minor amendments that result from concerns that were raised during the consultation. The first is about contributory negligence and the second is a minor amendment, which is required as a consequence of provisions in the Primary Medical Services (Scotland) Act 2004.

Once the scheme is fully bedded in, it is expected that it will generate income of between £18 million and £25 million a year for the national health service in Scotland, but because most compensators are insurance companies that operate on a Great Britain-wide basis, it has always been recognised that the scheme will be most effective if it is implemented across Scotland, England and Wales. The compensation recovery unit of the Department for Work and Pensions

would, in accordance with an agency arrangement under section 93 of the Scotland Act 1998, administer the scheme on behalf of Scotland, as well as for England and Wales. The same DWP unit currently operates the existing road-traffic accident scheme—which will be superseded—on behalf of the NHS in Scotland. Those are basically technical amendments, but they are significant in providing improved NHS services for Scotland. We are keen that the measures be put into place as quickly as possible, so I invite the committee's support.

The Convener: Thank you. Members want to ask a number of questions.

Kate Maclean (Dundee West) (Lab): A similar proposal was consulted upon prior to the Smoking, Health and Social Care (Scotland) Bill. I wonder why the Executive did not include the proposal in the bill at that time, but now supports a similar proposal.

Lewis Macdonald: That is because some of the arrangements were not in place then. I do not know whether Kathleen Preston knows the background of the different statutory provisions that have come forward in both Parliaments.

Kathleen Preston (Scottish Executive Legal and Parliamentary Services): My understanding is that when what is now the Smoking, Health and Social Care (Scotland) Act 2005 was going through Parliament, it was not clear what the United Kingdom Government's proposals for the Medicines Act 1968—which is on reserved matters—were going to be. As a result of the changes that the UK Government is making to the Medicines Act 1968, it is necessary to make this consequential amendment to the NHS Scotland Act 1978. There is currently a requirement that drugs must be dispensed under the supervision of a pharmacist. Because the corresponding provisions of the Medicines Act 1968 will be changed, it is necessary to give Scottish ministers the power to prescribe by regulation circumstances in which that requirement will be relaxed.

Kate Maclean: My understanding is that there was quite a lot of support for the changes at the time, but there were concerns about the implications for staff training and about which pharmacy support staff it would be appropriate to allow to take on those responsibilities. Have those fears been allayed?

Lewis Macdonald: I said in my opening statement that we will, following the provisions being put in place, consult on regulations before they are introduced. The issue that Kate Maclean raises is one of the matters that we want to ensure is fully addressed before regulations are introduced. It is important also to say that although there is, as I said in my opening remarks, a new power for pharmacists to delegate responsibility for carrying out actions, the pharmacists will retain responsibility for supervision. Even if they are not personally present, it will still be the pharmacists' responsibility to ensure that staff who act on their behalf are fully trained and are competent to do so.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): That will obviously place quite a responsibility on pharmacists. If a pharmacist delegates responsibility, he obviously needs to know his staff very well and training needs to be carried out on a continuing basis. Can you clarify what responsibilities the pharmacist will delegate to trained staff? I assume that if the pharmacist is not on the premises, there will not be a pharmacist there.

Lewis Macdonald: Examples might include an event at which across-the-counter medicines can be sold. At a summer event, such as a rock festival, a pharmacist might make provision for medicines to be supplied from temporary premises; that could be a relatively routine process. That example is among the kinds of unusual circumstances in which such delegation might occur. More commonly, the sale of general sale-list medicines is another example. Although it is important to ensure that anybody who buys any kind of medicine from a pharmacist is able to access advice about it if they require it, certain types of medicine are fairly routine in character and could be sold across the counter by a trained person who knows what is appropriate for different conditions.

14:15

Dr Turner: Do you therefore expect pharmacists to draw up protocols to which their staff must adhere strictly, or would you expect staff to phone the pharmacist?

Lewis Macdonald: We expect that pharmacists will put in place procedures whereby if they are not present and a pharmacy assistant is asked for advice about a general sale-list medicine that an individual patient wishes to purchase, that assistant could obtain clearance or authorisation from the pharmacist. We expect that it will be possible for members of staff acting on the pharmacist's behalf to seek and obtain advice.

Dr Turner: From your letter to us, it seems that you plan to restrict pharmacists to being responsible for two pharmacies. However, some people might have six, seven or eight pharmacies.

Lewis Macdonald: Again, we will consult on that at the appropriate time. The letter indicates the areas on which we might consult. At the moment, the requirement is that a pharmacist be

present on the premises. Clearly, to increase the number of premises for which a pharmacist may be responsible from one to two will broaden the provision significantly. We will consult on whether there might be circumstances in which we would go beyond that provision.

Dr Turner: Do you expect pharmacy staff behind the counter to be trained in conducting blood-sugar tests and blood-pressure estimations, or are those tasks specifically for the pharmacist?

Lewis Macdonald: I ask Bill Scott to respond.

Professor Bill Scott (Scottish Executive Health Department): We are attempting to make the best use of the skills of all the staff in the pharmacy. The staff will operate under standard operating procedures: they will undertake work in areas where they are trained to be competent, but they will have to adhere rigidly to a standard operating procedure. The pharmacist will still be in overall charge and will approve the standard operating procedure.

We have agreed with the Scottish Pharmaceutical General Council a sum of money for training pharmacy support staff to the required national standard.

Dr Turner: Will the Executive always fund that or will pharmacists have to find from within their businesses the money to train staff?

Professor Scott: I do not think that the Executive will continue to fund that training. The intention was to get a critical mass of staff in a pharmacy. Clearly, pharmacists have businesses to run and they will make representations as contractors when we consider in the negotiations any burdens that will be created by the NHS requirements.

Dr Turner: Many people might be anxious that the present service will be diluted and that, unless more pharmacists come on board, the same number of pharmacists will treat the same number of people, but will have extra duties.

Lewis Macdonald: Our action is based on our consultation. Although I acknowledge Jean Turner's point, the consultation evidenced significant support for the kind of direction that we seek to make.

Shona Robison (Dundee East) (SNP): My question is supplementary to Kate Maclean's and Jean Turner's points about the costs of training and staffing. I accept what the minister said about further consultation on the regulations. Will you also commit to undertake a financial assessment of those costs as part of the consultation?

Lewis Macdonald: I ask Bill Scott to respond again. He is the chief pharmacist; he has considerable dealings with the sector on that matter and is more directly aware than I am of its expectations in respect of support for training costs.

Professor Scott: There was overwhelming support for what we are trying to do in our initial consultation on manpower. Pharmacists see the proposals as being a way of helping them to manage their situation. A fair number of highly qualified technical staff already work in pharmacies. The proposals will also apply to hospital pharmacies. There will be standard compliance costs with any changes in regulations, and those costs will be attached to subsequent changes.

The Convener: Nanette Milne wants to move on to another aspect of enforcement.

Mrs Nanette Milne (North East Scotland) (Con): Paragraph 20 of the memorandum refers to "the package of reforms" under the legislation. Will the minister clarify what is being referred to?

Lewis Macdonald: That phrase refers to the range of measures that I have outlined and to which Bill Scott referred. Those measures are about enabling the pharmacist not to be present when medicines are being dispensed, ensuring that other pharmacy staff who take on such routine responsibilities are properly trained and supervised and that there is accountability through keeping records of responsible pharmacists. Our ensuring that such a record exists will be key to the package of reforms that will allow other members of the pharmacy's staff to undertake certain duties that the pharmacist currently undertakes.

Mrs Milne: Unsupervised staff will keep records of everything they do when the pharmacist is not present.

Lewis Macdonald: It is clear that staff would keep records of any medicines that are prescribed and dispensed.

Professor Scott: Staff activity would be monitored through standard operating procedures. They will have to contact the pharmacist about any deviation from those procedures.

The Convener: Once the proposals have been agreed to, do you intend that the Medicines and Healthcare products Regulatory Agency will continue its role of enforcing the Medicines Act 1968 in Scotland, and that that will include enforcing the new record-keeping requirement?

Lewis Macdonald: Broadly speaking, yes.

Professor Scott: We think that some monitoring of compliance with the requirements will be done through the inspectorate of the Royal Pharmaceutical Society of Great Britain, which currently undertakes some work on behalf of MHRA.

Lewis Macdonald: I wrote to the committee on that subject to clarify that point.

Janis Hughes (Glasgow Rutherglen) (Lab): How do you envisage the permanent record being kept? Will it be kept electronically? If so, are additional costs on the community pharmacy sector or the Executive expected?

Lewis Macdonald: I invite Bill Scott to answer that question, too.

Professor Scott: Thank you.

The Convener: It is handy that you have Bill Scott with you.

Lewis Macdonald: I must admit that it is.

Professor Scott: It has not yet been determined whether there should be paper or electronic records, but it is likely—with modernisation of our services—that records will be electronic. Currently, we have a package of measures relating to e-pharmacy, of which the records will clearly be part.

Janis Hughes: I accept that the community pharmacy sector is geared up to providing the e-pharmacy service, but will the proposals incur additional costs on that sector? Does the Executive think that there will be additional costs on it in ensuring that the package of reforms is introduced?

Professor Scott: It is clear that there will be some costs, but the current indications are that those costs will be de minimis costs on pharmacists. I cannot see why the Executive would have to bear any costs from what we are developing because it will be for community pharmacists to keep the records.

Lewis Macdonald: The potential benefit from the de minimis costs is clearly much more significant than the costs are, because it is part of the modernisation process across the board, which may allow pharmacists to do other work more efficiently than they do at the moment.

The Convener: Paragraph 22 of the memorandum states:

> "The Bill will also impose other duties on the responsible pharmacist".

Can you give us a clue as to what those other duties might be?

Lewis Macdonald: That relates to the duties that might be undertaken by pharmaceutical societies. They are to do with some of the professional judgments that pharmacists are best placed to make, for example in respect of dispensing medicines.

Professor Scott: That is correct. The responsible pharmacist will have to determine what duties can suitably be undertaken by other members of staff. However, the clinical duty of assessing the appropriate prescription will have to be undertaken by the pharmacist; they will not be able to delegate that duty.

Lewis Macdonald: Again, the other duties relate to the package of reforms. They are to do with the supervision of staff.

The Convener: Shona Robison has a question on recovery of NHS costs.

Shona Robison: The minister may remember the debate that we had in Parliament on the issue, when members expressed concerns that the recovery scheme could result in increased insurance premiums for individuals and employers. The review of employers' liability compulsory insurance has now been carried out. Is the Executive satisfied that the insurance market has addressed the issues that were raised in that debate about potential inequalities in premiums?

Lewis Macdonald: Members will be aware that the introduction of the recovery provisions has been delayed to accommodate the consequences of the ELCI revision. In short, the answer is that it is felt across the board that the provisions now acknowledge the changes that have been made in that regard and are compatible with them.

Dr Turner: I would like more information on how the scheme will be administered and the level of funding that might be required to administer it.

Lewis Macdonald: I am sorry—I did not follow that.

Dr Turner: How will you collect the money and administer the scheme? We all know that lots of people over the years have had insurance pay-outs in relation to road-traffic accidents. I assume from what I have read—I may be wrong—that you intend to claw back money from people who have had pay-outs and who have required treatment from the NHS. Will that be done through the insurance companies?

Lewis Macdonald: Having been ably supported by Bill Scott on the previous subject, I now move on to Ross Scott.

Ross Scott (Scottish Executive Health Department): NHS costs will be recovered from the compensator, not from the person who is compensated. A person who is involved in a road-traffic accident and who is compensated for that will not pay the NHS costs—the insurance company that compensates them will pay those costs. The scheme will be operated by the compensation recovery unit in the Department for Work and Pensions on behalf of the Scottish Executive and the Department of Health. Insurance companies will have a legal obligation to notify the CRU of instances. The CRU will follow

up cases with individual hospitals, assess the cost, recover the money and pass it back to the appropriate NHS body.

Dr Turner: It strikes me, as an ordinary person, that if the insurance companies have to pay, that might put premiums up. You say that it will not be the person who has had the accident who will pay, but the insurance company.

14:30

Ross Scott: The person who is compensated will not pay; whoever compensates that person for their injury will pay for the costs of NHS treatment through their liability.

Dr Turner: I read that you worked out a sum that you might be able to claw back. How did you work out that sum?

Lewis Macdonald: We calculated a percentage of the total United Kingdom estimate.

Ross Scott: The estimate was done by economists in the UK Department of Health, who calculated a 10 per cent share of what was assessed to be the UK figure.

Lewis Macdonald: It is very much a ball-park figure. I think we said that it would be between £18 million and £25 million, which is between 7 per cent and 10 per cent of what the Department of Health calculates will be recoverable from insurance companies and other sources of compensation.

Dr Turner: If I understand the position correctly, insurance companies should have been offering to pay this money all along but, perhaps, have not been doing so.

Ross Scott: They are obliged to pay out only for road-traffic accidents. The scheme will widen that to cover all instances in which people receive compensation for personal injury, so it will include workplace accidents as well.

Dr Turner: This is probably not related to the issue that we are discussing, but what about travellers who come to this country with medical insurance? Is that a separate issue? Would the money that their insurance companies pay come under a different scheme?

Ross Scott: There will be a separate scheme. The person has to be injured before a case arises.

Dr Turner: So the issue is really related just to personal injury.

Lewis Macdonald: Yes.

Shona Robison: Ross Scott said that the money would go

"back to the appropriate NHS body."

Would that be the health board that treated the person? Would the money go directly to the board or the hospital?

Ross Scott: The money would go directly to the board that treated the person; the scheme would not distinguish between hospitals. That board would have mechanisms by which the money could be given to the appropriate hospital.

Shona Robison: I assume that the hospital will have the flexibility to use that money however it sees fit.

Lewis Macdonald: Yes.

Euan Robson: In relation to the powers that you will get when section 153 of the Health and Social Care (Community Health and Standards) Act 2003 is amended, are you content that, in making regulations, you can do so without their being so complex that you will cover several pages when you take into account contributory negligence? Without wishing to anticipate a debate about what will be in the regulations, are you confident that you will be able to produce something that is readily comprehensible rather than something that is a labyrinthine legal impossibility?

Lewis Macdonald: The objective is always to make legislation as comprehensible as possible, whether it is primary or secondary legislation. That can be a challenge, especially when it relates to matters of financial compensation for legal liability, but it is a challenge that we will endeavour to meet.

Some of what is before the committee today relates to contributory negligence and is concerned with ensuring that a settlement can take into account any level of contributory negligence, and that the amount of compensation can be proportionately reduced by the level of contributory negligence that is agreed, where that is agreed out of court.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): You mentioned workplace accidents. How does the system operate in that regard at the moment? How will it operate in the future? How would you differentiate between a workplace accident, injury and disease?

Lewis Macdonald: I will ask Ross Scott to comment on the status quo. I think that the answer is that nothing is in place at the moment and that the scheme is the first of its kind, essentially.

Ross Scott: At the moment, an employee who is injured in the workplace will be compensated, but there is no scheme by which we could recover the NHS costs of treating that injury. That is what this scheme will do.

The scheme does not include industrial disease; it relates only to personal injury, including

industrial injury. Industrial disease was discussed in relation to the 2003 act, but it was decided that it was too difficult to define or identify what an industrial disease is because somebody could have a disease that had developed over a number of years.

Mr McNeil: How would the recovery mechanism operate? What would be the impact on the worker who has broken their leg falling from scaffolding and has visited the accident and emergency unit?

Lewis Macdonald: The impact would be primarily on the employer's liability insurance company rather than on the worker.

Mr McNeil: How would we ensure that?

Lewis Macdonald: The DWP would recover the cost from the company that provided the insurance cover to the employer. As with road accidents, the recovery is not made from the person who is compensated but from the compensator.

The Convener: Basically, the money will come from the insurance company that is behind the person who was at fault.

Lewis Macdonald: That is exactly it.

The Convener: On first reading, people assume that the scheme will mean that people who get personal injury compensation will have money taken away from them. However, it does not work like that. The insurer behind the person or body who is at fault will end up paying the NHS costs; the victim of the accident will get their compensation in the normal way and it will not be removed from them.

Mr McNeil: My only concern is that many such personal injury cases are taken on a no-win, no-cost basis. I am concerned that the situation is not as regulated as that which relates to road-traffic accidents, which involves clear procedures. I am concerned that there is a bit of a difference, but we will have an opportunity to consult on the matter.

Lewis Macdonald: Yes.

The Convener: I think that that has exhausted our questions. I thank the minister and his officials for coming along.

That ends the public part of the meeting.

14:37

Meeting continued in private until 14:47.

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