HEALTH COMMITTEE

Tuesday 18 April 2006

Session 2

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HEALTH COMMITTEE

9th 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)
*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)

*attended

THE FOLLOWING ALSO ATTENDED:

Carolyn Leckie (Central Scotland) (SSP)
Euan Robson (Roxburgh and Berwickshire) (LD)

THE FOLLOWING GAVE EVIDENCE:

Dr Harry Burns (Chief Medical Officer for Scotland)

CLERKS TO THE COMMITTEE

Lynn Tullis
Simon Watkins

SENIOR ASSISTANT CLERK

Graeme Elliott

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 5

Scottish Parliament

Health Committee

Tuesday 18 April 2006

[THE CONVENER *opened the meeting at 14:03*]

Health Inequalities

The Convener (Roseanna Cunningham): I welcome everyone to the Health Committee's first meeting after the Easter recess, in particular Harry Burns, the chief medical officer for Scotland, who will discuss with us the report of the Kerr subgroup on health inequalities. The matter has been of some interest to members.

Dr Burns, do you want to make an opening statement or go straight to questions?

Dr Harry Burns (Chief Medical Officer for Scotland): It might be helpful if I put the Kerr report into context.

The Convener: Well, we have had quite a few dealings with the Kerr report; indeed, the man himself has been before the committee. We are particularly interested in the question of health inequalities.

Dr Burns: An important issue is how all of this has been constructed. Those who know me know that I can talk about health inequalities till the cows come home. I have been involved with the matter since I worked as a consultant surgeon at Glasgow royal infirmary and found that, because of their socioeconomic position, people from the east end of the city did not make such a good recovery.

In the 20 years since then, we have gone up many blind alleys as far as strategies to correct the problems of health inequalities are concerned. The Kerr report represents the conclusion of a lot of thinking that acknowledges that although we have been doing what we can to change the social and economic situation in deprived communities and have been trying to persuade people to lead healthier lifestyles, an element has been missing, which is the targeting of national health service resources at deprived populations.

The evidence in the Kerr report from south Wales, which was submitted by Dr Julian Tudor Hart, showed clearly that targeting additional resources and using them in specific ways can lead to considerable improvements in life expectancy. The theme of the chapter of the Kerr report that contained that evidence was what the NHS can do to improve health inequalities to complement social and economic improvements. I am happy to take questions on the reasoning behind that.

Helen Eadie (Dunfermline East) (Lab): The paper that has been circulated to the committee refers to people living in the most deprived communities. It says that, of the various studies that have been undertaken,

> "Several have shown that for conditions such as hernia, gall bladder disease and joint replacement, members of the most deprived sectors of the population may be more likely to consult with a GP but are less likely to receive surgery."

Will you comment on that, please?

Dr Burns: There are often clinical reasons for that. People from the most deprived sectors of the community will often have a wide range of illnesses. They will not just present one condition. They might have chronic bronchitis, angina and so on. Those factors might make people less suitable for surgery. There can be sound clinical reasons.

Let us take angina as an example. A patient from a deprived area might have less expectation of treatment when they go to their GP. They might ask their doctor whether they can have some pills to remedy the condition, whereas someone from a more affluent area will have done much more research and will argue for surgical intervention or whatever. There is evidence to suggest that although angina is more prevalent in deprived areas, patients from those areas will be less likely to be investigated and to have surgical treatment. That is often related to the extent to which patients expect treatment from the health service. That needs to change.

It is possibly also to do with the reduced availability of resources in primary care. There is evidence that consultation times at practices in deprived parts of the west of Scotland are shorter than consultation times in practices in affluent areas. We know that patients from deprived areas will tend to consult their GP with more problems, which means that there will be less time to spend on each one. Patients from deprived areas do not get as much primary care resource as they should. The paper argues that the health service should be pushing for equality of outcome, not equality of access. It suggests that we should increase the availability of health care in deprived areas to create a better outcome for people with greater needs.

Helen Eadie: On people having less time with their GP, have studies been carried out into why that is the case for some patients?

Dr Burns: Professor Graham Watt, professor of general practice in Glasgow, has shown that practices in deprived areas are less likely to have the resources to achieve high-quality measures of general practice. They are less likely to be training practices or to have quality practice awards, because the GPs are running faster to stay still. It comes down to the fact that although we spread resources equally across the population, the need in some areas is greater, so the people who work in those areas are fantastically dedicated but simply have to run faster. That is the single biggest explanation.

Kate Maclean (Dundee West) (Lab): I will probe a bit more on the point that Helen Eadie raised. From the report, it seems that the problem with people going on to receive elective surgery arises not in the local practices but after the GP consultation. The report says that although more people in deprived areas are likely to consult a GP for conditions such as hernia, gall bladder disease and joint replacement, they are less likely to receive surgery. Where is that surgery being stopped? It is not being stopped at the GP stage if people are willing to consult the GP. Are they not attending hospital out-patient appointments? Are they attending out-patient appointments but, when they get appointments for surgery, opting not to go and have it? If a condition such as a hernia or gall bladder disease turns into an emergency, a minor, inexpensive procedure can become an expensive process.

Dr Burns: The reasons for that are complex and not easily pinned down. Having been a consultant surgeon in the east end of Glasgow and having had a large practice of patients from the most deprived constituencies in Scotland, I can say that it is not a question of clinicians deciding that patients should not get the surgery.

Kate Maclean: I know that.

Dr Burns: Either the patients themselves decide that it is not in their interest or they have other ill health that makes it difficult or unsafe for them to be anaesthetised.

Kate Maclean: I am aware that such inequality would not be a clinical decision; I was trying to find out at what stage patients decide that they will not go any further. They go to the GP, but are they then not attending out-patient appointments or surgery?

Dr Burns: For some conditions, patients are less likely to consult their GP. If they do so, in some instances the GP will tell them that they are unlikely to be accepted for surgery because they are too obese, their angina is really bad or their blood pressure is difficult to control, or they will go to a hospital and have the discussion with the consultant and then decide. It is difficult to unravel all of that.

Kate Maclean: Is there too much focus on prevention and screening and not enough on ensuring that people complete the medical journeys that they begin?

Dr Burns: We must do it all. We must try to prevent ill health to begin with but, once ill health has developed, we must treat it effectively. The literature suggests that the most effective way of preventing such ill health is to have a much more proactive form of primary care in which conditions such as angina and high blood pressure are detected and treated early, and are not allowed to progress to heart failure for example. It becomes difficult to treat some of the other things that happen later on. It is risky to take out the gall bladder of someone who has chronic heart failure, so we should stop it getting to that level.

Janis Hughes (Glasgow Rutherglen) (Lab): The Kerr sub-group on health equalities specifically said:

> "NHS Scotland should embark on a programme of enhancing primary care capacity".

We all accept that that means that a patient should see not necessarily a GP but the qualified health professional who is most suited to their needs. We all know that early intervention can produce better outcomes and we have recently seen the advent of community health partnerships. How will they be able to provide the service on the ground? I am thinking specifically about reaching out to people in deprived areas who may not choose even to take the first step of visiting their general practitioner, which would lead to some of the other things.

14:15

Dr Burns: The outreach element is exactly what Dr Tudor Hart provided. He knocked on doors; in a village of 2,000 people, he was able to do that and his wife was his practice assistant. We need to enhance the primary care team. You are right: that does not necessarily mean more GPs, although I suspect that in some of the most deprived areas it will. It might mean more GPs with special interests, for example in alcohol problems. Equally, it could mean more community psychiatric nurses, nurse specialists, physician assistants or counsellors. The critical element is to involve the primary care team in designing the intervention. The last thing that is likely to work is if a health board designs the intervention. I want the practice staff, who know the local population and the local needs, to say which areas are under pressure. Therefore, the resources need to be devolved at least to CHP level and, I would argue, to practice level. That is an issue for remote and rural inequalities.

Recently I visited a practice in an affluent area of Glasgow, where the staff were at pains to point out that the area had two streets of quite deprived people. It is important to recognise that there will be small pockets of deprivation, particularly in remote and rural areas, and that it is the GP who knows where those people are. We have got to involve the GPs. I would not try to tell them how to run their business but I would say—and this is what the new GP contract helps us with—that we want them to know what everyone's blood pressure is, who has high cholesterol and what is being done about it. We want to know the level of untreated ill health that is out there. We want to offer people treatment. That is the kind of proactive approach that we need. If that means knocking on doors, many GPs and other practice staff will be up for that.

Janis Hughes: Do you foresee CHPs working with local community groups, for example, to highlight the services that they can provide and to give people the opportunity to have better health care?

Dr Burns: I am sure that many services, such as those that deal with behavioural change, smoking cessation, alcohol counselling and so on, will be provided in that way. Voluntary organisations will be the appropriate providers of many of those services. It would be great if the CHPs involved them in service delivery.

The Convener: You used phrases such as "someone from a more affluent area" and "someone from a deprived area". It occurred to me that in many allegedly affluent areas there are pockets of deprivation. There is a danger in taking too broad brush an approach. Obviously, if you are dying you are dying, regardless of which bit of an area you live in. I assume that when you say "someone from a deprived area" what you really mean is people who are suffering from social and health deprivation. When you say "someone from a more affluent area", you really mean that someone who is more affluent has the wherewithal to access services. You talked about remote and rural areas. My concern is that what you are doing will be seen as a massive resource transfer, or at least as intending to carry out such a resource transfer, and that the pockets of deprivation throughout Scotland that are within allegedly affluent areas will continue to miss out. No one would want that to happen.

Dr Burns: Towards the end of the paper is a paragraph headed "How does this approach apply in rural areas?" In it, we make the specific point that individuals should be identified by general practices. The Kerr report makes the same point. GPs will know which people are in most need, so we want GPs to design the interventions, regardless of where the people are.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Since the 1990s, much intervention work has been done. As you might agree, a lot of information should be coming from deprived areas, such as the ones I worked in when I was in general practice. We had diabetes clinics, well-woman clinics, well-man clinics and clinics for chronic obstructive airway diseases—which are mentioned in the paper.

A very important point has been raised on the subject of deprivation. Back in the 1990s, deprivation payments to GPs were halved overnight. Do you remember that?

Dr Burns: Well—

Dr Turner: Perhaps not. As Roseanna Cunningham says, we cannot take a broad-brush approach. Even within a deprived area, practices will work very differently. Do you agree?

Dr Burns: Absolutely.

Dr Turner: As you say in the paper, the time that a GP spends with each patient is most important. In deprived areas, people will go to their GP with many issues; in more affluent areas, people might know that only one issue can be dealt with at a time. It is very unpleasant for a GP to have to say to somebody, "I am sorry, but I can deal only with the most important problem today. You'll have to make other appointments for the other five problems." GP time with patients is the most important issue, but funds and deprivation are also important issues.

Health visitors and nurses have been working in communities—and I agree that we need more of them—but how will standards in hospitals be maintained when there are fewer hospital beds? You must notice the differences between your time as a surgeon and now. People are now in and out of hospital very quickly, which leads to an added burden on general practices. Patient needs are going unmet because some GPs are being worked to a standstill. In future, how will we cope with the lack of beds and the lack of capacity in the system? How can we ensure that deprivation payments are directed to the people who need them—in deprived areas and in affluent areas?

Dr Burns: I will answer the point about deprivation payments first. We are talking not about funding general practice but about funding the broad set of interventions within primary care. The new general medical services contract has done much to change the notion that GPs are paid a global sum plus add-ons, and much to focus attention on what can be improved in practice populations—whether the improvements are made by nurses, physician assistants or GPs. We have to establish a level playing field for health outcomes rather than for inputs to general practice. That will evolve and, in a minute, I will come on to discuss how we have started.

On secondary care, the "Delivering for Health" report, which was the Executive's response to the Kerr report, makes a specific commitment on the management of chronic diseases—that is, on dealing better with long-term conditions.

When I started off my career, the fifth floor of the Glasgow royal infirmary was the vascular floor and it was full of diabetics and of people with end-stage vascular disease. Since then, the situation has changed dramatically, because better care early in their conditions means that people do not now have to come in to have legs amputated. Similarly, there has been a fall of about 40 per cent in acute myocardial infarction mortality in Scotland since the 1990s. There have been huge changes in the prevalence of certain illnesses in communities. We are gradually moving away from having to deal with acute conditions to having to deal with chronic conditions, which need to be managed in primary care. I agree absolutely that poor social conditions lead to an increased demand for hospital beds, but we do not quite understand the scale of that.

If I am allowed to, I will share an anecdote. In the early 1990s, I went over to visit Kaiser Permanente in California to see how it operated. At the time, Glasgow had 4,000 acute beds. I took Kaiser Permanente's bed occupancy rates and calculated, on an age-specific basis, how many beds Glasgow would need if it had the same rates. With those occupancy rates, Glasgow would have needed only 1,400 beds. The difference was that when people have heart surgery in California, they go back to a $2 million house in Palo Alto, rather than to a fourth-floor tenement flat in Dennistoun or Shettleston.

There is an increased demand for health care; the challenge is to reorient care. We will get a level playing field in life expectancy only if we get in early and change the health experience of the most deprived elements of our community. That must be about preventive medicine, as applied in primary care. That is where we must focus our energies, which will lead to a reduction in the demand for acute beds. We have talked about that often.

Dr Turner: There has been screening for osteoporosis in Glasgow for some considerable time, with a high rate of success. Nevertheless, orthopaedic waiting lists have been extended time and again, despite extra capacity being put in at the Golden Jubilee hospital and other places. We are trying to prevent hip fractures, which perhaps takes a long time. Do we need to hang in there for a long time to see the benefits of early screening?

Dr Burns: Orthopaedic waiting lists have been reduced throughout Scotland. For patients to get into the osteoporosis screening programme, they have to have had a fracture or have shown evidence of osteoporosis. We could bring forward the point at which we screen. As Dr Turner knows, there are issues about the ethics of screening too early and screening with a low expectation of finding a result, in case we find false positives. Screening is a difficult area, but I think that we will see the benefits of screening for osteoporosis. As science and technology improve, it might be possible—and safe—to bring forward the point at which we screen to considerable benefit. We know how to avoid osteoporosis by undertaking impact-type exercise and increasing calcium intake. Perhaps we need to do more on that side.

Mrs Nanette Milne (North East Scotland) (Con): A crucial statement in the paper is that there is a need to strengthen individuals' capacity to take responsibility for their own health. Until we do that, it will be difficult to solve or prevent problems.

A couple of things concern me. In much of the work that is needed, we are talking about primary care teams rather than about general practitioners. I know that we lack nurses and allied health professionals. What is the timescale for addressing current needs?

My second question follows Roseanna Cunningham's question about pockets of deprivation. I am from the Aberdeen area. As you know, Grampian has been top-sliced—we get 9 per cent of the funding for 10 per cent of the population, under the Arbuthnott formula. There is a concern that Grampian NHS Board is running to stand still. There are pockets of serious deprivation in Aberdeen and the rural parts of Aberdeenshire, but if resources are to be refocused on deprived areas, will that affect those of us in the north-east even more?

14:30

Dr Burns: The matter of increasing individuals' capacity to take responsibility for their own health is in the report for a reason. There is evidence to suggest that psychological resilience and an internal sense of control over one's health—being able to say, "I'm responsible for my health, not them out there"—have physical consequences that lead to better health. That is being investigated by the Glasgow Centre for Population Health. Aspiration, control, confidence and so on appear to bring beneficial physical consequences.

On rurality, I return to the point that individual general practices will eventually be funded to deal with pockets of deprivation—clusters of houses, or whatever—that they encounter. I do not envisage a removal of resource from one area to be given to another area, but I would argue for differential investment. We need what is, in health service terms, defined as capacity to benefit from an intervention. There is no doubt that need is greater in deprived areas; therefore, we should aim to fund services in those areas to ensure that identified need is met. That means that, over the years, more investment should go to the deprived areas. That should have been happening since 1948.

Mrs Milne: I asked a second question, about the capacity of the workforce.

Dr Burns: I am sorry. As we speak, the nursing schools are beginning to develop extended roles: nurse endoscopists are being trained; radiographers are being trained to take over from radiologists in X-ray departments; and physician assistants are being developed who will do many of the diagnostic tasks and so on that doctors do. The workforce is being diversified in imaginative ways. I agree absolutely that we need to be more imaginative, but that is not going to happen until the health service is challenged to provide a different set of skills. We will keep on doing what we have always done until we can say, “Look, we need different outcomes from the health service, so we need to develop a different kind of workforce.” That is happening, however, and the pace will increase as different challenges are posed.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): You may have addressed some of the issues that I wanted to ask about.

We have a problem with the level playing field, although the level playing field may be an issue for us, as politicians, rather than for someone in the CMO’s position. The level playing field results in people having less time with their doctors, being less likely to see consultants, being more likely to die younger, being more likely to be seen in a single practice that is already over-burdened, and being more likely to be seen by a younger doctor who has never been in a deprived community in his life until he is parachuted in there. According to the report, the level playing field also results in the gap between the rich and the poor growing rather than shrinking. What are we doing about those fundamental problems? How will we challenge the view that providing equal access to a GP actually kills people and that the Arbuthnott formula is a complete disgrace in terms of tackling the problems at that level? Those questions are fundamental to delivery.

Dr Burns: Those are the principles that we have adopted in the report. If we are to tackle the increased prevalence of disease in deprived communities, we must match that increased prevalence with an increased number of GPs. From my experience of GPs in north and east Glasgow and south-west Glasgow, I know that some of the finest, most committed and hard-working GPs that you could ever meet are there; they are just running fast to try to cope with the amount of ill health that they have to deal with.

The aim this year is to fund enhanced services in five community health partnerships throughout Scotland—two in Glasgow and one each in Edinburgh, Lanarkshire and Dundee—to the tune of an extra £1 million each, to ensure that they provide increased time to see patients and to let them develop services that they think are appropriate. That may not be enough funding, so we will need to keep an eye on the situation. As far as I know, we are the only country in the world that has attempted to tackle the issue in that way. We have learned from a small practice in south Wales and we think that our proposals are the way to go. We will try to learn as we build up the system. Next year and the year after that, more funding will be available, which will be targeted at developing general practice and primary care up to the level that is required to deal with the issues that Duncan McNeil raises.

Evidence suggests that even if we ensure that the time that is available per condition to patients in deprived areas is the same as the time that is available to patients in affluent areas, the gap in life expectancy will still not be completely closed. The evidence is that about 30 to 50 per cent of the gap in life expectancy probably results from reduced access to care and that the rest probably results from social, economic and behavioural problems. We need to tackle both aspects. For the past 20 to 30 years, we have concentrated on changes to housing and so on, but those changes have not brought about the expected benefits. Therefore, we must ensure that the NHS tackles the issue.

An analogy that I use is that, in the 1950s, we knew that there were two ways to deal with tuberculosis: one was to reduce overcrowding in housing and the other was to treat tuberculosis with streptomycin. No one would have suggested doing only one or the other—we had to do both. We need to continue to tackle the social and economic dimensions while expanding primary care and establishing better management of chronic conditions and better preventive care. That is what the report says.

Mr McNeil: How can we ensure that we get a better Arbuthnott settlement that addresses the problems? Working back from evidence that the committee has taken about the financing of the health service, it is difficult for us to see where the money actually goes.

Dr Burns: You are not the only ones.

Mr McNeil: Not only was there a small amount of money involved, but it was not getting to the people who are not in doctors surgeries. How are we going to increase the number of GPs and shift them from affluent areas to poorer areas? What is the timeframe for that?

Dr Burns: As you know, the Arbuthnott formula is being reviewed. In evidence to the review committee, I explained the notion of anticipatory care and my belief that the evidence points overwhelmingly to a need for an expansion in primary care. We will have to wait to see what shift of moneys will result. We need to add money until we reach the point at which there is a level playing field for primary care in deprived areas. I do not know when that point will be reached, but we need to be committed to reaching it.

Mr McNeil: When can we expect the results of the review?

Dr Burns: I do not know. My sense is that my arguments gave the group cause to think, which has perhaps delayed the results of the review, although that might be no bad thing.

On attracting staff, there can surely be few things more inspiring to committed health care staff than helping the people who are most in need. If we give folk the opportunity to exercise their skills in deprived areas without running them ragged, they will take it. After all, as I have said, some of the most committed and able GPs whom I know work in Glasgow's east end. They want to work there because doing so gives them the best opportunity to exercise their skills. I do not think that we will find it difficult to establish primary care services because people find the work very exciting. I am aware of no other country in the world that has deliberately narrowed health inequalities through systematic investment in health care.

Mr McNeil: No one is questioning your commitment, but you have asked us to trust you and the review group that more money will be made available, and you have suggested that we will get more GPs into deprived areas by appealing to their better nature. However, the GPs are not in those places; in fact, they have not been there for the past 20 years. They are simply not venturing outside the local practices in the comfortable areas where they were born and brought up.

Dr Burns: I know that more money will be made available this year. Five CHPs will receive £5 million to get the approach going and to see how it works.

We can attract GPs in many ways; for example, salaried GPs are now quite common and are being used by quite a few health boards. Indeed, I know of a homeless persons practice in Glasgow that is run by salaried GPs. Instead of wanting to run small businesses—which is what most general practices are—those people just want to work for a salary.

CHPs have many tools at their disposal to establish such an approach. If it does not work, we will review the plans; however, at this stage, I have no reason to doubt that it will work.

The Convener: Just to reiterate that the matter is not confined to certain areas, I point out that a homeless persons practice in Perth is run by salaried GPs.

Helen Eadie: For clarification, did Dr Burns say that £5 million would be available for all CHPs in Scotland?

The Convener: I think that he said that £5 million would be given to each CHP.

Dr Burns: In the first wave, £5 million will be available to five CHPs. We do not know whether that will be enough; indeed, it might be too much. We shall see. It is simply a ranging shot.

Shona Robison (Dundee East) (SNP): You have made it clear that you are talking about new investment rather than the transfer of existing resources—although I am sure that that debate has already taken place.

You are absolutely right to say that 70 per cent of health inequalities problems are socioeconomic in nature. However, that highlights the fact that investment in the NHS is only part of the solution. One question that the committee has discussed is how local authorities that represent deprived areas are funded. After all, if we are talking about joined-up government, one supposes that there have been discussions about how we can ensure that the local authorities that represent deprived areas are not discriminated against. For example, services in very deprived communities in Glasgow and Dundee are under real pressure. Are ministers with different portfolios discussing how local government financing can join up with plans to ensure that resources get to the most deprived communities? If those discussions are not taking place, we can complete only part of the jigsaw.

Dr Burns: At the coalface, Glasgow, Dundee and the Lothians have developed combined community health and social care partnership models. The leaders of some of those CHPs have come from local government, and attempts are being made to run local government social work, care and health budgets not as a single pool—which would raise governance issues—but in parallel, and under the control of the community health and social care partnerships.

Interesting models are emerging that will seek to harmonise these important services and to remove the boundaries between them. As I said, we are moving into new territory, where we will have to develop new ways of handling budgets. It would not be appropriate for me to talk about local government funding, but as far as I can see, there is tremendous good will on the part of a number of local authorities that are dealing with highly deprived areas and are trying to harmonise and pull together services.

14:45

Shona Robison: I suppose that the point that I am making is that the same arguments that you, as chief medical officer, are making about how funding should be distributed in the health service could equally be applied to local government. Funding needs to be allocated in areas that are currently discriminated against because of the funding formula and the council-tax base.

The Convener: I am not sure that the chief medical officer can answer questions about local government funding.

Shona Robison: As chief medical officer, his role is, I presume, to tackle public health problems.

Dr Burns: With the five leading CHPs—the first wave of CHPs—we are trying to make more explicit what services are available through broad primary and social care services. We shall learn from that, and that learning will be communicated widely. I hope that that will influence many decisions in many quarters. There are crucial things that we can learn from that experience.

The Convener: I have a question that arises from the phrase that you used in connection with prevention and early intervention. You said that we need to get in early on—I think most members of the committee would agree—but I would like to explore further the question of how to target services. I have had a discussion with representatives of the Royal College of Paediatrics and Child Health, who pointed out forcefully that the biggest single indicator of future health problems is birth weight. They feel that birth weight is simply not included in the equation as a red flag. If you do not agree with that, will you comment? If you do agree, are we doing anything to begin the monitoring that might be needed at the earliest stage? One might argue that monitoring should go back to a few months earlier than birth, but birth weight as an absolute factual indicator cannot be contradicted.

Dr Burns: I am not sure that I agree with the Royal College of Paediatrics and Child Health that birth weight is the biggest single indicator, although it is the biggest single indicator that a paediatrician has to deal with. I argue—as would others, such as respiratory physicians—that the biggest single indicator of future health is whether or not a person smokes, but both points of view are equally valid. There is no question but that birth weight has an influence on the risk of problems such as hypertension and diabetes 40 or 50 years down the track, so rather than just monitoring birth weight, we should be trying to deal with the problems. We know, for example, that maternal smoking is powerful in reducing a child's birth weight through its causing problems with placental nutrition, so we should be doing something to reduce the number of low-weight births in Scotland.

We have started work on identifying risk. If we are going to tell primary care teams that there is a swathe of people out there who never come near them because they are negative about their health or their lives, or because they ignore their symptoms—

The Convener: Because they are Scottish.

Dr Burns: Exactly. How can we advise primary care teams to deal with that? We have started work with our statistics colleagues on developing risk scoring systems that will allow GPs to go first to the groups of patients who are most at risk.

The Convener: I am asking whether we should start the process as early as birth. It is one thing to intervene at the point at which an adult has already begun to smoke and drink too much, in which case they will already be exhibiting a lot of the problems, but it is another matter to enter the equation at a much earlier stage to try to head off some of those problems.

Dr Burns: There is an interesting choice. If we really want to influence the lung-cancer figures, adult smokers rather than teenage smokers must be targeted because adult smokers will get lung cancer in the next three to five years. That risk might be reduced if they were to stop smoking immediately. Teenage smokers are tomorrow's problem—they will get lung cancer 40 years down the line—so both must be targeted. We must worry about babies with low birth weights and we must intervene, but we must also deal with adults who are in danger of dying in the next year or two.

Scotland's infant mortality statistics are among the lowest in Europe. The mortality rate of boys and girls up to the age of 15 and the mortality rate of adults over the age of 75 are lower than the European averages, but the mortality rates of working-age men and women are the highest in western Europe. We must deal with that age group if we want to change the figures within the next generation, but we must not ignore people at the age extremes. Improvement of the health of babies before and shortly after birth will pay off in future generations, but we must change the attitudes of working men and women to their health if we want results soon.

The Convener: A resource issue enters the equation. How should resources be allocated to different age groups as well as to geographical areas? The equation becomes very complex.

Dr Burns: It does, but it is possible to do a calculation because we can calculate the improvement in life expectancy from a range of interventions per thousand pounds that are spent.

The Convener: Are we doing such calculations?

Dr Burns: In some respects we are. Two elements are involved. First, I encourage health boards and CHPs to take on board the evidence and to have a public debate on it. That would mean disinvestment in some areas of low health gain. Secondly, we need more information—we need the information that the pilot studies will offer us.

The Convener: Will you clarify what you mean by the phrase,

“disinvestment in some areas of low health gain”?

To which areas are you referring?

Dr Burns: The National Institute for Health and Clinical Excellence has said that the cost effectiveness of some drugs is extremely high, while the benefits of some drugs are not great. There must be a public debate on resources in the future—I hope that there will be. As more and more effective work can be done, there will need to be a debate on how much of the national cake goes into health.

The Convener: Are you talking about rationing?

Dr Burns: I am talking about prioritisation.

The Convener: That sounds like rationing.

Mr McNeil: There is rationing now—indeed, it has just been described. Having a level playing field militates against unhealthy people, and large numbers of unhealthy people consequently die. Perhaps you could give an estimate of the numbers that are involved so that we can put things in perspective.

Identification of who is who is crucial to all of us. Information technology can help. Perhaps we can be told when we can look forward to an update on what is being done and whether IT and the gathering of records can be rolled out in deprived areas rather than in other areas.

On risk assessment, you will be more aware than I am that the midspan project underestimated by 48 per cent the incidence of heart disease among manual employees. There are other figures. General practitioners’ surgeries are effectively managing people, but hospitals deal with a large number of people who are missed—I am talking about five times as many people. How can we use IT to focus on the problem? That is a challenge for politicians, who need to recognise that money must go where needs are greatest.

Dr Burns: Our information systems in Scotland are extremely good for that purpose. We have linked data—each patient’s record is linked electronically going back to the early 1980s. We can use those data to target individuals who have been in hospital with heart disease and whose GPs are sitting with information on them. GPs can look at their practice population and say, “These are the individuals with whom I need to deal first.”

As for risk, the midspan study did not show that we underestimate the prevalence of heart disease; rather, it showed that using conventional risk-assessment exercises—which are based on an American population in Massachusetts and are used all over the world—comes back to what we said about Kaiser Permanente, which is that the social mix is completely different. The study showed that, for a given level of cholesterol or blood pressure, the more socially and economically deprived people have a higher risk of having a heart attack than do people on whom the risk-scoring system is based, so we must develop our own Scotland-based risk-scoring system to take account of that. That is being done now. We have the evidence and we are well on the way to developing a system that will target the people in Duncan McNeil’s constituency who are most at risk.

I return to the point that we need patients to be on side. We want primary care to be proactive, but we will not force people to do something that they do not want to do because that would be unethical. However, we want to make it explicit to people that we can make a dramatic difference.

People always talk about Finland, which gets on my wick. They say that Finland has made dramatic changes to its heart-disease mortality since the 1970s, but the fall in heart disease mortality there since the 1970s is identical to that in Scotland, although we do not get credit for that. The two curves are identical. I argue that some of that fall is a result of reducing the prevalence of smoking here. We take more exercise and many of our health behaviours are improving and we do not give ourselves enough credit for that. Much of the reduction in the heart-disease mortality rate has been because the health service has started—albeit that it has been in an ill co-ordinated fashion—to deal effectively with the risk.

The health inequalities paper says that we should co-ordinate activity and systematically offer people the opportunity to change their life expectancy so that we can see how far we can go in reducing health inequalities, and that we should ensure that the health service, local authorities and central Government are doing what they can. They are all trying to do things but—for goodness’ sake—we must ensure that the health service is up there acting in a co-ordinated fashion.

The Convener: That is probably a useful note on which to end. I suspect that we will continue to have a conversation with you.

Dr Burns: I will be happy to do that.

The Convener: We will consider public health for our work programme, so we may return to you on several issues. Thank you for coming along.

14:58

Meeting suspended.

15:01

On resuming—

Hepatitis C

The Convener: Item 2 is our consideration of the case for a public inquiry into infection with hepatitis C as a result of NHS treatment. Members will recall that on 31 January we heard evidence from the Scottish Haemophilia Forum and the Minister for Health and Community Care on the case for a public inquiry into infection with hepatitis C as a result of NHS treatment. During the evidence-taking session, the minister agreed to provide supplementary written evidence on the traceability of blood transfusions or blood products that people received prior to 1981. He also undertook to write to us on governance arrangements as they relate to potential private suppliers of blood or blood products and on the compensation scheme for those who were infected with hepatitis C as a result of involvement in clinical trials. The committee also agreed to write to the Lord Advocate for a clarification of practice concerning deaths that result from hepatitis C and of post-mortem practice. We also agreed that we would reconsider the case for an inquiry once we had received all the additional information.

We have now received a response from the minister, which has been circulated to committee members. We have also received submissions from the Scottish Haemophilia Forum and Thompsons Solicitors and a response from the Crown Office, all of which have been circulated to members. Today, we need to consider all the evidence and decide whether we want to call for an inquiry into infection with hepatitis C as a result of contaminated blood and blood products.

We have in attendance today Euan Robson and Carolyn Leckie. The resignation of Mike Rumbles from the committee prior to the Easter recess means that we are one member down. As a result of the timing of that resignation, we have as yet been unable to replace Mike Rumbles with another Liberal Democrat member. Our standing orders do not allow a substitute to attend in the case of a position being vacant. I take this opportunity to give the committee's best wishes to Mike Rumbles. He was on the committee for a very long time and was always a very dynamic committee member. He contributed hugely to our debates and will be missed. I anticipate that at some point in the future Euan Robson will come on to the committee, but perhaps we should not prejudge that decision.

Carolyn Leckie made a specific request to speak this afternoon. As members of the Parliament, both Carolyn Leckie and Euan Robson are entitled to do so. Carolyn Leckie also asked me to circulate to committee members a set of papers that she made available late this morning. We received the papers too late for all members to receive them in advance of the meeting, so I am not inclined to allow the papers to be submitted formally at this stage.

However, all committee members have received a copy of Carolyn Leckie's covering letter, which was sent to me and to those members who managed to get a copy of the set of papers. I would expect her comments to be in keeping with the issues that she raised in that covering letter. I would have preferred it if the papers that were circulated so late in the day had been made available earlier, because it is impossible for us to ensure that all committee members have all the paperwork under these circumstances. It is a courtesy to members to allow them the maximum amount of time possible to read submissions.

Carolyn Leckie (Central Scotland) (SSP): If I may explain, although the papers that I circulated this morning were in my possession as the result of a freedom of information request, they had not been examined and their relevance was not noted until yesterday afternoon. Given the importance of today's discussion, it was a courtesy to the committee to circulate them. I thought that it was right to circulate the papers rather than keep them in my possession. I intended to take up the relevant issues anyway.

The Convener: The difficulty is that, because of the late notice of the papers, three committee members have not yet had them even now, as they were not available to them in the places where they were.

Carolyn Leckie: Their offices have now received them. I made sure of that.

The Convener: That may be, but—

Carolyn Leckie: I am just making this explanation for the record.

The Convener: At this very late stage, it is difficult to ensure that committee members have the paperwork. In future, I urge all MSPs who have things that they wish to bring to the attention of members of any committee to do so at the earliest possible opportunity. That makes it considerably easier to deal with the issues involved.

I want to open up the discussion on this subject. We should consider the evidence that we have heard. We need to decide whether we are going to call for an inquiry into infection with hepatitis C as a result of contaminated blood products. I invite members' views. Jean Turner, Shona Robison and Helen Eadie are indicating that they wish to comment on the subject.

Dr Turner: Reading through the evidence from Thompsons Solicitors, I am struck by the first three cases that are outlined, which describe how people did not know for some time that they had been infected by blood or blood products. In one case, the person did not know for 20 years; in another, the person did not know for around 12 years; and in another the person did not know for 14 to 15 years. That is a long time, whichever way we look at it.

To move on to the future, we must learn from the past. If I had received any such product, the most important thing for me would be to be notified of the potential hazard of being infected. Once it is known that people have been administered an infected product, it is important to track them down—to do one's utmost to find the people affected, whatever the cost. There is a duty of care towards the person who has been infected and towards their family. In one case, a spouse did not realise that they had been infected—I assume that it was because of the products that the wife had been given. Discovering such an infection affects the family. It can also give rise to problems among NHS staff and even among undertakers. When people died in the cases concerned, there was no further investigation. I think that investigations should be made even when the outcome is death.

Someone who has been infected but does not know it could be travelling about the country before developing appendicitis and turning up in a hospital to be operated on without anybody knowing that they have hepatitis C and the problems associated with it. To take another example, an undertaker might be working on embalming a body. Unless they were given specific information, they would be putting themselves in danger. That also applies to variant CJD. It is up to the professionals to let the patients know that they have an infection. I am aware of cases where the professionals know, but the patient does not know. It is imperative that people who could have an infection with such serious implications as hepatitis C has are told about it. There have been serious gaps in the attempts to find those people, which is a major flaw.

We all want to know why Scotland was so far behind in providing safe blood products. An astonishing letter that is part of the evidence refers to a head of department in the national service in Scotland tearing to bits somebody in the north of England because they were doing something that seemed to be best for patients. We need to figure out why that kind of thing can happen and how our processes for communicating with people can be made better than they have been until now.

It seems to me, after reading through all the evidence, that more questions remain than we have had answered. I am in favour of going ahead with an inquiry.

Shona Robison: I will focus my comments on the look-back exercise, which I think is the most significant piece of new evidence that we have seen. The minister refers to it extensively in his evidence to the committee. By his own admission in paragraph 6 of his evidence, the exercise concentrated only on the donor population and was carried out between 1995 and 1997. Why did it take eight years to begin to trace people, when it was known that hep C infections were happening up to 1987? Given that blood transfusions continued to infect people up to 1991, when screening was introduced, why did it take a further four years, to 1995, for any attempt to trace people to be made?

The term "look back" implies that all cases were looked at, but they were not. The exercise concentrated only on those donors who happened to come back to give blood. It did not address hep C infection from donors who did not come back. Unless anyone around the table can prove otherwise, it seems to me that the look-back exercise related to only a two-year window within which a donor may or may not have come back. That is a totally inadequate exercise in attempting to trace people who could have been infected.

Why did the look back cover only the period from 1995 to 1997? What if a donor returned between 1991 and 1995? What about those who returned after 1998? The minister states that he has computer records going back only to 1985. Why has he excluded a manual look back at hospital records prior to 1985 to identify those who had transfusions, which could have been done? A large number of recipients identified from the return donors were deceased. Why was no attempt made to counsel their relatives, particularly their partners? Why was there no recipient-centred strategy such as a system of recall, as we have had for smear tests when there were problems with those, which could have assisted in contacting those who had a transfusion during the danger years when people were being infected? There are hundreds of unanswered questions.

There is also the evidence in the letter from Professor Ian Franklin, dated 28 April 1998, which is on page 15 of the submission from Thompsons, which suggests that those not traced through the restrictive look-back exercise were ignored because of a lack of resources from the Scottish Office. That has to be investigated further to see whether it was the case.

If no one around the table can answer the questions that I have asked—which are only a sample of the questions that I think are raised in the new evidence—surely the committee has a duty to recommend that an independent inquiry be established to get answers not just to those questions but to the hundreds of others that I think have arisen in the evidence that we have taken since we started to consider the matter.

15:15

Helen Eadie: At the weekend, I looked at the Inquiries Act 2005, which was passed just before the dissolution of the Westminster Parliament last April. If I am right—I look to the committee clerks to advise me—the legislation on inquiries has been changed significantly. I wonder whether Frank Maguire of Thompsons and all the patients whom he represents want the kind of inquiry that they would get under the 2005 act.

Having read Frank Maguire's papers and the minister's response, I am in no doubt that action needs to follow because both raise concerns that the public and I want to be reassured about. However, I am not certain that a public inquiry is the right forum for that. A group—a task force or whatever—must be convened to address public concerns and allay fears. After reading Frank Maguire's papers, I have questions such as why it is that when we give blood, it is not necessarily screened for hepatitis C. I see that Duncan McNeil is shaking his head, but I made notes—

Mr McNeil: That claim was countered this week.

Helen Eadie: Okay, I look forward to hearing what Duncan McNeil has to say about that. However, I assumed that when Joe Bloggs gives blood, a check for hepatitis C is carried out before the blood is passed on to other patients. That is the sort of concern that must be categorically refuted, which can be done only through the expertise of an action task force.

Frank Maguire raises points about computer records and the minister states in his response that hospitals were asked to undertake manual tracing. We need to find out who monitored the results from that manual tracing to be certain that hepatitis C sufferers were identified. Other people have asked what has been done to ensure that the relatives of those who died from hep C were tested. I want immediate action in response to those questions; I do not want to wait for any inquiry for that.

The Inquiries Act 2005 changed previous legislation so that an inquiry would be accountable not to Parliament but to the minister, who would choose the chairperson. I want whatever action we take to be accountable to the Parliament and not only to the minister.

On Shona Robison's point, although the look-back exercise lasted only from 1995 to 1997, I noted in the minister's response that it was

> "a complex operation, requiring the coordination of reports from a number of centres over several years, and involving

records of donations going back over a long period prior to 1991."

It is not the case that the exercise looked only at that two-year period; it went back over many years prior to 1991. I wonder whether there has been a misunderstanding about that.

The Convener: I can see what the concern might be. Does Duncan McNeil want to come in at this point, as he was referred to?

Mr McNeil: It is difficult to keep pace with press conference after press conference and with all the radio shows. Many of the issues that I heard about during the recess last week were not before the committee. We did not have that courtesy. We did not get the papers until later, but we heard all those views being aired on our radios and televisions. Some members who are at the committee today participated in that process, but others who are not here gave a contrary view and stated that the head of the service had denied some of the things that were said. Carolyn Leckie has made some additional information available this morning and, apparently, that has been the subject of a press release as well. I do not know what position I am in today. If there is significant new evidence—not just new information, but significant new evidence—I want to hear both sides of the story.

The Convener: We will formalise the decision shortly, because there might be a couple of different positions that need to be considered.

Mrs Milne: I confess that I had no knowledge of the Inquiries Act 2005, to which Helen Eadie referred, but there are obviously still important questions to be answered. I am extremely concerned at the lack of patient information. There are still patients coming forward who are suffering from hep C and who did not know until recently that they had the illness even though they have obviously had it for a considerable time. I agree with Shona Robison that the look back has been severely inadequate. Therefore, it is terribly important to find out what exactly has gone on. Public confidence in the blood transfusion service and in the NHS itself is at stake.

As members will realise, I did not support the call for a public inquiry in the debate in December because, although I accepted that many questions needed to be answered, I took the view that they could be dealt with by taking a test case to court. However, at the committee meeting on 31 January, when I asked Mr Maguire about the feasibility of that and why an inquiry would be better than a test case, it was made plain that a test case was not a possible way forward.

I would like more information about the act that Helen Eadie mentioned, but we must by whatever means get to the bottom of what has been going on. I do not envisage that an inquiry would necessarily open the floodgates for compensation claims because negligence would still have to be established in any case, but it is terribly important that we find out what went on. I will be guided as to what the best way forward is on that.

Carolyn Leckie: I agree with Duncan McNeil that both sides of the story need to be heard. That is why we need an independent public inquiry because, so far, we have been asked to accept the judgment of the current Minister for Health and Community Care, previous health ministers and previous Governments that everything is okay, lessons have been learned and there is no need for an independent public inquiry. The only way that people can trust that judgment is by having an inquiry with independent analysis of the evidence and an independent judgment on it.

It is not about coming to a conclusion or judgment today, because that is impossible, to be frank. The large sheaf of papers that I have with me contains only the papers that are associated with the third bullet point in my letter. I extracted a few of those papers and circulated them to the committee. The reason why committee members got them only this morning is that I read them only yesterday afternoon; I moved as quickly as possible to circulate them to the committee. They are an example of the many questions that surround the issue and of why there is a lack of trust and confidence in all the Government departments and NHS services, such as the blood transfusion service, that have been involved in the story.

I will concentrate on my third bullet point, because it relates to some of the evidence that Frank Maguire submitted, which is part of the documents that the Scottish Executive has released. I have many other documents that have been obtained from other sources and I have told the committee previously that it can access them. The letter from the Scottish National Blood Transfusion Service to the northern region of the National Blood Transfusion Service to which Jean Turner referred says, in effect, that the northern region of the NBTS needs to come into line. Defensive medicine was being practised and, if one arm of the blood transfusion service did one thing, the rest of the service would be exposed to the risk of litigation.

That came at the end of a protracted discussion and debate about the availability and efficacy of a non-specific test—an alanine amino-transferase test—to identify non-A, non-B hepatitis in the period before 1991. The test was available and accurate in five cases out of six in America and in other European countries from 1986. The Scottish National Blood Transfusion Service wanted to introduce it but was prevented from doing so by the Scottish Office home and health department and the Westminster Government. That information is contained in the documents.

More astonishingly, instead of introducing the routine screening that was the best available at the time and which could over five years have reduced the risk of infection by what was known at the time as non-A, non-B hepatitis, the working party advocated a research project. One paragraph of the documents that have been submitted states:

> "The position explicitly reached at the meeting is to recommend research of no great significance or scientific interest because the prospect of research would serve to counter pressure from for example haemophiliacs and Haemophilia Directors to embark on an indirect and largely ineffective form of screening".

Rather than introduce the only routine screening that was available to them, they substituted research for it and procrastinated for more than five years.

In the research, the working party identified the blood from donors that was prospectively at risk and had the markers that could be identified by the ALT test. The documents that I have supplied indicate that it knowingly allowed that blood to be received by people without their knowledge and that it followed up the matter in only a small way. Knowingly, it put those people at higher risk of transmission of non-A, non-B hepatitis, in order to conduct research that the Medical Research Council did not even support and that was a substitute for introducing the only screening available, which the Scottish National Blood Transfusion Service wanted to introduce but did not under Government and political pressure. That is where the letter comes in. The Scottish National Blood Transfusion Service abided by the political will of the Government departments of the day, but the northern region of the National Blood Transfusion Service stepped out of line and unilaterally introduced the ALT test. That is why the SNBTS was angry.

I have my judgment on the morality of what happened and what it says about how the process was conducted. I have provided just one example of many controversial developments associated with the issue. I am not asking the committee to form a judgment today or asking Duncan McNeil to accept my version of events without having seen the documents. However, what I have described shows that there needs to be an independent analysis and trial of the evidence, so that an independent judgment can be reached on it. We are having to fight tooth and nail to get every wee scrap of information. Documents have been withheld from the Executive. We have letters from the blood transfusion service to Government departments—the Department of Health and Social Security and the Scottish Office home and health department—but there are no replies. Where are the replies? The fact that there are loads of questions demonstrates the need for an inquiry. Only then will both Duncan McNeil and I be satisfied.

Kate Maclean: I feel at a disadvantage, because I have not been in my office in Edinburgh today. I do not have staff through here, so if papers were delivered to my office I have not had access to or been able to read them. Carolyn Leckie referred to information contained in certain documents. Can the clerk or Carolyn refer to papers that we have already received that include that information?

Carolyn Leckie: It is in the Scottish Executive documents that were released under the freedom of information regime.

Kate Maclean: I am talking about papers to which I have had access. I am wondering whether some of the documents that Carolyn Leckie has distributed are included in the papers that we have received already. I find it difficult when Carolyn keeps referring to documents that I have not seen. Three members of the committee have not seen those documents.

The Convener: Some of the issues to which Carolyn Leckie has referred are contained in the papers that members have seen. They might be presented in a slightly different way, but the information is in our papers.

Kate Maclean: The situation is not satisfactory.

15:30

The Convener: It is not satisfactory, as I said at the beginning.

We decided that we would reach some kind of decision today. We have several options to consider, which may or may not be formalised into a decision. The first option is to call for an independent inquiry. Both an independent inquiry and an independent public inquiry, which are not the same, have been mentioned. That matter would have to be clarified if an inquiry were proposed. We could argue for a debate in Parliament, although we had one in December and we would need to think what we wanted the debate to be about and how it would be different from the debate in December. I will ask Helen Eadie to formalise her comments, but she suggested some form of committee inquiry, with a small i rather than a large one. Alternatively, we could have a committee inquiry with a large i or decide to take no further action. We have several options. I want to bring the discussion to a close and, ideally, have the committee agree on future action.

Janis Hughes: I accept that there are a few options, but I agree with Kate Maclean and

Duncan McNeil about the further evidence that has been submitted—I was given it literally as I left to come to the meeting and, like other members, I have not read anything other than the covering letter. I accept the convener's point that some of the information is contained in the evidence that we already have, but Carolyn Leckie has referred to evidence that the majority of members have not considered. I hesitate to make a final decision today on the basis of papers that we have been given but not had the chance to read. I urge caution in making a final decision.

The Convener: It is a matter for members whether they make a decision on the basis of the papers or on the basis of the evidence that was already before us, which is what we should do. I do not want a roundabout discussion to go on for a great deal of time. I want some formal proposals that the committee can either agree to or not agree to.

Mrs Milne: I seek clarification on one issue, convener. You referred to an independent inquiry and an independent public inquiry, but you did not use the word "judicial" at any stage.

The Convener: No, because nobody around the table has used the term "judicial".

Mrs Milne: If memory serves me right, that was what was called for when we took evidence.

The Convener: I am asking for the various positions to be clarified.

Helen Eadie: Before we do that, could we have some clarification? The Inquiries Act 2005 was passed in April last year. I want to know whether that act affects Scotland and, if so, what the implications would be if we went down the route of an inquiry. Can the committee clerks find that out for us?

The Convener: I do not know when you knew about the Inquiries Act 2005, but some of the comments that applied to Carolyn Leckie apply also to you.

Helen Eadie: I found out about the act during last-minute reading before I retired for the evening last night.

The Convener: Decisions about inquiries go on all the time.

Helen Eadie: We have just had a recess, during which I was in Coventry. I came back late on Sunday night, did my work yesterday and then found out about the Inquiries Act 2005. I want to know what a public inquiry would achieve. If a public inquiry would be the appropriate route, members might wish to opt for it, but if we want to safeguard the people of Scotland, other action might be more appropriate.

The Convener: No reference was made to the Inquiries Act 2005 at any stage during the many debates about the McKie case, which suggests to me that the legislation is not particularly germane to the present situation. I would like some clarified positions to be made so that the committee can, if necessary, vote on them. If Helen Eadie wants to delay a decision further, the committee as a whole can decide on her proposal.

Shona, do you want to go first?

Shona Robison: Before I do that, would it be helpful to clarify something that Helen Eadie asked about?

The Convener: Yes, please.

Shona Robison: Let us be clear about the look-back exercise, which Helen Eadie has raised. It took place between 1995 and 1997, and the minister's evidence makes the situation clear:

> "Where a returning donor was identified with Hepatitis C after 1991, records were identified for any donations made prior to September 1991 and for each blood component made from these donations".

Only those returning donors during that period were considered, which is why the look-back exercise was inadequate.

Despite the information that Kate Maclean has talked about Carolyn Leckie producing, the bulk of the evidence that concerns the committee is within the existing papers, especially those from Thompsons Solicitors. Having seen the stuff that Carolyn Leckie has submitted, I assure the committee that the most important element of her paper is already in the Thompsons Solicitors paper, so we can come to a conclusion today. My proposal is simple: the Health Committee should call on the Scottish Executive to establish an independent public inquiry into the infection of people with hepatitis C through NHS treatment. Helen Eadie has mentioned the Inquiries Act 2005. Frankly, even if what she says is true—the minister would appoint the chair and the independent inquiry would report to him—it would be better than having no inquiry at all. Having been a member of the previous Health Committee and having heard all the evidence, I think that we owe it to the people who are affected to come to a decision today, and I put that forward as a proposal to the committee.

Kate Maclean: I ask for clarification of what Shona Robison has said. Carolyn, have you not submitted any new evidence to the committee today?

Carolyn Leckie: I have circulated papers that have already been released by the Scottish Executive under the Freedom of Information Act 2000. Their relevance became apparent to me only yesterday, and I quickly gathered them together for the benefit of the committee. The issue that I am highlighting has not, to my knowledge, been highlighted before, but the evidence is not new. The Scottish Executive has known about it, as it has had the documents. Information on the ALT testing has been submitted in Frank Maguire's documents.

Kate Maclean: That does not really answer the question that I am asking. Is there any evidence that the committee has not already seen? Have you submitted new evidence or not?

Carolyn Leckie: I do not know whether you have read the documents that have been released by the Scottish Executive—

The Convener: Leave your documents out of it.

Kate Maclean: I am talking about the papers that have been circulated to the committee. Have you today circulated evidence that is new to the committee?

Carolyn Leckie: If you have not read all the documents that have been released by the Scottish Executive, the answer is probably yes.

The Convener: I detect that Helen Eadie and Janis Hughes take a different position from Shona Robison. I do not know whether you want to formalise it in some way.

Janis Hughes: On the basis that Carolyn Leckie has said that there is evidence that we have not seen—

The Convener: I am trying to move us on, Janis.

Janis Hughes: On the basis that she has said that she has submitted evidence that she has received under the Freedom of Information Act 2000 that we have not seen, because it has not been submitted to us—

Carolyn Leckie: It is in the Scottish Parliament information centre.

Janis Hughes: But it has not been submitted to us in the papers that we have received for today's meeting. I would like to be able to see—

Carolyn Leckie: It is not a—

The Convener: Carolyn, could you please be quiet at this stage and let Janis Hughes formalise her position?

Janis Hughes: I would like the opportunity to see that evidence.

The Convener: So, you move that we continue the discussion to a future date to allow us to consider further papers.

Janis Hughes: Yes.

The Convener: Is there any other position that anybody wishes to formalise at this stage?

Helen Eadie: Could I add an amendment to Janis Hughes's position? I also wish to have that further information to clarify precisely what the impact of the Inquiries Act 2005 will be for Scotland and what benefit an inquiry under that act would have in contrast to an action strategy delivered by the minister. Undoubtedly, we have been given information that demands action.

The Convener: We can take it as read that the clerks will look at the Inquiries Act 2005 issue. If the committee's decision is to continue the discussion, that is one of the issues that will be looked at.

Dr Turner: I made my decision on the basis of the material that was submitted to the committee. I got Carolyn Leckie's papers as I was coming down the stairs to the meeting and had time only to open and glance through them. If there were to be an inquiry, her detailed information, which we have not been able to read as yet, would come out.

It would take an awful lot of time to take in all the material that she has presented, but only a short time is available to us. As I said, I made my decision on the material that we had in front of us and on the fact that the look-back exercise did not look back far enough. Not only were many areas missed out but there were a number of discrepancies, for example in communications between our system in Scotland and the system in England. Also, at the time the powers that be were the Westminster Government and the Scottish Office, not the Scottish Executive. I am in favour of this—

The Convener: I think that we understand your position, Jean. Do you want to come in at this point, Nanette?

Mrs Milne: I am in favour of an inquiry of some sort. Again, I apologise for my ignorance of legal matters, but is Shona Robison's proposal for a public inquiry significantly different from a call for a judicial inquiry?

The Convener: A judicial inquiry would be remitted to a named judge who would operate it on the basis of taking evidence. We have seen many such inquiries in the past. Strictly speaking, public inquiries do not have to be heard in front of a judge, but they usually are. The difference may simply be semantic. Perhaps Shona Robison will clarify whether she sees her proposal in terms of a judicial inquiry.

Shona Robison: Yes.

The Convener: Perhaps it would be better to actually say that.

Shona Robison: I am happy to say that.

The Convener: Right. That needs to be said; the purpose is for everyone to be comfortable.

Shona Robison: In custom and practice, it is the same thing.

The Convener: The situation appears to be that two proposals are on the table. The first is that, as a result of the evidence that has been before us, the committee calls for a public inquiry into all matters pertaining to hep C that was acquired through contaminated blood, but with particular reference to the issue of traceability, which has arisen in new form.

The second proposal, which Helen Eadie and Janis Hughes have jointly proposed, is that the committee's consideration of the issue be continued to allow for a further look at, among other things, the paperwork that Carolyn Leckie attempted to circulate today and the issue that Helen Eadie raised on the Inquiries Act 2005. Is that a fair summation of the two positions?

Members *indicated agreement*.

The Convener: Okay. If it comes to it, our standing orders require me to use my casting vote; I am not permitted to dodge the issue. Given that the committee now has an even number of members, I thought it would be helpful to say that in advance of any vote. Two proposals are on the table. We will have to take a vote. Will those members in favour of Shona Robison's proposal indicate their support?

FOR

Cunningham, Roseanna (Perth) (SNP)
Milne, Mrs Nanette (North East Scotland) (Con)
Robison, Shona (Dundee East) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: Will those members in favour of Helen Eadie and Janis Hughes's joint proposal indicate their support?

FOR

Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)

The Convener: I was afraid that that would happen. The situation is not one in which the status quo is the imperative. As I voted for the inquiry, I will use my casting vote for Shona Robison's proposal. It would have been preferable to come to a broader agreement, but if that is not the case, it is not the case.

The committee has agreed to call for an independent public inquiry into the issues that have been before us until now. That will be communicated forthwith to the Minister for Health and Community Care. I thank everyone for their forbearance.

Item in Private

15:45

The Convener: The final item on our agenda is consideration of matters in private. At our meeting next week, we will discuss our work programme. I seek the committee's agreement to consider it in private. Are we agreed?

Members *indicated agreement*.

Meeting closed at 15:45.

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