HEALTH COMMITTEE

Tuesday 31 October 2006

Session 2

£5.00

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

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HEALTH COMMITTEE
23rd 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)
*Euan Robson (Roxburgh and Berwickshire) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Mr Kenneth Macintosh (Eastwood) (Lab)
Mr Stewart Maxwell (West of Scotland) (SNP)
Margaret Smith (Edinburgh West) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Bill Butler (Glasgow Anniesland) (Lab)

THE FOLLOWING GAVE EVIDENCE:

Dr Robert Cumming (Scottish Health Campaigns Network)
Geoff Earl (Royal College of Nursing Scotland)
Dr James Gilmour (Fairshare Voting Reform)
Dr Dean Marshall (British Medical Association Scotland)
John Park (Scottish Trades Union Congress)
William Pollock (Association of Electoral Administrators)
Helen Tyrrell (Voluntary Health Scotland)
Dave Watson (Unison Scotland)

CLERKS TO THE COMMITTEE

Karen O'Hanlon
Simon Watkins

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 6

Scottish Parliament

Health Committee

Tuesday 31 October 2006

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

Health Board Elections (Scotland) Bill: Stage 1

The Deputy Convener (Janis Hughes): Good afternoon and welcome to today's meeting of the Health Committee. We have received apologies from Roseanna Cunningham. I particularly welcome Bill Butler MSP, who, at an appropriate time, will be allowed to question the witnesses on his member's bill proposal. It is standard practice that committee members question witnesses first, but I shall bring in Bill Butler after that.

Agenda item 1 is the Health Board Elections (Scotland) Bill. This is our second evidence-taking session on the bill. A number of documents in the committee papers provide background for today's session. In our call for evidence, we focused on four main issues: support for the general principles of the bill and, specifically, for direct elections to health boards; any omissions from the bill; the quality of consultation and the implementation of key concerns about the accountability of health boards; and the practical implications of implementing the provisions, and any alternative approaches. As with last week's evidence session, we will focus on those four issues.

The bill would have no other impact upon the constitution or operation of health boards or the powers of Scottish ministers in that regard. I would be grateful if members and witnesses could bear that in mind when asking and answering questions.

Today's witnesses are Dr Dean Marshall, who is chairman of the Scottish general practitioners committee of the British Medical Association Scotland; Geoff Earl, who is a board member of the Royal College of Nursing Scotland; John Park, who is assistant secretary of the Scottish Trades Union Congress; and Dave Watson, who is the Scottish organiser of Unison Scotland. Members will address their questions to the panel. Witnesses who wish to respond or make additional comments can make themselves known to me.

Do the witnesses support the bill?

Dr Dean Marshall (British Medical Association Scotland): The BMA does not support the bill. We acknowledge that the public do not feel involved in decisions about changes to their local health services, but we do not believe that direct elections to national health service boards will solve the problem. The bill was originally proposed in 2003, prior to the establishment of community health partnerships, which have a specific remit to consult local communities. If the CHPs prove to be effective, that would be a more appropriate way of addressing the problem than direct elections to boards. Regardless of whether the bill stands or falls, it is important that NHS boards continue to be required to consult the public on service changes. The BMA believes that the focus should be on how boards improve consultation processes and communication with the public.

Geoff Earl (Royal College of Nursing Scotland): The RCN considered the bill and discussed it at board level when it was first mooted. While understanding the principles behind the bill, the RCN does not support the idea of a fully elected health board. My colleague from the BMA mentioned legislation that was introduced in 2003. The RCN would like that to be given time to work and, if necessary, to be strengthened. We think that there would be a number of dangers in having a fully elected board, and that is one of our key reasons for not supporting the bill.

John Park (Scottish Trades Union Congress): As members will see from our submission, the STUC supports the proposals that are outlined in the bill. Supporting such measures has been a long-standing policy of the STUC. We are keen for the proposals to go ahead, because we would like democracy to be taken down further to a local level through health boards. We have been approached on numerous occasions by individuals throughout Scotland who feel disengaged from the process. Consultation can be valuable and meaningful, but that extra level of democracy would help boards to be more accountable.

Dave Watson (Unison Scotland): Unison Scotland supports the bill. We believe that public confidence in the health board consultation process is low. People often say, "Aye, we were consulted, but they'd made their minds up before they started the consultation." Part of the problem is a culture of the broader health establishment, in which the prevailing attitude is, "Health is a complex issue, but we know best." The bill is a modest injection of democracy, which will begin the process of culture change in the health service and rebuild confidence in the consultation process.

Helen Eadie (Dunfermline East) (Lab): In New Zealand, there are 21 district health boards; the smallest serves 31,000 people and the largest serves 489,000 people. The money that is spent in each of the health board areas ranges from £16.67 million to £302 million. It is stated in the

boards' objectives that they should be clearly accountable in following what the Minister of Health says—that issue was raised by our witnesses last week—and sanctions can be imposed for poor performance. Against that background, I want to ask those who oppose the bill about their opposition and to ask those who support it what lessons we could learn from the New Zealand example.

Dr Marshall: I do not have personal experience of the outcome of that example, so it is difficult to comment. I am aware that one of the issues in New Zealand has been the membership of the boards. There is evidence of concerns that some groups in society—for example women and the indigenous population, the Maoris—are underrepresented on the boards. We would be concerned that that might happen if direct elections to the boards were introduced in Scotland. The fact that it is difficult to know how effective such boards are does not change our view of the process as one that we do not support.

Dave Watson: The New Zealand example is interesting, but Helen Eadie's question focuses on the argument that we have a national health service and, therefore, if we had local elections somehow there would be a break-up of the NHS. We do not accept that. The bill's provisions are fairly clear. Strategic responsibility for the NHS in Scotland would remain with the minister. The bill would change none of the minister's extensive panoply of powers, most recently derived from the National Health Service Reform (Scotland) Act 2004, which provides for the minister to direct health boards. The issue of regional and national services, which was raised by previous witnesses, is a red herring in relation to the bill.

There are plenty of good examples of elected public bodies working together; even when they are of different political make-up, they still manage to get together regional planning and many other initiatives. We are talking not about political parties, but about a different type of election to health boards. We have a national health service, but many decisions are taken locally. Those local issues are particularly ripe for an injection of democracy.

Geoff Earl: I am not really aware of the New Zealand example. If the RCN were to look at that information, it would be interested in the make-up of the boards, for example how reflective it is of the community. That follows on a bit—

Helen Eadie: I offer a point of information. It is stipulated that at least two members of each board must be Maoris and that women must also be represented. However, concerns have been expressed along the lines that you suggest.

Geoff Earl: That brings me to the point that was made by my colleague from Unison, who suggested that the proposed elections to health boards would be different from party-political elections. I would be surprised if the health board elections did not follow the same process that is used for party-political and council elections. I would be surprised if the individuals who stood for election were only those who wanted to reflect the views of their communities. Political parties would soon coalesce around the issues, which would introduce the danger of making the health service into a political football at that lower level.

RCN members discussed the bill's proposals at a national conference and voted overwhelmingly that, although we understand that there is a political aspect to health, too much of the health service is used as a political football. That is what happens at election times and having that going on not only at national but at local level would not be helpful to the development of a good local health service.

John Park: We are concerned that people of different genders and underrepresented groups should be elected to health boards. However, given our culture in Scotland, I have every confidence that the posts would be filled adequately and in the proper way.

It is important that people feel engaged in reform of the public sector. That will not happen overnight, but we believe that the proposals in the bill are a positive step in the right direction.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): The BMA's submission states that making health board elections party political

"would create greater political involvement at a local level in that decisions would be made to secure future votes rather than to evolve, innovate and develop services. Local health care provision would be determined by short term targets and distort long term planning".

People have been getting involved because they feel that there is a lot of short-term planning and they would like services to be provided in their communities. I find it difficult to understand where the BMA got the information that brought it to such a conclusion.

You say that if people were elected to health boards, that would stifle innovation in service development. You talk about campaign groups, but such groups do not delay anything—the NHS delays itself. I would like you to elaborate on why you made those points.

Dr Marshall: Our evidence was about what we envisaged would happen if the bill were enacted. When we say political, we mean political with a small p. The reality is that any election is a political process that will have an effect on the elected member of the board, who will have to be aware of

that as elections approach. We are concerned that politics might affect their judgment on certain matters.

I absolutely agree that there are problems of short-termism in the health service, although perhaps we have moved away from that somewhat recently by trying to take a longer-term view. We want to continue in that way.

We accept that there is a problem and we are just as keen as you are to resolve it, but electing members to health boards is not the answer. In our submission, we offer the example of community health partnerships. If they are set up correctly and supported, they offer a clear opportunity for the public to have an input at local level, which we hope will drive the agenda at board level.

14:15

Dr Turner: How many people at local level will be independently elected or selected on to community health partnerships? How many ordinary people have been selected on to health boards?

Dr Marshall: There is no election process for community health partnerships.

Dr Turner: I used the word "selected".

Dr Marshall: Selected by whom?

Dr Turner: How do people get selected? Are you more in favour of selection on to community health partnerships and health boards than of electing people on to boards?

The Deputy Convener: It is not for the BMA to answer for the operation of CHPs.

Dr Turner: Dr Marshall is implying that he supports selection.

The Deputy Convener: The implication was that the work that is done through the CHPs may help, but it is not for the BMA to answer for the CHPs.

Shona Robison (Dundee East) (SNP): I have a couple of questions specifically for the BMA. In paragraph 2.3 of your written evidence, under the heading "Stifling innovation and service development", you recognise that there has been considerable public anger about decisions and that that is a problem.

However, you go on to say:

"One of the greatest failures of the NHS in Scotland today has been the procrastination and delay in reshaping hospital services."

Some would say that there has not been enough delay, but by making that statement you pin your colours to a particular mast. You are saying that the reshaping of services should go ahead quickly. Do you accept that there is a debate not only among members of the public but within the profession—certainly within the royal colleges, which recently produced a paper on the issue, and even within the BMA—about where services are best located and how they are best delivered? Do you accept that even within the organisation that you represent there are differing views on the best way in which to proceed?

Dr Marshall: I am not sure that the question is especially pertinent to the bill, but I am happy to answer it.

Shona Robison: I believe that it is, because you say that the public are on one side of the debate and that health boards and the BMA take the view that the reshaping of services should go ahead in a particular way. I suggest that even among your members there are differing views on how services should be delivered. The medical profession does not have one view on the matter.

Dr Marshall: I accept that—I am not sure that we said anything in our evidence to contradict it. We are a member organisation, with a variety of views. We accept absolutely that there is an issue, but we do not think that this is the way in which to sort it out. In my view, it is about communication with the public—explaining the issues to people and allowing them to give their input. We do not think that electing people to boards is the way in which to solve the problem. We agree totally that people should be allowed to give their opinion and we are very aware that there have been what are called consultation processes in certain areas of Scotland that have seemed only to pay lip service to the idea. We need to consult better, but we do not think that direct elections to health boards are the way in which to do that.

Shona Robison: In the next section of your written evidence, which deals with accountability, you say that there is greater transparency in the appointment process for non-executive board members. On what do you base that statement?

Dr Marshall: I understand that non-executive board members are elected by an open process and that people can apply to be non-executive directors.

Shona Robison: However, you have said that ultimately they are selected and appointed by the minister.

Dr Marshall: Yes.

Shona Robison: My last question is directed to all members of the panel. You may be aware that last week the Convention of Scottish Local Authorities circulated the alternative proposal that primary care services should come within the

ambit of local authorities. Do you support that proposal as an alternative to the bill?

Dr Marshall: I am certainly aware that the proposal was discussed last week. We do not support the proposal. We are moving forward in the health service to try to provide seamless care between primary and secondary care. Further separation would not help our patients.

Education and other services are managed at local authority level—social work is a good example of that. The situation is slightly different in the health service. Local authorities have opportunities to affect the funding for their services, whether by taxation or whatever, but the health service is given a fixed amount of money. My experience as a general practitioner is often that social work colleagues have difficulties when money runs out halfway through the year and they must stop providing a service. We would not necessarily want that to happen in primary care, so we do not support the proposal.

Geoff Earl: The proposal has not been discussed at the RCN board, but I would be surprised if the RCN supported it. As was just said, the health service is undergoing changes to try to bring all aspects together. To split it up again would be disruptive and I am not sure whether that would be to best effect.

However, the RCN supports the automatic appointment of local authority councillors. Strengthening that is probably a good idea and we would probably support strengthening existing legislation on that.

John Park: The STUC does not have a position on the proposal.

Dave Watson: We think that it is right for CHPs to have a close link with local authority services, so it is right for councillors to be closely involved in the development of primary services. However, we do not necessarily go so far as to say that that should be the case with the health service generally, because primary and secondary care require to be linked in and it is important to have that role of care. At this stage, we do not support the proposal.

Euan Robson (Roxburgh and Berwickshire) (LD): I ask the witnesses who support the bill's general principles which health boards should be covered.

Dave Watson: Our position is that all health boards should be covered. The bill would apply to all health boards in Scotland.

Euan Robson: Would the Scottish Ambulance Service, for example, be included?

The Deputy Convener: That is a special health board.

Dave Watson: I am talking about geographical health boards, not special health boards, which the bill does not cover for a variety of technical reasons.

Euan Robson: What is the difference between national specific health boards and local geographical health boards?

Dave Watson: As I have said, the reason for the difference is that we are talking about national and local services. We have national delivery for the national health service and local health services, on which local judgments are made.

Euan Robson: Some national services might be delivered locally.

Dave Watson: A judgment would have to be made about that, but that is true for lots of services and it does not stop direct elections. Lots of local authority services are delivered under national direction. Ministers set out direction statements and local authorities live within those arrangements. We always have a fast and loose system in relation to national and local services. That is no different for health boards than for other services.

Euan Robson: You are clear about the fact that the bill applies just to geographical health boards.

Dave Watson *indicated agreement*.

Mrs Nanette Milne (North East Scotland) (Con): The RCN submission says:

> "We believe that the new Scottish Health Council needs time to bed in and develop the way in which the public is involved in decisions".

Will you expand on that? Where are we with the Scottish health council and how will it develop in a way that will preclude the need for direct elections?

Geoff Earl: The Scottish health council is relatively young so, like all such organisations, it will have teething problems. We are not highlighting specific matters, but when gaps are identified over time, or when strengthening could occur, we should examine that.

From the RCN's point of view, we have something in place but, before we have let it develop, grow and offer something, we seem to be proposing to introduce something else. Such things happen quite often in the health service—perhaps that is what we mean when we talk about short-termism. We are worried about such short-termism in relation to elections. If there were a four-year period, we would start getting into campaigning two years into a term. That is not necessarily the best way to plan health services. We really need 10 to 20 years in which to look into many areas. The health council could do that. We are not saying that some aspects are good and

others are weak; the organisation is young and the idea is new—we should allow it to develop.

Dave Watson: We supported the new consultation arrangements as they were set out in the National Health Service Reform (Scotland) Bill. They were very welcome, and we think that they should continue. There is nothing in the Health Board Elections (Scotland) Bill that would stop those arrangements going ahead. Other directly elected bodies, such as local authorities, could well adopt the best practice of better local consultation, and many of them do. Direct election to the boards would not prevent proper local consultation. The difference with the Health Board Elections (Scotland) Bill is that we believe that it will be possible to engage with the local community. People often talk about a political process, but political processes are about enabling local people to make judgments and ensuring that they are properly engaged at an early stage.

One of the problems with the current consultation arrangements is that people are often engaged only when a facility is closing. We need to change the culture so that people are engaged earlier in the decision-making process. Direct elections are important because the consultation process would be added to if the culture was changed. People who were elected would have a different culture in relation to consultation from those who were simply going through a process, particularly when decisions might already have been taken. In our view, the big change that direct elections would bring about would be a culture change. That might not necessarily be easy to measure, but there could be a cultural change in how consultation is approached and adopted.

Mrs Milne: You have spoken about people being directly elected to health boards. People already have directly elected representatives on local councils, and they are represented on health boards. How will the direct election of individuals be different from things being done through the existing elected representatives?

Dave Watson: That is a fair point. It is important to understand the role of councillors on health boards. I do not think that it was ever intended for the councillors who serve on health boards to be there simply as some veneer of democracy for the health service.

The councillors who are put on health boards tend to be the leader of the council or the chair of the social work committee. We cannot change Scotland's health simply by changing the health service; a partnership is required with local authorities and many other services. It is because of the key role of local authorities in changing health patterns that local authority representation came on to health boards. That is a very indirect form of democracy. Councillors are there to fulfil the local authority role. That role could be supplemented by the direct election of local community representatives, who would have a different function.

To be fair to them, few councillors who serve on health boards view themselves as super-representatives for the whole community on the health board.

Helen Eadie: I have a further question on the role of councillors. On

"The automatic appointment of local authority councillors to boards",

the RCN's submission states:

"They already constitute a significant proportion of some of the larger boards".

NHS Fife and NHS Ayrshire and Arran are larger boards, but I would not say that councillors "constitute a significant proportion", given that there are only two councillors to a board. How do you square your comment on that?

Geoff Earl: I do not have the figures in front of me, but my officers have examined the make-up of different boards. Some boards have a higher number of councillors than others.

Helen Eadie: Greater Glasgow and Clyde NHS Board is the biggest one, and NHS Lothian will be next. However, I do not know how you square the circle if you are saying that two councillors on a health board is a significant proportion.

Geoff Earl: We are not saying that all health boards have a significant proportion of councillors on them. Some have more than others. The RCN is saying that this is an area that can be examined, and that it would be possible to build up more democracy through the work of councillors, rather than necessarily having complete elections for a whole health board.

14:30

The Deputy Convener: No other committee member has indicated that they have questions, so I invite Bill Butler to question the witnesses.

Bill Butler (Glasgow Anniesland) (Lab): Good afternoon, colleagues. I start by focusing on something on which everyone agrees—the positive advances that have been made in forms of public involvement and public participation. Not one submission said that anyone is against that. It is correct to say that that is a positive thing.

Why do the BMA and the RCN regard developments in public participation as incompatible with directly elected members? Conversely, why do the STUC and Unison regard such developments as compatible?

Dr Marshall: When we discussed the matter, we considered particular scenarios that might occur. For example, a community hospital in a small town in the Borders might be threatened with closure. The town's population might not be big enough for local people to get themselves elected to the board, so they would be left out and decisions would be made without their involvement. Conversely, they could mount a campaign and skew the board's decisions. That is our concern about the matter.

It is important to get people involved, but we need to examine the process rather than introducing elections. We do not think that elections to health boards will solve the problem. There would be a new process, but we would still have the same problems. Someone who has strong views on an issue might be elected to a board, but when they are on the board and they understand the range of issues on which the board has to make decisions, that might put them in direct opposition to the people who elected them in the first place. That is a difficult position for people to be in. It is much better for the local community as a whole to get involved in making decisions.

Bill Butler: Such are the challenges of democracy.

Geoff Earl: Apart from the political problems, a further problem with elected boards is the short-termism that might develop. The BMA's submission mentions maternity units. We all know from the clinical evidence that nurse-led maternity units are safer, cheaper and better, yet recently campaigns have been run against those units, particularly by the press, and people have jumped on the bandwagon and said, "We want to keep the consultant service." During elections, it would be easy for someone to jump on to that issue. There would be campaigns, with people saying, "We're going to have this and that." Those things might not make sense clinically, but the nature of elections is such that the things might happen. We have all been in elections and we know that that sometimes goes on.

Bill Butler: I hear what you say, and if that were a point of principle from which the RCN would not deviate, that would be fine. However, you state in your evidence:

"As we have outlined we are opposed to the principle of directly elected boards, but would suggest that some of the difficulties we foresee would be less likely to manifest themselves as problems if only some board members were to be elected."

Are you saying that you would support the bill if it stated that 30 per cent of members should be elected, or do you have a principled objection?

Geoff Earl: If the majority of board members are elected, the board might not reflect the clinical needs of the area.

Bill Butler: I hear what you say, but it puzzles me. You state in your submission that you oppose the principle, but you go on to suggest that you might be willing to consider the proposal if the percentage of elected members was smaller. Do you not see a contradiction there?

Geoff Earl: No. The principle is about elected members forming the majority of the board. There is a danger that issues will be brought up during elections even if elected members are a minority. I understand what you say about that, but our concern is that the board would be made up of people who were elected on a specific, narrow agenda on which they had campaigned, such as keeping a local maternity unit, even though it was against the clinical interests of the area.

Bill Butler: Okay, I get what you are saying. I ask Mr Park and Mr Watson to return to the question, which I do not think has been answered by the other two witnesses. You see developments in public participation as being compatible with directly elected members—why?

John Park: The trade union movement aims to promote democracy and it is simple for our organisation to support such proposals. We support the proposals because we believe that they will make things better. They will make services more accountable to people, which we believe is important.

As Dave Watson said, it is important to separate out consultation and accountability. There have been question marks over accountability because of the level of meaningful consultation. People feel disengaged from the process and think that they cannot influence what is happening. The balance needs to move back in favour of people who have a real interest. We all know health professionals who are out there doing a hard job day in, day out, who should be able to engage properly in the process as well. We should be trying to shift the argument away from whether there should be direct elections and towards improving engagement for people who use the services so that they feel that they can influence things. Sometimes it is important for people to understand why decisions have been made. If they are involved in the process and have an awareness of it, they tend to understand a bit better what is going to happen, even if they do not always agree with the decisions that are made.

Dave Watson: We feel that there is a case for improving the consultation process. We have all been through consultations. I have been a health board member and a union official in the health service and I have seen many consultations. They

are often a case of people taking a position and then attempting to persuade others of that view. What we need is a consultative process that has deliberative involvement of people in the decision making. We do not think that the proposal is incompatible with that.

For example, the argument is often given that we might have people from one locality who bring their own special interest to the board. That is why the bill proposes board-wide elections, as there are in the New Zealand system. People will, inevitably, have to take a strategic view or at least win support across what can be large health board areas. The point was made that the political parties will get involved, but I have seen the provisions relating to expenses and I am sure that very few MSPs could run an election campaign on £500. That is deliberate and will discourage people from running that type of political campaign. It will also discourage third parties and—God forbid—even trade unions from intervening in the process if we are limited to £250 of third-party expenditure.

I am afraid that what my colleague said about maternity units highlights the problem that the broader health establishment tends to have with consultation. It tends to think that it knows best, and it does not want people disrupting things when it knows what is best for them clinically. The reality is that other directly elected bodies—the Parliament, local authorities and others—have to make those judgments all the time. They have to balance the professional, technical views on issues against the views of the people. Essentially, it is about democracy. If we followed the opposing argument to its logical conclusion, the country would be run by technocrats. We are not run by technocrats; we are run by a democracy.

Bill Butler: Okay. Thanks, Mr Watson. That is very clear.

I have a couple of questions for Dr Marshall and Mr Earl. Your written submissions touch on issues that were raised in written evidence that we received last week from health boards such as NHS Greater Glasgow and Clyde. The RCN's written submission talks about the danger of short-termism, which has been mentioned. The BMA's submission talks about the danger of difficult decisions not being made. Are you saying that the NHS is too complex and challenging for directly elected members?

Geoff Earl: No, I am not saying that ordinary members of the public could not do the job because it is too technical. What we are saying is that it is a wide-ranging and complex business. Sometimes, with complex businesses, a wider range of input is to the greater good.

Bill Butler: Is it any more complex than, say, education?

Geoff Earl: I am not involved in education, so I cannot comment on that. That is not what I am here for.

Bill Butler: That is a good answer, but it does not answer my question.

Geoff Earl: In the health service, a wide-ranging input can sometimes be better. It is a bit like saying, "We need more accountability and greater involvement, so let us have an election." How many people vote at elections or are actively engaged in the process? For small, local elections, the majority of people will vote as they have traditionally voted and the turnout is very low.

Bill Butler: Are you saying that we should do away with democracy because it is inconvenient?

Geoff Earl: No, not at all. Elections are useful, but they are not necessarily the best way in which to get accountability.

Bill Butler: Okay. I hear what you are saying, although I disagree with you. Dr Marshall, will you have a go at the question, please?

Dr Marshall: Sorry. Can you repeat the question, please?

Bill Butler: Yes. In certain written submissions—including yours, the RCN's and those from the health boards—concerns have been raised about short-termism and the danger of difficult decisions not being made. Are you saying that the NHS is too complex and challenging for so-called ordinary members of the public?

Dr Marshall: Thanks. I just wanted to ensure that I answered the right question this time.

No, I am not. I am a member of the public—we are all members of the public. As I said in my opening statement, what needs to be better is communication. The BMA is not saying that the NHS is too difficult for members of the public to understand. What we are saying is that, in the vast majority of cases, the issues are never explained properly and we do not believe that direct elections to health boards will make the slightest bit of difference to that.

Bill Butler: What about the element of accountability? Participation is different from accountability. Do you not agree that there should be accountability?

Dr Marshall: Absolutely. Boards are already accountable to the minister, who is elected by the population, and the minister is also accountable to Parliament, so there is already accountability. I am wary of falling into the trap into which my colleague from the RCN fell concerning elections

but, nevertheless, I find the idea of board-wide elections interesting. In England, there are elections for foundation trusts that people have to opt into. In one example, which we cite in our written submission, 0.3 per cent of the local population opted to be involved in the elections but, when the ballot went out, only 21.7 per cent of the people who had opted in voted. We are concerned about that. That goes back to my previous answer.

Bill Butler: We cannot guarantee greater turnouts, as turnouts vary. However, are you saying that, if we could guarantee a greater turnout, you would reverse your position?

Dr Marshall: No.

Bill Butler: I did not think so.

Dr Marshall: I refer you to my previous answer. As I said, being elected to the board would put people in an incredibly difficult position. I would not want to do the job. They would be in an incredibly difficult position.

Bill Butler: Okay. Can I ask one more question, deputy convener?

The Deputy Convener: If you make it quick.

Bill Butler: I will. The BMA's submission makes the point that the cost of the elections under the bill for the first four years would be between £1.5 million and £3 million. It states:

"BMA Scotland believes that this money could be better spent on clinical services. For example … 800 hip replacements or … 5,400 attendances at Day Surgery."

I would like all the witnesses, beginning with Mr Watson, to comment on the potential costs.

Dave Watson: Sorry? I was trying to follow the argument.

Bill Butler: Mr Watson, do you agree with the BMA that the cost that would be involved is far too great and that the money should be spent on direct services?

Dave Watson: It does not seem so to me. I know that there is disagreement between you and the Executive on the costings. Frankly, even if the costs were at the higher level, the cost of having a democratic system is small in the context of a £7 billion budget. Also, the costings do not take account of the savings that could be made as a result of fewer people being selected to be involved in the boards. If we followed the argument against direct elections to its logical conclusion, we would not have a Parliament or local authorities. Democracy costs money, but the costs are modest compared to the gains of winning public support for changes in our health service.

John Park: I agree with Dave Watson. We cannot put a price on democracy. We are not talking about a massive amount of money in the grand scheme of things. If it helps people to feel more involved, engaged and able to influence decisions that are made, it is a price that is worth paying.

Geoff Earl: The purpose of showing how many hip replacements the money could pay for is not to say that we should have one thing or the other; it is just to give that cost another value. The RCN would be happy to see money spent on improving the consultation process or on a democratisation of the NHS. However, we do not feel that a fully elected board is the best way in which to achieve that. We are not saying that the money should not be spent, though.

Bill Butler: Of course, there is another piece of evidence—

The Deputy Convener: We need to move on to the next panel.

Bill Butler: I am sorry. I invite Dr Marshall to respond.

14:45

Dr Marshall: We stand by our evidence. It would be interesting if we asked the public what they thought.

Bill Butler: You are right. It could be an election issue.

Dr Marshall: I accept that the cost of the bill is a drop in the ocean in comparison with the overall health budget, but I would be interested to find out whether people would rather spend money on having a whole load of elections or on allowing someone who has been waiting a significant amount of time to have their hip operation to have it tomorrow.

Bill Butler: Perhaps we should ballot them.

The Deputy Convener: You are now exploiting my indulgence, Mr Butler.

I thank Dr Marshall, Geoff Earl, John Park and Dave Watson for coming along today. Before we move on to our second panel of witnesses, there will be a brief pause while the clerks change the witness name-plates.

I welcome Dr Robert Cumming, who is from the Scottish health campaigns network; Helen Tyrrell, who is the director of Voluntary Health Scotland; Dr James Gilmour, who is from Fairshare Voting Reform's campaigns committee; and William Pollock, who is Scotland and Northern Ireland branch chair of the Association of Electoral Administrators.

The first question is for Dr Cumming and Helen Tyrrell. Do you support the bill and, if so, why?

Dr Robert Cumming (Scottish Health Campaigns Network): I support the bill, as do my colleagues in the Scottish health campaigns network. The reasons for my support go back a long way and relate to how politics has affected the health service. I worked as a consultant for 28 and a half years and spent 38 and a half years in the national health service. The fact that the health service has always been a political football has had a disruptive influence on its operation, regardless of which political party has been in power. The process whereby a Government is elected on a Thursday, a different trust chairman is in place on the Monday and the chairman of the health board is changed a month later is deeply unsettling and is not helpful to the overall co-ordination of the running of the health service.

Helen Tyrrell (Voluntary Health Scotland): With its membership, Voluntary Health Scotland has developed a vision for health throughout Scotland. That vision involves local people being able to articulate their health needs and to take part meaningfully in developing solutions to meet those needs.

There is overwhelming evidence that people's experience of engaging with the health service is mixed. It is often a case of too little, too late. At Voluntary Health Scotland we hear frequently from our 300-strong membership of failure to engage with service users, local people and voluntary groups at an early enough stage in proposed NHS developments and service changes. Our experience has been backed up by the survey that the Scottish Executive commissioned.

We believe that accountability for the large sums of public money that are spent must be to the people who contribute to public spending through taxation, as well as to the bodies that are responsible in statute for providing the services.

A practical reason for our support for the principles of the bill is that services that have been planned and developed in partnership with service users from the beginning are much more likely to be sensitive to need. Greater user involvement is likely to foster the partnerships that the NHS has developed to replace the contract relationship of previous Administrations.

The Deputy Convener: Does Dr Gilmour or Mr Pollock have any comments to make at this stage?

William Pollock (Association of Electoral Administrators): No.

Dr James Gilmour (Fairshare Voting Reform): No. As you know, Fairshare has no view on the main issue of the bill. We are here to assist the committee with the technical aspects of the proposed voting system.

The Deputy Convener: I am aware of that. Thank you for that. I hope that we will have some questions for you on that issue.

Helen Eadie: I invite Dr Cumming and Helen Tyrrell to comment on some of the views that we have heard from the bill's opponents. Today, we heard that some people have an elitist, we-know-better-than-you attitude. What are your opinions of the opponents who base their opposition on the idea that clinicians and specialists know best?

Dr Cumming: A great deal has been made of community health partnerships and the Scottish health council as one of the reasons for opposition. If those were working fine, the previous witnesses' objections would have been withdrawn. Those bodies are still in their infancy and are still, in some ways, quangos. As I understand it, Scottish health council members are chosen in exactly the same way as health board members, so there is ministerial involvement.

The situation is similar with CHPs. I have attended about 20 almost consecutive meetings of Greater Glasgow NHS Board—or Greater Glasgow and Clyde NHS Board, as it now is—since 2003 to find out what is happening in relation to the acute services review north Glasgow monitoring group, which I am also on. I have been amazed that one of the greatest points of contention—which happens seldom, I must say—has been how CHPs will work, who will sit on them and what the representation will be. I can see great problems with CHPs working; there is a long way to go before they are seen to be functional.

The election of health board members would be a definite input from the public as opposed to the establishment of another quango that might or might not work.

Helen Tyrrell: We have to start again from the principle that services are most likely to be responsive to need when local people are involved at the beginning. We are in danger of making the assumption that local people are not capable of making sensible decisions about health services. We all know of high-profile campaigns that have been led by committed and active individuals who represent a particular perspective, often in response to a proposed service change, but members of the public have great capacity to make sensible, informed decisions about the vast bulk of local health service configuration, change and provision. We do not always credit them with enough of that capability and we must make all possible efforts to foster such participation, which is one reason why Voluntary Health Scotland will support the bill as an adjunct to, but not as a

replacement for, other methods of involving the public that are currently being adopted.

Helen Eadie: I would like your comments on two issues that came up in questioning with the previous panel of witnesses and in last week's meeting: the politicisation of health boards—in particular, the candidates for election to them—and cost. Should the budget allow for extra hip replacements or should some of it be allowed to go towards democracy?

Dr Cumming: The question, "What price democracy?" has been asked. Democracy is the most important issue in how health services are provided to the community. Health issues are important to people. Although there may be apathy across the board on many other matters, the responses of communities throughout Scotland to perceived threats to their health services suggest that apathy is not a problem with health. I think that you would get a good response on a single issue such as election to health boards and apathy would not necessarily be a problem.

What was the other issue again?

Helen Eadie: One issue was the politicisation of health boards and the other was the cost of democracy.

Dr Cumming: I have answered on the cost of democracy. Politicisation is a difficult issue. The BMA representative made the point that the elections will not be political with a capital P. That is the issue. Candidates should be vetted before an election takes place. I think that the bill states that ex-councillors are not appropriate individuals to be elected members of the health board. Often, vetting and declarations of interests take place only after candidates have been elected, but for elections to health boards you will have to be jolly sure that candidates are not political with a capital P. It has been suggested that such assurances will be sought.

Helen Tyrrell: The administration of any public service is not value free and is therefore bound to be political with a small p. We have welcomed the proposed inclusion on health boards of locally elected members, but we realise that those members, who will be relatively few in number, might have limited accessibility for the vast bulk of local people—particularly those who are more marginalised or excluded.

On the issue of cost, I can only reiterate that democracy is not a free service and does not come cheaply. The Scottish Executive Health Department's involving people initiative has already led to the spending of considerable sums on involving the public, and quite rightly so. The department acknowledges that the cost is appropriate and worth while.

Dr Turner: Has the involving people initiative led to improvements in communication with the public? Have you any proof that people have been listened to? The initiative has not been running for long, but it is true that a lot of money has been spent on it. Have you any evidence that it is working?

Helen Tyrrell: To an extent, we have been involved in the process from the beginning. We partner the Executive in helping to improve the involvement of patients and the public in the national health service. It is hard work. We have been involved for four and a half years, working extensively in local areas to try to ensure the involvement of local people—particularly people from the equality and diversity groups. There are six strands in the fair for all equality and diversity agenda: minority ethnic groups; the gay, lesbian and transgender community; refugees and asylum seekers; and a number of other excluded groups. It is very hard work to reach them, but the Executive has made significant progress. It has been expensive and there is a long way to go.

If progress had been more effective than it appears to have been, I doubt that Voluntary Health Scotland would be receiving quite so many comments about the difficulty of engaging with people. Language, rurality and many other issues can make it difficult to engage with everyone, especially the people in marginalised groups. We should acknowledge the progress that has been made but also acknowledge that, in supporting the principle of the Health Board Elections (Scotland) Bill, we would be supporting an extra way of ensuring wider involvement—especially because of the type of election process that is being proposed.

Dr Turner: Dr Cumming, in paragraph 1(d) of your evidence, you talk about health boards supporting the election of health board members

"as recognition that they fully support public involvement".

I take it that that refers to councillors who sit on health boards.

You also talk about health board members not having enough time to study their voluminous papers before meetings, and about problems with the tabling of some of the most important items at meetings. It was inferred earlier that elected members would have difficulty with complex decisions. What is your opinion of how boards work now and of how they could work with elected members?

Dr Cumming: What I said in paragraph 1(d) was that the

"logical conclusion of the establishment of 'Involving People' committees"

would be for health boards to go further and

"support the election of Health Board members".

Glasgow has held four involving people committee seminars on topics of interest to the public. The first was a re-examination of accident and emergency provision. In the acute services review, that provision was originally going to be reduced to two units. Two years down the line, the health board decided to have a referendum, if you like, on the validity of the proposal. A well-attended seminar was held at the Glasgow Royal Concert Hall, at which people were split into groups and there were good discussions. The final recommendation was that, instead of the then five units and one paediatric unit, Glasgow should have three units rather than the proposed two. That was the consensus of the involving people committee. Unfortunately, when the report reached the board, the board said rather blandly that, despite the results of that consultation with the committee, it saw no reason to alter the proposal to have two A and E units.

15:00

The last meeting of the committee took place four months ago and focused on the involvement of general practitioners and pharmacies in health service provision. However, those who attended that meeting have still not received a report of it. I find that slightly discouraging. The principle behind involving people committees is good, but the practice needs to be polished up a lot more.

I get board papers at the same time as the health board. However, the papers for the last board meeting, which was held a week past Tuesday, ran to 214 pages, and arrived on Saturday morning and had to be digested by Tuesday. There is no way that any health board member can take that amount of information on board and reach informed decisions on the various issues under discussion.

In the past, the most problematic papers used to be ones that were tabled only at the meeting, when the members had had no chance to look at them. I raised the matter with Mr Andy Kerr at the May meeting and, since then, no papers have been tabled at meetings. That is a slight improvement, but there is still not enough time for board members to digest all the papers that they receive by the time of the meeting.

We were most concerned by the way in which board members received a paper on the bed-modelling exercise in Glasgow just after they had sat down for a meeting. The paper, which described Glasgow's future provision of beds in the new-build services north and south of the river, was complex. The consultation period on the paper ran from July to December, and the paper contained a reference to the method used to determine the figures and indicated that the material could be consulted on. In that case, I had to reply in September but, by the middle of October, I still had not received the documents on how the bed-modelling exercise had been carried out. The issue is on-going and has, in fact, delayed the formulation of the outline business case for the new-build Southern general hospital by a year and a half. That makes me concerned about the competence and accountability of Greater Glasgow and Clyde Health Board and its consultation process.

I realise that I might sound parochial, but other members of the campaign network who attend health board meetings will tell you similar stories.

Euan Robson: Should the bill's terms extend to all health boards or just to the geographical ones?

Dr Cumming: It should include all health boards. After all, the Scottish Ambulance Service is also a major health board.

Helen Tyrrell: You raise an interesting question. One can immediately see the rationale behind introducing elections for geographically based health boards. However, the national services and special health boards also deliver many services locally and I hope that, after due consideration and given time, the bill can be extended to include them—notwithstanding, of course, the difficulties of engaging the local electorate in the matter.

Shona Robison: My first question is to Helen Tyrrell and Robert Cumming. I assume that you heard the previous evidence that one alternative to the bill that has been promoted is the extension of representation of elected members, councillors and local authority representatives on health boards. Is such an alternative valid?

Dr Cumming: Not entirely. Local councillors do not necessarily have any remit with regard to health, whereas the individuals elected to health boards would, one hope, have some kind of health remit in their portfolio. After all, that is why they would be elected. It is important that elections to health boards involve people who have a genuine interest in and knowledge of health, instead of being simply political elections. In order to be effective, elected representatives would require a major commitment to and knowledge of the operation of health services.

Helen Tyrrell: The idea of extending the remits of elected representatives is interesting, but their great strengths would show in areas that we have not discussed much so far. Primary care has been mentioned, but we have mostly thought about and discussed acute services. However, the great strength of having local representation lies in the area of improving public health. Links with local council services are particularly important in that respect. We must remember that, although acute

services account for the bulk of spending in the national health service, primary care and health improvement services are important. The strength of local councillor involvement in the process is important.

Shona Robison: Dr Gilmour, in your submission, you come out strongly against the voting system that is proposed in the bill. Your submission says that there would be a single non-transferable vote system and explains why there should be a single transferable vote system instead. The proposed elections are compared with the local authority elections that are due to take place next year. Should the health board elections be decoupled from local authority elections or do you envisage health board elections being held at the same time as local authority elections?

Dr Gilmour: Billy Pollock would give you a better view of the practicalities of the options. However, I say that it would be unreasonable to have another election on the same day as the Scottish Parliament and the local government elections, especially as—under the current arrangements at least—a completely different set of boundaries would be involved.

Shona Robison: I was going to ask Mr Pollock the same question. Mr Pollock, I take it that you are in favour of decoupling the health board elections from the other elections.

William Pollock: I argue against having the health board elections even in the same year as the Scottish Parliament and local authority elections. With the Scottish Parliament and local authority elections, everything happens on the one day, although those elections take several months to organise—they are like Christmas in that respect. Everybody understands that. That said, the health board elections are scheduled for 1 May 2008 and for four years later, so they would not fall in the same year as the next Scottish Parliament and local government elections.

The Deputy Convener: What are the potential cost implications of health board elections?

William Pollock: I have done some work on those, but there are many ifs and buts, because we do not know exactly what would be involved. Using current figures, the Association of Electoral Administrators reckons that the cost of an all-postal ballot would be anywhere between £1 and £2 per elector, although that is very much a baseline figure. It would depend on the size of the ballot paper, what would go out with it, Royal Mail prices and many other unknowables.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I want to ask Dr Cumming about the section of the bill entitled "Disqualification for nomination, election and holding office as an elected member". The bill would disqualify members of Parliament, members of the Scottish Parliament, councillors and criminals

"from being nominated as a candidate for election as, or from being elected, or from being, an elected member"

of a health board. Do you agree that the list of those who would be disqualified should be extended to ensure that ordinary people are nominated to health boards and that we should ensure that no health professionals are allowed to be nominated to them?

Dr Cumming: Perhaps people who have vested commercial interests, such as those who are involved in private finance initiative projects and other businesspeople, should be added to the exclusion list. However, I hope that health professionals would have something sensible to add to the discussions. We have talked about people with wide knowledge of health matters. Health professionals are probably in a better position than others to consider what is happening.

Mr McNeil: Are we not falling into the trap that the BMA and the RCN fell into when they gave the impression that only health professionals can deal with health issues? I support public involvement in a balanced process and am disappointed that you agree with the BMA.

Dr Cumming: I am actually on the other side from the BMA in relation to the bill. I do not want all members of health boards to be health professionals. A mixture or spread of interests in the candidates chosen would be appropriate.

Mr McNeil: But you agree that a disproportionate number of members of health boards have a background in working in the health service and that professionals, such as clinicians, are all well represented.

Dr Cumming: They are moderately represented; I would not say that they are incredibly well represented.

Mr McNeil: Are you saying that they are not well represented on health boards?

Dr Cumming: Are you talking about elected members?

Mr McNeil: I am talking about the board in general.

The Deputy Convener: Mr McNeil is talking about the current composition of health boards.

Dr Cumming: I am sorry; I was thinking of the proposed membership, which would mean that there were not too many health professionals. We have to have health professionals on boards.

Mr McNeil: Do we need more?

Dr Cumming: Not necessarily. The members are already accountable to the chief executive and the Minister for Health and Community Care.

Mr McNeil: The board members will be accountable to the board and the minister, will they not?

The Deputy Convener: That is my understanding. Perhaps we could get clarification of that from Mr Butler.

Dr Cumming: The health board would be collectively responsible to the minister.

Mr McNeil: All the board members would be responsible.

Dr Cumming: As a unified board.

Mrs Milne: Rightly or wrongly, I see an analogy between directly elected health boards and directly elected community councils—both include directly elected members of the public. Community councils are not allowed to be party political, but in my experience it is well known which members of them are party-political activists—many of them are.

It is notoriously difficult to get members of the community to put themselves forward for election to community councils. I can think of several that were scrapped in areas where people might be expected to get involved in what is going on in their area, simply because there was no public interest in them. Do you draw a similar analogy? Might we experience similar difficulties in getting people to put themselves forward for election to health boards?

Dr Cumming: The public's interest in health is enormous, so I think that they would be interested in becoming members of health boards. There would not be the apathy to which I referred earlier. Community councils are regarded as slightly amorphous bodies that cover a lot of different issues. Health boards cover the single topic of health, which is vital to people.

Helen Tyrrell: I do not see a direct analogy with community councils, because community councils have a responsibility and stake in a range of local and public service issues. Health and education are two areas with which the public are concerned. Notwithstanding that, the bill has to consider the processes that would need to be put in place to promote access and say who is eligible to stand for election to boards.

Mrs Milne: I hear what you are saying. I have been involved in working in health and I know that people are interested in it, but health is a wide-ranging issue with lots of separate areas. Would people seek election to health boards for single-issue reasons or would they be interested in the broad range of issues in which health boards are involved?

Dr Cumming: I think that they would be interested in the broad issue of health. Obviously, single issues would come up from time to time, but all sorts of aspects of health, such as the provision of general practice services, community services and hospital services, are intertwined. If CHPs, which have to incorporate all those components, work, that might be a way forward.

Helen Tyrrell: The public are interested in the whole range of health issues, particularly local services. We have to acknowledge in democratic processes that there will always be people who are particularly concerned about a single issue. There will always be many more people who are concerned about broad issues. Our challenge is to ensure that both are represented and can participate.

The Deputy Convener: Will you comment on the advantages and disadvantages of the voting system as proposed in the bill?

15:15

Dr Gilmour: There are two features in the bill that are very good. All board members are to be elected together—at large, as they say in the jargon—and each voter is to have only one vote. The defect in the voting system prescribed by the bill is that the vote is not transferable. Our written evidence gives two examples of where that could cause big problems.

Imagine, for example, that the four of us sitting at this end of the table were the candidates from a particular community within a much larger health board area, that we had done our sums carefully and knew that we had enough support in the health board area for all four of us to be elected, and that we had carefully chosen only four candidates. However, imagine that our supporters were somewhat undisciplined and that they liked the lady much more than they liked the three men, so that the overwhelming majority of them gave their vote to Ms Tyrrell. Under Bill Butler's prescription, she would be elected with an overwhelming majority, and the other three of us would not be, so the community that we had hoped to represent, which should have four members on the health board, would have only one member.

The solution to that problem is to make the vote transferable, so that the big surplus piled up on the most popular candidate can be redistributed to the other candidates according to the voters' choice—and it would be the voters who decided. If the four of us were a cohesive group representing a cohesive community, those votes could be spread to the other candidates representing that

community, so that the community would get its fair share of the seats. It would not get more than its fair share, but it would get its fair share.

A similar thing could happen if the local community miscalculated and put up too many candidates. If the votes were spread evenly across those candidates, the result could be no one at all being elected to represent the community. However, if the votes were transferable, they could be concentrated on the appropriate number of candidates, so that the community could get its fair share of seats—no more, no less. That is the key feature that is missing from the bill.

The Deputy Convener: I invite Bill Butler to question the witnesses.

Bill Butler: There is something that I would like to say at the outset, as you asked for clarification about the bill.

The Deputy Convener: That would be helpful.

Bill Butler: All boards would remain accountable to the minister and only one part of the National Health Service (Scotland) Act 1978 would change—the part relating to a simple majority being directly elected. Everything else would remain the same. It is a modest and reasonable reform.

The Deputy Convener: Thank you for that clarification.

Bill Butler: I am delighted to give it.

I extend my gratitude to all the witnesses who have come along for this evidence session. In particular, I am grateful to Dr Gilmour for pointing out an error in the bill. If the bill reaches stage 2, we shall amend it accordingly. He highlighted a point relating to paragraph 30(1)(b) of schedule 1, and deduced that, because it states that a ballot paper can be rejected

"on which votes are given for more than one candidate,"

the single non-transferable vote system would be used. That was my mistake. We took that wording from a statute on a simple first-past-the-post system. We will amend the bill to include wording that provides for voters to cast a number of votes up to, but not exceeding, the number of directly elected places. Thus, the bill will be simply majoritarian. I thank Dr Gilmour for pointing that out.

I have a question for each of the witnesses. Dr Gilmour, you have referred to the two defects of most electoral systems—that voters can be managed and that there is a large potential for tactical voting—but you exclude single non-transferable vote proportional representation from that. Are you saying that every voting system apart from STV PR can be managed and that STV PR has no defects? If so, what about what happens with the Democratic Unionist Party and Sinn Fein votes in Northern Ireland, which are—if I may say so—beautifully politically managed?

Dr Gilmour: No voting system is without some defect. All voting systems are compromises. There is no question about that.

The problem with the voting system in the bill is not only that it would be open to tactical voting, but that it would require careful tactical voting and voter management if the respective communities were to receive their fair representation. The key difference between the system in the bill and STV—indeed, I would go as far as to say between STV and all other voting systems—is that STV's openness to tactical voting is minimal. From the voter's perspective, STV is the one voting system in which people can vote most positively. Under STV, people vote most for what they really want. They do not need to engage in a lot of tactical decision making by voting against their preferred candidate so that they can keep someone else out. STV minimises the requirement for that and allows people to vote positively.

In explaining that the system in the bill is due to an error—of course, we were not aware that it was an error—you said that you plan to introduce a version of a well-known voting system called the cumulative vote, whereby voters may accumulate more than one vote for any one candidate. That would certainly be better than the system that is proposed in the bill, but it would still fall short of what STV could deliver. The clear intention as set out in the policy memorandum is that directly elected health board members are properly representative of the communities that they are elected to serve and are accountable to the people who vote them in. The cumulative vote system would be a considerable improvement on the currently proposed system, but I suggest that STV would be even better. If you really want to achieve your objectives, the only logical way to go is to use STV. STV is the most effective voting system. That is the only reason why I support it. I have no particular love of the arithmetic involved and I have no political commitment to it whatsoever.

Bill Butler: It is always good to hear Dr Gilmour, who is entirely sincere in his position. I am grateful for his pointing out that error.

My next question is for Mr Pollock. I am grateful to him for his answer in response to a previous question on the cost implications of the proposed elections. Is he content that the bill envisages that the returning officer at a health board election will be the person who is the returning officer for the local authority with the largest number of councillors, and failing that the returning officer of the local authority with the largest electorate?

William Pollock: Yes. I qualify that by pointing out that the bill needs to set a date for determining what constitutes each local authority's electorate in the event that the local authorities involved have an equal number of councillors. As the bill stands, the size of the electorate could be disputed.

Bill Butler: I am grateful for that, Mr Pollock.

My next question is for Helen Tyrrell. The third page of the VHS submission states:

"consultation often comes 'too little, too late' … this often has the undesirable effect of 'politicising' local people".

What do you mean by politicisation?

Helen Tyrrell: We mean that, ideally, people should be involved right from the beginning when plans for service development, service change and service delivery are on the drawing board. Quite frequently, that does not happen and the process simply rolls ahead. The committee has heard from colleagues about consultations the results of which appeared to be a foregone conclusion. Even when that is not the case, the frustration that local people feel sometimes leads them to latch on to a particular element of service change proposals and create a political standpoint on them. That could be avoided by involving people at a much earlier stage.

Bill Butler: Far from being incompatible with the participation improvements of the past few years, could the proposed form of direct accountability actually complement and strengthen that participation?

Helen Tyrrell: Yes. Indeed, participation would likely be more immediate and more transparent. For those reasons, we support the proposal.

Bill Butler: I have just two questions for Dr Cumming. You will know that some of the bill's opponents have said that direct elections would impede the modernisation of the national health service and that there would be no change or progress because of parochial interests. What is your opinion of that argument?

Dr Cumming: I think that the complete reverse is true. More involvement from and consultation with the local community would progress matters better than people taking stances that are not fully understood. I take a diametrically opposite view to the opponents and suggest that elected health board members would improve modernisation because there would be much greater input from people and dialogue with the health boards.

Bill Butler: Do you agree with Ms Tyrrell that the directly elected element complements the measures for greater participation?

Dr Cumming: Absolutely.

Bill Butler: I am grateful to the witnesses and colleagues. Thank you, convener.

The Deputy Convener: I thank the witnesses for attending.

Standing Orders

15:26

The Deputy Convener: Agenda item 2 is the Subordinate Legislation Committee's proposed change to standing order 10.3.2, on the 20-day rule, which would allow the committee some flexibility in reporting to lead committees when a large number of instruments are laid at once, such as before recess, or when there is a particularly difficult or complex instrument to consider. If it were not possible to report to the lead committee within 20 days, the Subordinate Legislation Committee would endeavour to report within a couple of days thereafter. We have a paper that explains the background.

If members have no comments, I take it that there is no objection to the Subordinate Legislation Committee's proposal to change the 20-day rule. Is that agreed?

Members *indicated agreement*.

The Deputy Convener: That ends the business in public.

15:27

Meeting continued in private until 15:51.

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