# MEETING OF THE PARLIAMENT

Wednesday 15 December 2004

Session 2

£5.00

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

# CONTENTS

## Wednesday 15 December 2004

## Debates

# Scottish Parliament

*Wednesday 15 December 2004*

[THE DEPUTY PRESIDING OFFICER *opened the meeting at 14:30*]

## Time for Reflection

**The Deputy Presiding Officer (Trish Godman):** The first item of business this afternoon is time for reflection. Our time for reflection leader today is the Very Rev Graham Forbes, provost of St Mary's Episcopal cathedral in Edinburgh.

**The Very Rev Graham Forbes (Provost, St Mary's Episcopal Cathedral, Edinburgh):** I well remember many moons ago sitting in Langholm police station when I was Her Majesty's inspector of constabulary. The phone rang on the sergeant's desk. Here, I thought, was a chance to check out how the cops reacted to a 999 call. The emergency was light years away from "The Bill" or "Taggart". A cow was cheerfully making its way towards the high street, and Langholm's traffic—all three cars—had ground to a halt.

The arrival of the police car caused the cow to speculate on the future of its existence, and it was last seen heading across the fields and for the hills. Problem solved. The locals laughed, and life returned to normal, leaving the poor farmer to go off in search of his lost cow. The inevitable then happened as a police constable who was desperate to impress chirped up, "Sir, you'll be more used to lost sheep."

About 30 minutes later, we stopped about 5 miles short of Lockerbie. Here, above that quiet town that hit the headlines 16 years ago next Tuesday, most of the wreckage and bodies from Pan Am flight 103 had reached their final resting place. A small outbuilding in the churchyard had been beautifully and simply renovated and was the memorial to the victims. The thick, leather-bound book of remembrance contained on separate pages in alphabetical order just the name, age and country of origin of each victim. I had some time for reflection. I stood there. "Thy kingdom come," I prayed.

In less than an hour, I had gone from one Border town where a cow going on walkabout was a major event to another Border town where international terrorism had struck. For me, Wednesday 21 December 1988 still looms large. I chair the body that the Parliament funds to investigate alleged miscarriages of justice. I assure members that Mr Al-Megrahi's application, like all other applications that we receive, will be investigated thoroughly and impartially, without fear or favour.

For you, our Parliament, during this time for reflection, we pause to remember what happened at Lockerbie in December 1988 and what is happening at Warminster today as the Black Watch holds its memorial service for the soldiers killed in Iraq, holding in our thoughts those families in which life will not return to normal. We live in one world, where a small Borders town or a Scottish regiment make us for a moment look beyond this day's important parliamentary business.

We look beyond for a moment and pray, "Thy kingdom come."

## Point of Order

14:34

**Tricia Marwick (Mid Scotland and Fife) (SNP):** On a point of order, Presiding Officer. An hour ago, the SNP group leader was handed a document entitled "Fair to All, Personal to Each: The next steps for NHSScotland". On inquiring at the Scottish Parliament information centre, I was informed that the document is embargoed until after the minister sits down at the end of his speech in the debate that follows. The document is therefore not available to members or to inform the debate.

Presiding Officer, you will be aware that at yesterday's meeting of the Parliamentary Bureau I raised concerns about the late delivery of material for debates and that the Minister for Parliamentary Business agreed to consider the matter. However, this is not the late delivery of material, but the deliberate withholding of material by the Executive. That is unacceptable and undemocratic.

I recognise that the Presiding Officers are not responsible for the distribution of material for debates, but will you join me in expressing your anger on behalf of the Parliament at the Executive's behaviour today?

**The Deputy Presiding Officer (Trish Godman):** I have a deal of sympathy with what the member says. It is a matter of good practice that all material relevant to debates in this Parliament should be made available to members in sufficient time for the debate. However, the issue of such material is not a matter for me and I can only hope that the Executive will take cognisance of what has been said. Minister, would you like to say a few words?

**The Minister for Health and Community Care (Mr Andy Kerr):** I understand that the document is available now in the Scottish Parliament information centre and not only when I sit down. [*Interruption.*] Tricia Marwick raised a point—perhaps I could respond to it. My understanding of this situation is that I was going further than has been the practice previously because there is no absolute obligation on the Executive to issue any such documents. However, I issued copies of the document to leaders of the parties more than an hour ago.

## Business Motion

14:35

**The Deputy Presiding Officer (Trish Godman):** The next item of business is consideration of business motion S2M-2167, in the name of Margaret Curran, on behalf of the Parliamentary Bureau, setting out a revised programme of business this afternoon.

*Motion moved,*

That the Parliament agrees the following revision to the programme of business for Wednesday 15 December 2004—

after,

| | |
|---|---|
| 2.30 pm | Time for Reflection |
| *followed by* | Parliamentary Bureau Motions |

delete,

*followed by* Ministerial Statement on Concessionary Fares.—[*Ms Margaret Curran*.]

*Motion agreed to.*

# NHS Scotland

**The Deputy Presiding Officer (Trish Godman):** The next item of business is a debate on motion S2M-2155, in the name of Andy Kerr, on "Fair to All, Personal to Each: The next steps for NHSScotland" and four amendments to the motion.

14:36

**The Minister for Health and Community Care (Mr Andy Kerr):** Today I will outline the progress that we have made and set out the next steps we will take to deliver the health service that the people of Scotland deserve. I have published our paper, "Fair to all, Personal to Each" and copies have been placed in the Scottish Parliament information centre.

It is important to start with an understanding of where our health is as a country. In 1997, the death rates from cancer, coronary heart disease and stroke each stood at 302 per 100,000 people in Scotland. That is why we were right to tackle those issues first. They are the killer diseases. We made that choice and our efforts have meant that by 2003 those death rates had been reduced by 22 per cent. That is more lives saved and more families together for longer.

Although health is improving for the vast majority of people in Scotland, it is improving fastest for those who are most affluent. A boy born today in the best-off areas of Scotland has eight more years of life ahead of him than a boy born in some areas of Glasgow. In Shettleston, almost half will not even reach the age of 65. Those are chilling statistics and we must act to address them. We all want to stay healthy for longer and we should all have the chance to do so, no matter where we were born and no matter where we live.

The task is not easy and it will not be quick. Our drive to improve Scotland's health is the work of a generation, but it is the right thing to do. We have major challenges. We are sicker as a nation than many others, and alongside that we have the challenges of geography and demography to confront. It is against those that we assess where we are now and what we must do next to improve the health of Scotland.

People get ill. They have accidents and emergencies. They contract disease and develop painful conditions. When that happens, we need and expect a first-class health service to meet our needs. Our health service has more than 70 million patient contacts each year and 90 per cent of those are with the local general practitioner, nursing, physiotherapy and community pharmacy services. The scope of health care that is provided locally is immense. The maximum 48-hour wait for an appointment with the local health care team is the minimum standard that we expect.

I turn now to the additional improvements that we will deliver in our national health service. As I do, I restate our commitment to its founding principle—that health care should be provided equally to all those who need it, free at the point of need. That principle was supported by the Scottish people in 1948, it is supported by them today and it is at the heart of our work in this Scottish Government.

To provide equity, we need to increase capacity, which is what we have done. In 1999, the health budget was £4.9 billion; this year, it has risen to £8.3 billion; and, by 2007-08, it will have risen again to £10.3 billion. However, those figures are not the badge of pride. The badge of pride—the measure of success—lies in the results of that investment. That investment has paid for 2,700 more nurses; 1,250 more allied health professionals, including radiologists, lab technicians and physiotherapists; and 1,150 more hospital doctors.

**Brian Adam (Aberdeen North) (SNP):** The minister has indicated some of the significant health inequalities in Scotland and the measures that he has introduced to assess his actions. How is he measuring the value of the funding formula, in particular the deprivation money that is provided to tackle health inequalities?

**Mr Kerr:** The member will be well aware that, under the Arbuthnott formula, we now allocate health resources according to population profile, need, demographics and ill health in communities. Arguably, we support the health service in that respect. However, the Executive provides a multitude of other resources such as funding for housing in Glasgow. Moreover, the better neighbourhood services fund money has been consolidated and is being invested in communities. We fully understand that one's health is not just a matter of what is happening in the health service; indeed, the issue runs through strategies across the whole Executive.

We are using that investment to make a real difference. For example, communities now have new diagnostic equipment, more kidney dialysis units, new and modernised general practitioner surgeries, local diagnostic and treatment centres and new hospitals. More important, this funding has given patients across Scotland access to the best drug therapies for cancer and has dramatically reduced treatment times for cancer, heart disease and stroke.

New radiotherapy equipment and enhanced chemotherapy delivery have made a big difference and cancer treatment is now quicker and more effective. In 1999, a patient could wait up to a year

for open heart surgery. Today, the longest wait from diagnosis to bypass surgery—or its non-surgical equivalent, angioplasty—is 18 weeks. In the four years between 1999 and 2003, the average wait for all heart bypass surgery fell by an astonishing 40 per cent. That is a major, life-saving improvement for thousands of Scots.

Because of the improvements that our investment has brought, we can now move on. I can announce today that, by 2007, no patient will wait longer than 16 weeks from GP referral through attendance at a rapid access chest pain clinic to cardiac intervention. That represents a significantly shorter maximum wait than is available to patients elsewhere in the UK and will put Scotland among the best in Europe—and indeed the world—for coronary heart disease services that are available to all.

We will continue to increase capacity. For example, we will invest in the Golden Jubilee national hospital to ensure that, by 2007, it will carry out an additional 10,000 procedures a year in shortage specialties.

**Shona Robison (Dundee East) (SNP):** During the minister's extensive briefing of the press, it was suggested that part of the Golden Jubilee national hospital would be leased back to the private sector. Is that true?

**Mr Kerr:** If indeed the Executive had made that extensive briefing, the suggestion might have been true. To be honest, such decisions have not yet been made. That said, I must point out that when we took over that hospital it had 32 beds. Now there are more than 100 and proposals for a cardiothoracic specialty centre in the hospital would add another 125. Of course, in striving to improve patient services, I will consider suggestions from across the board. I must repeat that no decisions have been made. What the member read in the press was inaccurate.

**Carolyn Leckie (Central Scotland) (SSP):** The minister said that he would increase capacity through the Golden Jubilee and mentioned that the number of beds has risen from about 30 to more than 100 since the Abu Dhabi Investment Bank was bailed out. Despite those claims, how does the minister explain the fact that at the same time 250 acute surgical beds have been lost throughout Scotland?

**Mr Kerr:** Perhaps Carolyn Leckie should just listen to what I am saying. I said at the start of my speech that we are doing much more in our communities to provide clinical services and to ensure that patients have to travel less and face less intimidation. Nurse-led clinicians are now carrying out procedures that would have been left to specialist consultants a few years ago. I argue that what the member has said is false and not accurate.

**Fiona Hyslop (Lothians) (SNP):** Will the minister give way?

**Mr Kerr:** I need to make progress, Presiding Officer. [*Interruption.*] Of course, we are making progress and if colleagues would care to listen instead of heckling, they would find out more about it, but that is their choice.

I have given a commitment to take the total number of procedures in the Golden Jubilee hospital to 28,000 a year. We will also provide an additional £125 million for NHS medical equipment in the next three years. That is investment for patients.

Waiting times for hospital treatment have improved. Not long ago, patients were waiting up to 18 months for in-patient and day-case treatment. We reduced that, first to 12 months and then to nine months, and I am absolutely confident that we will meet our target of a six-month maximum wait by December 2005. However, because we have worked hard to bring down the waiting times for in-patient and day-case patients, we have not done well enough in reducing the waiting times for those who are waiting for other appointments. We are rightly focused on waiting times because the issue is about the quality of service. Every day that anyone waits is a day of anxiety and uncertainty, and often another day of pain.

**David McLetchie (Edinburgh Pentlands) (Con):** Will the minister advise us why the target for the Golden Jubilee hospital is carefully selected for achievement by the end of 2007? If such rapid progress is being made, why does he not set targets for the end of 2006 so that, when the Parliament next goes to the polls, we can measure the effectiveness of the Executive's health strategy?

**Mr Kerr:** I have tried to explain that we are in a direction of travel that is focused on waiting times for individual patients and that we want to ensure that that continues. Waiting times have reduced from 18 months, to 12 months and then to nine months, and we now have the six-month target and the others that I am about to announce. By the end of 2007, no patient will wait more than 18 weeks from GP referral to an out-patient appointment, which will be a significant improvement in the patient journey. Also by the end of 2007, no patient will wait more that 18 weeks from diagnosis to in-patient or day-case treatment.

Alongside those new waiting-time targets and guarantees, by the end of 2007 we will end the system of availability status codes, for two straightforward reasons. First, everyone who is available for treatment and whose doctor agrees that they are ready for it should benefit from the

new shorter waiting times that I have announced. Secondly, the public have the right to see how their health service compares with that in the rest of the UK and, by ending that system of codes, we will allow the performance comparison to be made more easily and fairly. That change will be good for all patients in Scotland, but particularly for those who are waiting for highly specialised treatment, because it will give them the same guarantee on waiting times as everyone else has.

Of course, there is another side to the coin. If hospital appointments are agreed in advance and a patient, without warning, does not turn up, they cannot expect the same guarantees as everyone else has. Missed appointments waste NHS resources, which affects every patient. If patients accept their responsibility to turn up for appointments, or to arrange an alternative one in plenty of time, they will get the guarantee. If they do not, the clock will go back to zero.

**Des McNulty (Clydebank and Milngavie) (Lab):** Given that the minister went to the Golden Jubilee hospital with me on Monday, does he accept that there is considerable enthusiasm among the staff for the cardiothoracic unit to go to the hospital? That would improve the quality of treatment, speed up the rate at which it can be provided and provide a top-quality service in Scotland in the appropriate setting.

**Mr Kerr:** I agree absolutely. The hospital is an impressive facility and the more we invest our resources in it, the more benefits that patients from throughout Scotland will receive from the sort of specialist centre that the member mentioned.

Real equality of provision—the equality that lies at the heart of NHS values—is about more than simply increased capacity; it is also about choice. That is why the steps that I am outlining today will increase patient choice and the quality of health care. Of course, choice is neither absolute nor infinite; it is governed by good clinical practice, standards of provision and medical evidence. People have the right to receive the best treatment on the basis of their clinical needs, not on the basis of how much money they have in their pocket. Choice and capacity are partners, not alternatives. If we believe in equality of access to health services, we must believe not only in the delivery of the service, but in choice about the manner in which it is delivered.

With every generation, as people's expectations and incomes rise, they demand more say and flexibility in how they and their families are treated. We should be as ambitious for people as they are for themselves. The question is not whether people can and should exercise choice; it is whether we can have the health service that gives them that choice. We must replace money as the basis of choice with information for the patient and with flexibility in the service. Patients need information about performance and procedures, about how to help to manage and improve their health, about who can help them and their families and about how to get that help. They need information about where they can get the treatment that they need and how long they will wait for it, so that they can decide whether to travel further but wait less, or wait longer and be treated closer to home.

**Stewart Stevenson (Banff and Buchan) (SNP):** Will the minister give way?

**Mr Kerr:** I need to make progress.

A patient was told by his GP that he would have to wait 27 weeks for the cataract surgery that he needed. The patient used our national waiting times database—the first in the United Kingdom—and found that if he was prepared to travel further from home and have an overnight stay he could have the operation in nine weeks' time. He did that and had operations on both his eyes.

We are building a health service that meets Scotland's needs. We are tackling the three diseases that kill too many of us and we are driving up the quality of service by bringing down waiting times and extending patient choice. Because of the improvements that we have made, we are building a health service that can move on to the next priorities and tackle diseases and conditions that directly affect the quality of life of hundreds of Scots. There is more to our health service than life or death. It bothers me—I am sure it bothers many members—that many people in Scotland suffer daily from conditions that reduce their quality of life. We have made some progress, but it is time to do more. By 2007, we will deliver a maximum wait of 18 weeks from referral to completion of treatment for cataract surgery, which will benefit 20,000 patients each year. Cataract surgery is a relatively minor operation that makes a major difference. We will deliver a maximum wait for hip surgery following fracture of 24 hours, from admission to a specialist unit to operation. That is a critical step that will save lives.

When there is an emergency or a life-threatening accident, the NHS is second to none in the speed and effectiveness of its response. However, our accident and emergency centres deal with many other patients, whose lives are not threatened but who need care and treatment. By 2007, all accident and emergency centres will deliver a maximum wait of four hours from arrival to admission, treatment or discharge.

If we are to make good those commitments, we need to tackle other problems. If we are to take the next steps in driving down waits and easing patients' anxiety, we need radically to improve the capacity of our diagnostic services. Of course,

patients are seen quickly when there is urgency. However, we want all patients to have faster access to diagnostic tests. Therefore, we will increase capacity in diagnostics and in the other priority areas—both in the NHS and from the private sector for the NHS. That additional capacity will speed up diagnostic and treatment times for patients and give us the flexibility that we need to deliver a health service founded on equality of access.

Let me be clear. We will contract the additional capacity in a way that ensures that it is additional to the NHS. There will be strict clauses and rules on staff recruitment to prevent poaching.

**Mr John Swinney (North Tayside) (SNP):** Will the minister clarify two points. First, will he explain—

**The Deputy Presiding Officer:** Mr Swinney, please speak into your microphone.

**Mr Swinney:** Will the minister explain why the Government has spent so much time reducing capacity over the past five years, as Carolyn Leckie said, only to produce now a document that acknowledges that we need more capacity? Secondly, will he tell Parliament how he can guarantee that staff recruitment and retention in the NHS will not be undermined by the use of the private sector and the expansion of private capacity?

**Mr Kerr:** The member's questions take us to the heart of his party's argument. The fossilisation party argues that the health service must not change. I am pleased that some old institutions, which were not up to scratch and did not deliver the services in the right environment for patients and staff, have been closed. We have replaced such institutions with modern capacity for our skilled staff to work in. There is an endless list of improvements that we have made in the service.

On additional capacity, I repeat that we will prevent poaching. We will take the necessary powers within the contractual relationships, as SNP members well know, and we will ensure that we have a veto over the use of public sector staff in private contracts. We can and will do that through our tendering processes. That happens elsewhere and it can happen in Scotland.

**Margo MacDonald (Lothians) (Ind):** Will the minister give way?

**Mr Kerr:** With respect, I must make progress. I have taken a number of interventions.

Today I am setting out the biggest and most comprehensive package of investment and improvement that there has ever been for the NHS in Scotland. We are investing for a purpose: to increase quality and drive down waits. We are improving the service for a purpose: to widen patient choice and improve the service that patients receive.

There has never been a better time to deliver change. We will deliver major, sustained investment, a new contract for hospital doctors and consultants, new pay and recognition levels for the whole health care team and new GP contracts, to promote increasing local services and a greater focus on health improvement. I expect focus, leadership and results from every health board chair in Scotland.

Already, more than 25,000 health care staff are involved in new ways of working, in which their efforts make a real difference to patients. I want those examples to be replicated quickly throughout Scotland.

I said earlier that it is not the money that we invest in the health service that matters, but the results that we get for patients through the modernisation of the health service. However, getting value for that money matters. That is why, hand in hand with the increased investment, the increased capacity and the extension of patient choice, goes my insistence that we drive up the productivity of the service. To help us to do that, we need to know the real cost of what we do. Therefore, I will introduce a new system, initially for the most common procedures, in relation to which it is clear whether a hospital's costs are high or low. I will do that from the next financial year. The proposal will help boards to improve their efficiency and effectiveness and it will help the public to judge how well we are making their money work for them.

A powerful combination of sustained resources, the skill and dedication of all health care staff, leadership locally and nationally and the commitment and expertise of our clinicians and health professionals will deliver for patients across Scotland. There will be 16 weeks from GP referral to cardiac intervention; 18 weeks from GP referral to an out-patient appointment; 18 weeks from diagnosis to in-patient or day-case treatment; 18 weeks from referral to completion for cataracts; 24 hours to surgery following a hip fracture; and a maximum wait of four hours for non-urgent accident and emergency care.

We are embarking on a big and comprehensive package of improvement and investment, the like of which has never been seen before in our health service. We want to deliver safe, high-quality services that are as local as possible but as specialised as necessary and that is what we will do.

I move,

That the Parliament notes that continuing action is needed to turn round the poor health of many people in Scotland; supports the emphasis that the Scottish

Executive has placed, across portfolios, on health promotion; agrees that the Executive is right in tackling the three big killers of coronary heart disease, cancer, and stroke and recognises the progress made to date in reducing mortality rates from these diseases; believes in putting patients first so that they are at the heart of NHS service developments and priorities, and supports the Executive's determination to target additional investment and increase capacity so that the next steps are focused on reducing waiting for out-patient appointments and hospital admissions, on speeding diagnostic tests and on extending patient choice.

14:57

**Shona Robison (Dundee East) (SNP):** Like my colleague Tricia Marwick, I am strongly of the view that the content of the minister's speech, which signalled some major policy changes, should have been given to Parliament in a ministerial statement rather than being presented to the press in extensive briefings in advance of this debate.

We have arrived at this debate following numerous failed initiatives of one sort or another, with the announcements today being only the latest twists and turns on the part of the Executive. The only consistent factor has been the failure of the Executive to deliver the necessary stewardship of the NHS to deliver on waiting times and lists that are now at record levels. Time and time again, we have heard the same old promises and have been told that targets have been set. However, it is not the setting of targets but the meeting of targets that matters. Is it not strange that all the targets are set for the period beyond the next election? That is convenient, is it not?

Let us examine some of the promises that have been made. Members might remember the promise to buy back the Health Care International hospital for the public sector at a cost of £38 million, following the bung from the public purse that the Tories gave HCI in the first place to enable it to be set up. The minister might remember that the previous Minister for Health and Community Care announced with great fanfare that that renationalisation would be the solution to waiting time problems across Scotland. Two years down the line, however, we are told that the latest wheeze from the latest Minister for Health and Community Care is that large parts of the Golden Jubilee national hospital will be rented out to the private sector. The minister tells us that we should not believe everything that we read in the press but should we believe everything that we hear him say on "Newsnight"? Speaking about the Golden Jubilee hospital on that programme, he said that if we have assets lying empty, we can staff them using the private sector.

**Mr Kerr:** Was that the Golden Jubilee hospital?

**Shona Robison:** If the minister does not know what he was talking about on "Newsnight", that is not my problem.

The minister's proposal adds up to a triple whammy for the public purse and a triple bonus for the private sector.

**Margo MacDonald:** Will the member give way?

**Shona Robison:** I want to move on. I will give way later.

Many other initiatives have come and gone. What has been missing, however, is a sustained, coherent national strategy to sort out the NHS.

**Mr Kerr:** On a sustained and coherent strategy, this Executive set out to deal with Scotland's three biggest killers. In terms of treatment and waiting, we are the best in Europe and the UK. In terms of in-patients and day cases, we are ahead of the rest of the UK. I accept that we have a stubborn problem with out-patients, but I will deal with that.

**Shona Robison:** As the minister will know from our amendment, we recognise the progress that has been made. However, we will not acknowledge that the Executive has made any progress on reducing waiting times and waiting lists. If the Executive has been as successful as Mr Kerr tries to make out, why are waiting lists at record levels?

Mr Kerr is turning to the private sector out of desperation. That is a dangerous road to go down.

**Helen Eadie (Dunfermline East) (Lab):** Will the member give way?

**Shona Robison:** No—sit down.

The problem with that move is that it will be dangerous to the NHS and hard to reverse. The role of the private sector can expand only at the expense of the NHS. The private sector in Scotland is very small and for it to expand, the staff can come from only one place—the NHS. The minister is robbing Peter to pay Paul. The SNP is not alone in saying that; the same concerns are being expressed by the British Medical Association, the Royal College of Nursing, Unison and others.

The minister talks about having anti-poaching conditions in the contracts. He might want to listen to what I have to say, because he might learn something. Although the same assurances were offered in England, it has now been admitted that there are limitations on the extent to which legal safeguards can be achieved. A helpful researcher provided us with an interesting briefing from the Lib Dems down south, which is entitled, "Flagship Government private health scheme exposed as rigged and a threat to patient care". It uncovered problems that were associated with a private treatment centre that was being planned in Oxford—a proposal that is very much along the lines of what the minister is considering. It was revealed that that centre would replace rather than

add to NHS activity and reduce rather than add to NHS capacity and that it would be allowed, quite freely, to employ NHS staff—all breaches of so-called Government promises.

The Lib Dems down south referred those plans to the National Audit Office for investigation. Their health spokesperson said:

"It is unacceptable that the best interests of politicians and private companies are being put before the interest of patients".

I could not agree more. What a shame it is that the Scottish Lib Dems do not take the same view. They will support the Executive's proposals to keep their bums on ministerial seats.

**Margo MacDonald:** On a point of order, Presiding Officer. Do we have a code of practice as regards what language it is acceptable to use in the chamber?

**The Deputy Presiding Officer:** No, we do not. That is for me to decide. Carry on, Ms Robson.

**Shona Robison:** I shall do just that.

From some of the minister's comments, it is clear that the Executive is prepared to allow NHS staff to work within the private sector. I will again quote what the minister said on "Newsnight". He stated:

"We can also have a contract that says you can use people who work in the public sector, as long as we understand the level of their engagement with the private sector."

That still means that they will not be working in the NHS while they are working in the private sector.

**Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD):** The member is now six minutes into her speech. She has quoted every other party in the Parliament, but has not outlined her own party's policies on the matter. Would she care to do so in her remaining minutes, in advance of putting her bum on her seat?

**Shona Robison:** I will come to that. The member knows my views. I have said time and again that the only solution to the problem in the NHS is to build capacity in the NHS. I will say more about that in a minute.

The idea that it will be possible to stop staff working in the private sector is a farce and cannot be enforced. The minister has already acknowledged that it will be okay for staff to work for the private sector in their spare time. I want to return to the point about building capacity in the NHS. If NHS staff have spare time or if there are doctors and nurses to be recruited from abroad—we have heard that the private sector will be doing that—why on earth are we not taking advantage of that within the NHS in Scotland? If that capacity exists within the NHS or can be provided by doctors and nurses from abroad, surely we should be using it in NHS in Scotland? Why is the Executive so keen to pay the middle man and to boost the profits of the private sector? Capacity building can and should be done in the NHS.

**Mike Rumbles (West Aberdeenshire and Kincardine) (LD):** Is that it? Is that what the member's party's policy is?

**Shona Robison:** If the Lib Dems do not believe in building capacity in the NHS, we will have to differ on the subject. It is unfortunate that the Scottish Lib Dems did not listen to the warnings from their colleagues down south about what would happen if the private sector model was used in Scotland. Is it not strange that the Lib Dems say one thing north of the border and another thing south of the border?

**George Lyon (Argyll and Bute) (LD):** Will the member give way?

**Shona Robison:** No, thank you.

**George Lyon:** On that point?

**Shona Robison:** No, thank you. The member should sit down.

The important thing is to focus on building capacity in the NHS. I agree that the diagnostic and treatment centre model has a lot going for it. Because those centres are able to concentrate on elective procedures, they are not affected by emergency demands. To date, the 20 centres in the NHS in England appear to be working well—indeed, another 25 are planned. It can be argued that the reduction in waiting times in England is due to keeping the diagnostic and treatment centres within the NHS—only two or three of the centres have been developed in the private sector. If the minister has not been given that information, perhaps he should have been before he embarked down this road.

The fact that most of the centres in England are in the public sector tells me that that model could be very important to the NHS in Scotland. All that we have so far in Scotland is one centre at Stracathro and one in Leith. Surely we should be looking at what works. The minister is shaking his head, but why are we not doing that in the NHS? Why will he allow the private sector to do something that could be done in the NHS? The evidence from England tells us that the approach is working. Instead of going down the private sector route, the minister should have looked at the evidence.

The minister should think again about going down the private sector route. Instead of siphoning off NHS staff to boost the private sector, he should use the spare capacity at the Golden Jubilee hospital for NHS work; establish diagnostic and treatment centres throughout Scotland—but keep

them in the NHS; utilise the spare capacity in NHS staff; and recruit doctors and nurses from abroad, which he has not been doing. That is how he will build capacity in the NHS.

I move amendment S2M-2155.3, to leave out from first "supports" to end and insert:

"recognises the progress made in reducing mortality rates from coronary heart disease, cancer and stroke; believes in putting patients first by expanding capacity in the NHS to tackle unacceptably high waiting times for out-patient appointments and hospital admissions, and is concerned that any expansion of the private sector in Scotland can only be achieved at the expense of the NHS."

15:07

**Mr David Davidson (North East Scotland) (Con):** I welcome the minister's decision to make a step change. However, the question remains how many steps he will take and whether his journey towards Damascus will be a meaningful one. Having heard what he had to say on air this morning, I have to say that he was less than convincing about the second step.

I have some simple questions for the minister. He has told us how many extra patients he expects to treat by the end of 2007, but not how many extra patients he intends to treat in the first and second years. Will he give the Parliament details on which services are the subject of the tender documents, how many documents have gone out, how many companies he is addressing and what outcomes he is demanding? I assume that, as the contracts will have an outcome, the minister will know the costs involved.

The minister is talking about the extra 10,000 people who are to be treated by the end of 2007. How many of them will be treated by the independent sector? He has not told us that. My concern is that he is to spend only £45 million over three years. He claims that we are spending £8.3 billion at the moment and that the figure will rise to £10.3 billion over the next three years. Quite frankly, £15 million a year for three years is a spit in the ocean.

What will we get for that amount of money? How many additional staff will come in through the private sector, for example? We could say to the minister, "Right, your target is to treat 10,000 extra patients", but we could also say, "If the Executive had moved a bit more quickly, 10,000 additional patients could have been treated a year for each of the past few years". If the Executive had done that, 40,000 or 50,000 additional patients could have been treated both on time and in the way in which they should have been treated. Why has it taken the Executive so long to listen to our advice on the subject of seeking better collaboration and partnership with the independent health sector?

Over the past few years, we have seen pledges from ministers with responsibility for health and from the Executive of extra cash and extra staff. Despite all of that, there have been fewer treatment episodes.

**Helen Eadie:** Will the member take an intervention on that point?

**Mr Davidson:** In a moment.

The Executive's information and statistics division figures show that, since 1999, waiting lists are up 22,000 and the number of in-patient day-case discharges has fallen by 70,000—a drop in activity of 6 per cent. I could go on and on. All the figures are the minister's, yet he says that the Executive has made magnificent progress with its extra cash, staff and investment. He might say that but neither patients nor general practitioners have seen the benefit of that investment.

**Helen Eadie:** David Davidson and I were on the same committee that received information from Dr Andrew Walker. Does Mr Davidson accept that Dr Walker said that activity rates have quadrupled and, in some cases, have increased fivefold? One example is the 4,885 hip replacements that took place in 2002—a fivefold increase in the past 10 years.

**Mr Davidson:** We are talking about figures from the ISD that relate to the whole health service, not just selected good stories that come through.

At the moment, 1,932 patients are occupying blocked beds. Will the minister seek to apply the same vision to ensure that non-council-owned care and nursing homes receive the appropriate fees to allow them to cover their costs and remain open? They are beginning to close their beds right, left and centre and without them, bedblocking will become worse and we will lose even more capacity in the health service, particularly in the acute sector.

The minister talked about the "Fair to All" publication, in the preamble to which he mentions lifestyle and responsibility. However, we heard nothing about how he will change health. We heard a little bit about deprivation and the effects that it produces in the epidemiology of society. In simple terms, however, is he going to change the availability status codes for the 30,000 patients who currently fall outside waiting time guarantees? He gave us a hint about that, but he did not specifically spell it out. What will he change the availability status codes to? At the moment, anyone who is a low clinical priority or needs very specialised treatment is almost pushed aside. It is the old game: which are the easiest targets to pick off to put out in the press release, regardless of the individual needs of patients? Even the BMA says that.

**Tommy Sheridan (Glasgow) (SSP):** The member mentioned press releases and the journey to Damascus. Will he put out a press release this afternoon on a certain journey from London to Inverness and denounce the use of private companies for ambulance services?

**Mr Davidson:** That is the minister's responsibility, not mine. I am not a minister yet.

The diagnostic and treatment centres that the minister talks about were rejected by Malcolm Chisholm, yet now we have a turnaround. The equipment additions—at £125 million over three years—are welcome, but are they replacements or additions? We were not told. As far as the Golden Jubilee hospital is concerned, I do not mind who delivers care there, as long as care is delivered. The NHS contracts out services to ensure that patients get the benefit, and anyone would welcome that.

On health promotion, the minister did not give us information about how he will prevent people from becoming ill, thus taking demand away from the health service. I mention once again to him the obesity time bomb in Scotland. We have ever-increasing rates of diabetes type 2, which are becoming equal to rates for type 1. Treatment will require huge resources and, in 20 years' time, the health service will barely be able to afford to treat diabetes sufferers.

Shona Robison assumes that expansion of the private sector will be at the expense of the NHS. That is absolutely not so, because experience in England shows that such moves have delivered care for NHS patients more promptly and often more cheaply than the NHS itself can deliver. As I have said before to Shona Robison, who delivers care is an academic question, as long as that care is of the right quality and the right standard and at the right value.

**Shona Robison:** On that point—

**Mr Davidson:** I am running out of time.

I say to Ms Leckie that if the private sector can deliver equivalent care at no greater cost and still make a profit, the NHS is certainly not the efficient animal that the minister tries to make out it is—perhaps it is the minister's fault that we are losing that cost effectiveness in the operation of the NHS. Dr Turner's amendment has much merit because she picks up on preventive medicine and cost effectiveness in the health service. I look forward to hearing what she has to say.

We always welcome a late U-turn from a minister, whichever portfolio it concerns. However, we need more details. We need a guarantee today from the minister that the new target waiting times will be delivered and we want to know what he will do if he does not deliver those waiting times. He is very keen on targets, so when we get the fine print let us see what targets he has set for the first year and what happens when he does not deliver them. The real issue here is wider. It is not just about waiting times; it is about the number of treatments and investment to reduce illness.

My amendment is not about privatising the NHS but about adding capacity to it. That is because adding capacity to the NHS is not about the system but is in the interest of the patients of Scotland. The patients should be at the centre of the health service and the health service should be built to cater for them, with GPs acting as patients' advocates and commissioning services for them.

I move amendment S2M-2155.1, to leave out from "continuing" to end and insert:

"there is an urgent need to reform the NHS in Scotland; calls on the Scottish Executive to place patients' needs at the centre of the service, to give patients the choice to move anywhere within the NHS, to ensure that NHS capacity is supplemented where necessary by better collaboration and partnership with the independent and voluntary health and care sectors and to move to a system where money follows the patients, and further calls on the Executive to free health professionals and local managers to respond to patient needs on a local basis and to transfer resources away from bureaucracy and into front-line care."

15:15

**Carolyn Leckie (Central Scotland) (SSP):** I indicate support for the amendments from the Scottish National Party and Jean Turner. I echo Shona Robison's comments about the insult to the Parliament and democracy in the fact that "Fair to All, Personal to Each" was not made available to all MSPs prior to the debate. I hope that Labour back benchers also complain about that.

Although it is always best to preface such a debate with an emphasis on improving health, reducing illness and increasing life expectancy, we must acknowledge that the big barrier to achieving those aims is poverty. The latest Joseph Rowntree Foundation report shows that the highest concentration of people living in abject poverty is in Scotland and that the highest concentration in Scotland is in Glasgow, with 64 to 68 per cent of families in many council wards there claiming means-tested benefits. That poverty is directly related to the lower life expectancy that Andy Kerr mentioned: life expectancy for men is a shameful 68.7 years in Glasgow and only 64 in Shettleston. In Springburn, infant mortality is more than double the national rate at nine per 1,000 live births.

If the barrier to better health is poverty, it is obvious that the solution is the smashing of that barrier, but exactly the same inequalities of health and access to health care were the driver for change—a phrase that is often used now—that led

to the creation of the NHS. It is telling that, in Cuba, a country that suffers a brutal embargo and is denied access to some essential medicines, life expectancy for men is 11 years longer than in Shettleston and, for women, four years longer than in Springburn. In a blockaded country with a planned economy, there are 5.3 doctors per 1,000 people, compared with 2.25 per 1,000 people in Scotland. In Cuba, there is a family doctor and nurse for every 120 families. Cuba has sent 10,000 doctors on solidarity missions to the poorest nations in the world, so perhaps the Parliament could make a formal request to Fidel Castro to send some solidarity doctors to Scotland. That would be rather ironic, given that we are about to send 150 doctors to help in an illegal war in Iraq. The situation is shameful.

When we take a microscope to the capacity of the NHS in Scotland and compare it with the capacity of the health service in Cuba or take a retrospective look at its own previous capacity, it does not take us long to work out why the public and NHS staff are dissatisfied with and terrified about the security and future of the NHS. In Cuba, there are 5.1 staffed hospital beds per 1,000 population; in England, there are 4.2; and in Scotland, there are only 3.5. In Scotland, 8,000 staffed beds were lost between 1993 and 1997 under the Tories and a further 8,000 beds were lost between 1998 and 2004 under the new Tories. A full third—33 per cent—of NHS beds in Scotland have gone. Part of that reduction in beds is explained by the private finance initiative.

**Mr Kerr:** On bed numbers, does Carolyn Leckie accept that services change? Does she accept that procedures such as cataract operations and endoscopies that do not require beds and which allow patients to go back to their homes when they want to go are a step forward for the service as well as for patients?

**Carolyn Leckie:** Andy Kerr knows that figures produced by Audit Scotland show that the claimed increase in community activity simply has not happened, and he cannot prove that it has.

Against that backdrop, the Executive and previous Governments gave HCI £30 million in 1994 and £37.5 million later to bail out the Abu Dhabi Investment Company, which could fill only 30 beds at HCI. The Executive was supposedly going to reduce waiting times with the purchase of HCI, but it clearly has not succeeded, and that admission is with us today. The Executive has added only the 70 beds to which I referred earlier, which represents a reduction of 180 beds on the number in the comparator period—that is, since HCI was purchased—so we did not get much for bailing out the Abu Dhabi Investment Company, did we?

I ask members to compare the running costs with those of other hospitals. At the new Golden Jubilee national hospital, the cost per in-patient per week, which was published just this year, is £9,845. Compare that with figures for the area covered by the former North Glasgow University Hospitals NHS Trust—one of the most deprived and complex areas in Scotland. There, running costs are £2,560 per in-patient per week. The cost is £134 per attendance at out-patients at the Golden Jubilee national hospital, but £30 in north Glasgow. That is despite north Glasgow having the greatest complexity and deprivation and the fact that health services there deal with transplants and so on.

The Abu Dhabi Investment Company got baled out and more good money is to be thrown at the Jubilee for private expansion, while Stobhill hospital, in north Glasgow, is targeted for closure. Why is the Executive prepared to put everything into the former HCI hospital while funding for other hospitals up and down the country is being slashed?

At page 11, paragraph 4.12, of the "Fair to All" document, the Executive has the cheek to talk about the Jubilee hospital as the solution to capacity problems. How many beds are going to be contracted out and what will be the cost of in-patient stays per week at the Jubilee in future? Can we have some answers to those questions?

Paragraph 4.18, on page 12, refers to

"contracts … worth up to £45 million over 3 years".

Which companies will those contracts be with? Will the contracts—like contracts for independent treatment centres in England—guarantee the companies a set number of patients and a set income? Experience there has led to patients who had been perfectly happy to be treated in their local hospital being forced into ITCs so that the contracts could be fulfilled.

Professor Allyson Pollock dismantles the Government's arguments very well in her book. It is no accident that Tony Blair told a group of private health care executives in May 2003:

"We are anxious to ensure that this is the start of opening up the whole of the NHS supply system".

By September 2003, the Westminster Government had admitted that private diagnostic and treatment centres—DTCs—could recruit up to 70 per cent of their staff from the NHS. Westminster has already admitted that—will Andy Kerr admit it? Here we have Andy Kerr, doing the bidding of Tony Blair in Scotland.

I ask members to consider the establishment of the NHS, back in the war years when injured people came back to the country in their thousands and millions. The decision was not to contract out more services or to create more private opportunities. Rather than contracting out,

a nationalised, centralised emergency hospital service was created. What was efficient for Churchill's coalition war Government was public, not private. I am comparing Andy Kerr with Churchill, but he is not really living up to it.

On the question of choice, there is an absolute fallacy. If everyone had access to universal, comprehensive, free and equal high-quality health care, nobody would choose anything else. The minister should not be ridiculous: the Executive's proposals are a smokescreen and a red herring and amount to absolute nonsense. All the Executive is doing is opening up the NHS—using public money for private profit. The vampires have been let loose by Andy Kerr and John Reid, and Tony Blair's man in Scotland is doing his bidding.

I move amendment S2M-2155.4, to leave out from "continuing" to end and insert:

"radical continuing action is needed to turn around the poor health of many people in Scotland, most of it poverty-related; further notes that the Scottish Executive needs to do much more if mortality and morbidity are to be drastically reduced, life expectancy increased and health inequalities removed; recognises that the most effective health promotion measure would be the eradication of poverty; recognises that, while Scotland's people continue to suffer unacceptable levels of ill-health, the NHS needs to have the capacity to treat patients quickly, effectively and as close to their homes as possible; believes that the NHS in Scotland has suffered unprecedented and unsustainable reductions of capacity, particularly through bed cuts, hospital closures, PFI and budget deficits in the last 10 years and that there needs to be an immediate reversal of that trend by securing the NHS as a publicly-owned, publicly-delivered, universal, comprehensive service free at the point of need with the capacity to meet the needs of the population, and considers private health care to be a parasitic drain on NHS assets, resources and staff that merely converts public money into private profit whilst undermining the founding principles of the NHS and threatens its very existence as envisioned by Aneurin Bevan."

15:23

**Dr Jean Turner (Strathkelvin and Bearsden) (Ind):** I love the title—"Fair to All, Personal to Each" is wonderful. At present, however, the situation is not fair to all, and anything that makes it fairer will be a great advance.

When I was in general practice, if the fast-track chest pain clinic at Stobhill had kept my patients waiting for 16 weeks, I would have been exceedingly worried. We got patients there in two weeks. It is best practice to operate on hip fractures within 24 hours.

I say to Carolyn Leckie that NHS Greater Glasgow has, I think, done a U-turn, in realising that the lack of capacity in the system in its area will keep Stobhill open for a little while longer. We hope that the casualty department will get its reprieve, which would be good.

**Mr Kerr:** Does the member also welcome—although I acknowledge that she has issues with this—the fact that £85 million of investment is going to that part of Glasgow?

**Dr Turner:** Yes, I acknowledge that. I have no problems with the ambulatory care and diagnostic unit, which we have always wanted. The only thing that we are arguing for is to keep beds at Stobhill.

Morale in the health service is low and nurses are concerned when the word "privatisation" is used. Members of the RCN, which has been mentioned, and Unison feel that they have not been involved in the discussions and that they could do something to shorten waiting times by working in acute clinics, which have increased in number.

To my mind, the private sector is about profit. If something is not profitable, it is not done. Nursing homes close when they do not manage to make profits. Nurses and doctors are trained in the NHS, not in the private sector. Often they are poached from the NHS, to be sold back into it. Agency nurses are a great example of that. They are trained in the NHS, but somebody makes great profits by selling back their services. Why cannot the NHS keep nurses and the profits?

All the nurses to whom I speak get upset when agency nurses are used. They feel that their wards are understaffed and that the agency nurses who come along do not know the ward to the same extent as the nurses who work in it. Therefore the burden of work is put on the NHS nurses and the agency nurses get off lightly. That is nothing to do with their training; it is just that they do not know the ward and their surroundings. When nurses are offered good conditions, such as those that apply in NHS 24 and promoted posts, they take them up, leaving other gaps in primary care, in the wards and, sometimes, in coronary care.

I wish that the pressures on waiting lists were discussed within the health service, because I believe that the problems could be solved by the consultants and nurses who work there. Rumours go round and in *The Herald* today one of the surgeons at Yorkhill said that, when the hospital had a surgeon for eight months, the waiting time went down from 67 weeks to 18 weeks. Waiting times can be reduced if we have the staff.

When orthopaedic surgeons went to Glasgow royal infirmary, that was supposed to ensure that the waiting lists would be shortened. In fact, the same number of surgeons were using fewer theatres and each surgeon specialised in hips, knees or whatever. It does not take a lot of arithmetic to work out that 20 surgeons cannot do very much in three or four theatres. When we reduce the number of buildings, we reduce capacity in beds and theatres.

It is not fair to expect people with chronic illness to wait for more research to be done. I would like to see more about that in the future plans. I know that the Executive approves of the report on chronic pain by Professor McEwen and I would like to see a national strategy for chronic pain and for diagnosis.

Last night, I attended a meeting of the cross-party group on kidney disease. We have reduced coronary heart disease and stroke, but if we could devise a blood test, which would not be too expensive, to check people for hidden kidney disease, that would also lower the stroke rate.

People who are in chronic pain do not have quality of life and they do not work. If we put a little money into chronic pain clinics, we would find that nurses and psychiatrists, along with doctors and physiotherapists, might reduce the drug bill. Professor McEwen's report puts the bill at £1,000 per person a year, which is a staggering figure. If we could reduce the number of drugs that people use and give them other means of dealing with their pain, we would save money.

Specialist nurses and physiotherapists give tremendous support to clinics such as musculo-skeletal units, which also screen for osteoporosis. That disease affects men as well as women as we become older. Not many can avoid it and if it is a family trait for someone, they are in trouble. Reducing the number of people who are at risk of osteoporosis would also reduce the risk of fractures. Glasgow has had a good programme of establishing who may be at risk of osteoporosis, and who knows what the orthopaedic waiting list would be like if that programme had not been undertaken. I would like screening for osteoporosis to take place all over the country.

I commend education in primary care. What Carolyn Leckie said about poverty is true. We must address all such matters. As for conveying information to patients, we have only to think of asthma and chronic obstructive airways disease clinics, which keep people out of hospital. Anything that can be done in the primary care sector and for which money is provided in information technology and clerical services makes a great difference.

I like much of what the minister says. I am scared of privatisation, because it lowers morale. I am pleased to hear that the Executive is trying to turn the situation round. Some figures are good. I do not expect us to manage to do everything tomorrow, but I am pleased that people have noticed that the system needs increased capacity.

I like to think that we can go forward together with open minds, because things change quickly in medicine. We might keep some of the beds that we intend to close when we realise that we could make good use of them for bread-and-butter matters and to declog the more specialist centres, to allow them to get on with their work. With the help of people in the NHS, I hope that waiting lists will reduce.

I move amendment S2M-2155.2, to leave out from first "supports" and insert:

"welcomes the additional investment on health promotion, including its targeting of heart disease, cancer and stroke; however, urges the Scottish Executive as part of its next steps strategy and to fulfil its aim of returning all patients to the heart of the NHS, to include as part of the strategy a comprehensive review of services dedicated to palliative care and chronic conditions and, further, develop a national programme of diagnostic care, all of which continue to be under-resourced and under-funded, and believes that such a review will save the NHS money by identifying, treating and controlling such conditions in a more structured, preventative and cost-effective manner which will alleviate the consequent pressure on hospital beds and in-patient services."

15:32

**Mike Rumbles (West Aberdeenshire and Kincardine) (LD):** The future of the health service in Scotland remains—rightly—at the forefront of political debate. Tremendous change is taking place and we all have high expectations of what the NHS can and should do for us. More than 4 million out-patient attendances occur in Scotland each year, of which 1.2 million are new appointments. Attention has focused not on the 95 per cent who are seen relatively quickly, but on the 4.5 per cent or so who wait more than six months.

When the Scottish Parliament was established and the new coalition Government took office, we changed how we dealt with waiting targets. We moved away from focusing on the number of people on waiting lists and turned our attention to the length of time for which patients had to wait to be seen. As a constituency MSP, I discovered—as I am sure other MSPs did—that people were not interested in how many other people were on their waiting list. They were concerned about how long they had to wait to be seen. Constituents contacted me constantly about horrendous waiting times of well over a year to be seen.

That is why I was pleased with the change to a focus on waiting times—which Liberal Democrats had always demanded—rather than on lists. Shona Robison of the SNP and David Davidson of the Tories seem not to have noticed that change in focus. David Davidson said that we are copying the Tories, but he could not be more wrong. The Executive is reducing waiting times; we are not privatising the NHS as the Tories would have us do.

**Shona Robison:** I remind the member that we called for a long time for waiting times to be measured. Does he acknowledge that even if

waiting times are the measurement, the coalition Government has completely failed to make a reduction?

**Mike Rumbles:** The coalition Government has been extremely successful in reducing waiting times and the facts bear that out. It is well worth remembering that the Executive has been successful in achieving its aim of delivering a maximum wait of nine months between diagnosis and treatment for in-patients. I hope that Shona Robison is listening. It is also on target to reduce that to six months by the end of next year. In addition, all out-patient appointments will be undertaken within six months.

That is extremely good news, but the situation is still not satisfactory. I say to Shona Robison that the minister recognised that today with the announcement of a further reduction in the target for waiting times. I hope that that will be welcomed as patients see a continuing improvement in service. There is no doubt that the patient is at the heart of the national health service. Andy Kerr's announcement of an 18-week target by the end of 2007 is challenging, but it must be met.

I want to focus on the minister's announcement that the Executive is to abolish availability status codes, whereby some patients are excluded from the waiting time guarantees. That is very good news. All patients will now be included in the important targets, apart from patients who exclude themselves. I do not think that exceptions were part of the partnership agreement and I am pleased that the minister has taken action on the issue. I commend him for doing so.

I was surprised by the attention that the media and the Opposition parties gave to last month's news that, while the existing nine-month guarantee had been met, the number of patients waiting for more than six months had risen to 7,512. I thought that we had got over the hang-up on number crunching in that regard. The Executive is successfully achieving its targets on waiting times and we must recognise that.

**Mr Davidson:** ISD statistics for the quarters from March 1999 to September 2004 show that out-patient waiting times have soared from 47 days to 55 days. Those are the Executive's own figures.

**Mike Rumbles:** Mr Davidson says "soared". That is the sort of rhetoric that we must move away from. We are doing extremely well, with 54 days in Scotland and 50 days in England. Figures have risen by three days across the board, but it is the long waits that are important. The Scottish Executive's achievements are dramatic in that respect.

We must not forget that more than half of our hospital patients are treated immediately and never join a list. Of those who do, 40 per cent are seen within four weeks and 70 per cent are treated within three months. I have not noticed David Davidson bandying about such statistics; I wonder why.

The NHS is doing a good job in delivering effective patient care, but waiting times are still too long for patients. People should not have to wait months to see a specialist or for treatment. All members accept that waiting times must come down even further, and successive Executive ministers with responsibility for health have been making them come down. I remind David Davidson that waiting times for patients did not just appear overnight—they have been a problem for successive Governments. I cannot remember a Labour or Conservative Government achieving such a dramatic lowering of waiting times.

**Shona Robison:** Will the member give way?

**Mike Rumbles:** I cannot do so at the moment. I have let the member in once already.

As I said, even those reductions in waiting times are not good enough and we must do more, which is what the Minister for Health and Community Care has just said. We simply must increase capacity to reduce waiting times further. The only practical ways of doing that are by importing services and staff from abroad—I am thinking of what the SNP wants to focus on—or enabling the private sector to engage more. I see nothing wrong with employing every means at our disposal to tackle such an important issue.

I would go further. If every NHS patient cannot be treated within the timescale, we should ensure that they are offered private treatment. That is only right if the NHS cannot cope in those specific circumstances. We should focus—as we are doing—on the patient. In the short term, effective use of the private sector is essential to tackle the long-term waiting times backlog.

The Minister for Health and Community Care is entirely on the right track and we should back what he seeks to do to improve patient care. The needs of individual patients in the NHS are too important to leave to political and dogmatic prejudices. The direction of travel is right and the Executive must not be deflected from driving down waiting times, which it has been successful in doing. We must act to ensure that we have a first-class NHS that puts the needs of our patients first.

15:40

**Mr Duncan McNeil (Greenock and Inverclyde) (Lab):** As medicine and health technology continually advance, so must health policy. Whereas our approach to delivering 21st century health care is cutting edge, the nationalists and

others are still stuck applying the leeches. I wonder what great Scots such as Sir Alexander Fleming would make of the SNP's timorous approach or its opposition to change and innovation. Would he have discovered penicillin if he had asked, "Do we really need antibiotics? Can't we just have more leeches?"

**Shona Robison:** One of Duncan McNeil's pet subjects is the consultant contract. When the consultant contract was introduced, we were told that one of the big benefits—

**Mr McNeil:** I have got only seven minutes. Please hurry.

**Shona Robison:** We were told that one of the big benefits of the consultant contract was that it would commit consultants more to the NHS. Does Duncan McNeil think that their working in the private sector through the private centres will do that?

**Mr McNeil:** I am sorry, but Shona Robison has wasted her time and has taken too much of mine. I cannot afford to give her any further answer.

The Minister for Health and Community Care has pointed out the fact that progress has been made. It has had an impact on my constituency, which has a poor public health record. Like many other members, I have friends, relatives and constituents who are alive and well today because of the initiatives that have been taken. We should be celebrating that work, not condemning it. However, to the minister's credit he accepts—as I do—the fact that we cannot stand still. His willingness to consider innovative ways forward is to be welcomed. Who is against that?

A prime example of what needs to be done is the better use of technology, which has not been focused on yet in the debate. When I go into hospitals, I see staff pushing shopping trolleys full of medical records around the corridors. Quite apart from the issue of what those staff could be doing instead, is it any wonder that medical records get lost? It is simply not acceptable that constituents who visit a consultant, having worried about that visit for weeks, turn up only to find that their records are no longer there but have been lost.

Information technology is not just about better administration; it can give Scottish patients access to the expertise of the best doctors.

**Stewart Stevenson:** Will the member take a brief question?

**Mr McNeil:** Let me make this point.

IT can give patients access to the best doctors not just in the west of Scotland, in Scotland or in the UK, but in the world. That is our ambition; that is where we should be going.

**Stewart Stevenson:** Will the member take an intervention?

**Mr McNeil:** I have limited time and Shona Robison took too much of it. Stewart Stevenson should blame his colleague.

The raft of tough new targets on waiting times is to be welcomed, but those targets will be met only if we couple the extra investment with real reform. Having listened to the minister, I believe that he is determined to drive through that reform.

I am pleased to hear of the emphasis on improving access to health care through new capacity and better use of existing capacity. For those who have been sad enough to listen, I have been saying for long enough that access to health services is as important as the services themselves. A service that people cannot access is no service at all. So, it is good news for patients that all available space at the Golden Jubilee national hospital is to be brought into clinical use. It is good news for patients that the Executive will seriously consider Professor David Kerr's report on the national framework on service change to see what further opportunities it brings.

It is good news for patients that we will provide mobile diagnostic units in our communities. That is especially good news for constituents in the more deprived parts of my community. Within the local authority boundary, in Kilmacolm, the average male life expectancy is 80. A few minutes by car into the east end of Greenock, the figure is 65. Early diagnosis, which those mobile units will deliver, could add years and quality to people's lives.

Let me nail some of the nonsense about this being all about saving money. As the minister reminded us, by 2007-08, the health budget will have risen to £10 billion—a 110 per cent rise since 1999. This programme of reform is a marked contrast to the SNP's repeat prescriptions. They dismiss the innovations out of hand. "Let them wait", is the SNP's only response.

The minister says that there will be specialised care treatment centres to concentrate on a few key operations that will dramatically improve patients' quality of life; that cannot come soon enough for my constituents. The SNP says, "We don't care. Let them wait." The minister says that there will be penalty clauses in the contracts for services to prevent the poaching of NHS staff. The SNP is not interested; it says, "Let them wait." The minister is designing reforms to guarantee that they will add to NHS capacity. The SNP does not care; it says, "Let them wait."

The SNP is used to waiting, of course. It has been waiting for independence for a long time now, but we will not wait with it. It will never achieve independence because it is out of touch.

The SNP does not care about patients having to wait; it is more worried about holding on to an old and outdated ideology. Patients—my constituents—do not care about that ideology or about what lies behind the procurement method for their operations; they just want them to be done.

The principles of providing free health care to those who need it must include providing that care when they need it. That is what the minister's measures will do, if we have the courage to drive them through. It might be too much to ask a party whose health spokesman is Shona Robison, but I ask the SNP to put to one side the sniping, moaning and groaning and to show a bit of compassion. I ask the SNP to move on and put the patient first.

15:49

**Roseanna Cunningham (Perth) (SNP):** I see that we are once again generating more heat than light and more noise than anything else. Perhaps we would have had a better debate if the minister had ensured that members were better informed. I hope that he will reflect on that.

**Mr McNeil** *rose—*

**Roseanna Cunningham:** Perhaps Duncan McNeil could let me get started before he intervenes.

The most recent figures on waiting times, which were published at the end of November, showed that the number of patients who are being treated per month across Scotland is now at an all-time low, while the median wait for treatment is at an all-time high. I have no doubt that health professionals in the NHS in Scotland are working extremely hard and doing an excellent job. I know that they dislike the focus on waiting times, but reality dictates that that is the way in which people experience the service.

In my area, folk have to wait 10 days longer than the Scottish average, which is 11 days longer than they had to wait last year, and 18 days longer than when this Executive first came into power in June 1999. Not only that, but the percentage of patients who are admitted within the first three months is down a staggering 15 per cent on June 1999. That is the reality in Tayside, and all the talk will not talk that reality away.

The record is difficult and it has to be overcome. The numbers are not empty statistics; they represent ordinary people waiting for treatment. The minister listed targets for specific conditions, but I will give members some reality. I have a constituent who was diagnosed on 12 September 2003 with an aortic aneurysm—a life-threatening condition, which could take him away just like that. His GP expected that he would be treated surgically within one to two weeks. The chief executive of the health board told me that that was the ideal, but that it was not possible in this case because of the pressure of patients who had similar or worse medical problems. After a last-minute cancellation and because of a lack of high-dependency beds—a lack of capacity—in the Tayside NHS Board area, my constituent finally had his operation on 13 February. That was a five-month wait after a diagnosis of an aortic aneurysm. He had to live with that diagnosis for five months and I do not think that that is acceptable.

If that is the situation for a life-threatening condition, what is the picture like for those whose conditions are not considered to be serious enough to merit any kind of priority? The waiting times for non-life-threatening ailments do not get much in the way of coverage in the chamber, but they should; one or two members have spoken about that.

For example, one young mother with a full-time job was diagnosed in the middle of 2003 as needing a tonsillectomy. Tonsillitis seems like such a trivial illness. At the time, she was told that she would have to wait 60 weeks just to be seen by an ear, nose and throat consultant. During 2003 alone, she suffered from tonsillitis 10 times and was off work for approximately 14 weeks in total. She got to see a consultant on 20 July this year. I give credit to NHS Tayside—she waited 53 weeks, rather than 60. She had her operation on 13 September, a whole year after diagnosis. In that time, she feared losing her job and her future promotion prospects, because of her frequent absences. That is not just a cost to industry—it also had a catastrophic effect on her quality of life.

**Mike Rumbles:** Is Roseanna Cunningham not missing the point? The Scottish Executive is doing exactly what she suggests. Eighteen weeks should now be the maximum waiting time. The Executive has succeeded in ensuring that no one waits for more than 12 months or nine months. The waiting time is now down to six months.

**Roseanna Cunningham:** I am fascinated if that is the guarantee right across the board, including for situations such as that which I have described. I would be interested if the minister, in his closing remarks, would tell me how he will get a current wait of something like 60 weeks down to 18 weeks across the board. If he can do so, I will be much more satisfied than I am at present.

My concern relates to how long people should have to put up with so-called non-serious conditions, which have a profound effect on their quality of life. Are we expecting that they should resort to paying for treatment? Make no mistake—leaving aside the proposals that have been

announced today, people are already utilising the capacity of the private sector. They are doing so all the time. Who, if they can afford it—which is the problem—would not think seriously about getting their granny an earlier cataract operation or their mum an earlier bone scan? Who would not think about getting the poor woman with chronically bad tonsils into surgery, so that she can be free of tonsillitis for ever, without having to wait for more than a year? It happens all the time, and we know it.

The Executive is cynically forcing people into the private sector by stealth. Extended long-term use of private sector capacity, whether via the back door as just described, or by the front door in the way in which I presume the Executive is proposing, is not the right way of solving the problems of our national health service. No matter what the minister says, I believe that it will result in even greater staff shortages in the NHS and that it has the potential to undermine permanently the ethos of the NHS. The more that private health insurance looks like a necessary resort for people, the more that they will resent paying again for something for which they consider they have already paid. Sooner or later, that will become the big political issue. Labour, I regret, will have taken us to a destination that the Tories never dared try.

15:52

**Margaret Jamieson (Kilmarnock and Loudoun) (Lab):** I support the motion in the name of the minister, but I have concerns about how we will be able to track the targets and the 42 per cent increase in investment that has taken place since devolution. We have raised that issue on a number of occasions since 1999 in the Audit Committee. When we have done so, we have received every excuse under the sun from civil servants for why we cannot measure what we get for our investment.

The Health Department gives no direction on the outcomes that are expected from investment. The minister has said that he expects health board chairs to deliver. I agree totally with that, but he must also expect his civil servants to demonstrate their ability to deliver by ensuring that he has the most robust information to demonstrate how policies are delivering in every health board in Scotland. I sincerely hope that, in the contracts that are drawn up with the private sector we—the Scottish people—will see exactly what we will get for our money, which would put paid to the cries of some people that we are lining the pockets of the private sector.

A complete audit trail needs to be in place from the beginning of the patient experience. I want to know how we will ensure that sufficient resources will be in place to assist general practitioners to make the most appropriate referrals, that referral protocols will be in place and that compliance will be monitored.

As many MSPs do, I have constituents who attend my surgeries to complain that they have been waiting for more than six months for an out-patient appointment. However, when I have asked to see referral letters, I have found that the GP has indicated there that such waiting times are routine, but has not told the patient that. One of my constituents complained to me recently that she was waiting too long for an out-patient appointment. When I asked her for the details of her referral, she told me that she was being referred for a check-up and yet she was on that same waiting list. Cannot the medical profession be confident and honest with people and tell them that they have the skills and the level of competence to deal with conditions? If a patient needs further reassurance, another GP can provide treatment. It is not rocket science; it is just common sense.

There is a myth that all patients need to occupy a hospital bed if they are referred to the acute care sector and that that is how we measure performance. What absolute rubbish that is. If someone is discharged from acute care at 11 pm, they are not counted as an in-patient because we continue to use the outdated method of counting only patients who are lying in a bed at midnight. Someone who is discharged at 11 pm is counted as a day patient. It is irrelevant whether a patient is treated as an in-patient, day case or out-patient, as long as they receive appropriate care within the appropriate timeframe for their condition. Is the SNP seriously saying that a referred patient must occupy a bed irrespective of their condition? Medical advances and new techniques mean that more and more patients can be, and are, treated without having to stay overnight in hospital, and that more patients than ever are cared for in the primary care sector.

It is also a fact that more patients are seen by other health professionals outwith the medical profession. The use of the private sector is not new; it is used frequently in some health board areas, although it has never impacted on the national health service in my area. What is new is the clear direction that has been given by the minister to reduce waiting times. We are doing that in a Scottish way while taking account of experience elsewhere in the United Kingdom, throughout Europe and the world; we are not just importing ideas from other areas, warts and all.

Why should we not do everything to reduce waiting times for patients? Does anybody seriously think that a patient will choose to wait longer by refusing an earlier appointment because it is in the private sector? I do not think so. The regulation of

the private sector, using staff from the NHS, is very welcome.

I look forward to my constituents, who have been appropriately referred, receiving care in an appropriate facility from appropriately qualified staff within the time limits that have been set by the minister today.

15:58

**Mary Scanlon (Highlands and Islands) (Con):** I will raise a point that came from the minister's speech. As I understand it, no staff will be poached from the NHS by the private sector for diagnostic and treatment centres. Unless the minister has some kind of derogation, I think that he will find that he will be in breach of our current employment legislation if he bars an NHS doctor who has the same training, qualifications and experience as a private sector doctor from applying for a job in the private sector.

My second point was also made by Margaret Jamieson: rather than simply look at the health sector as it is, I ask the new Minister for Health and Community Care to look seriously at referral protocols, at co-operation between the different health authorities, including social work, and at early intervention.

At the moment it is easier for people to get on a waiting list for a hip operation and to be treated for a condition that they have suffered from for months than it is for people to get a referral to an NHS podiatrist. In the early days of the then Health and Community Care Committee, when Margaret Jamieson was a member, we received a briefing from Andrew Walker during our discussions on whether beta interferon should be made available to patients at £10,000 per patient per year. He pointed out that, for £10,000, 1,000 elderly patients could, with chiropody and podiatry care, become mobile and independent. All too often, we are too busy looking at the big structure of consultants, acute hospitals and operations to take into account the fact that referral protocols from GPs are insufficient and do not utilise the excellent professionalism of, for example, podiatrists and speech therapists. Those people have much to give, but are often left out of the loop. I ask the new Minister for Health and Community Care to examine that. I also agree with Margaret Jamieson's point about audit.

As for the shorter waiting times and the targets that the minister announced today, I have to say—as someone who has participated in almost every health debate since 1999—that we have heard it all before. In fact, we have heard the same news from three health ministers. I am afraid that I must tell the minister that despite his aims, objectives and targets, waiting lists are up by 25 per cent and waiting times are up by 10 days.

**Mike Rumbles:** Will the member give way?

**Mary Scanlon:** I am sorry; I have too many points to make.

As far as bedblocking is concerned, I looked at one of my old parliamentary questions last week after hearing the news about the patient at Carstairs state hospital. When I asked that question, I was told that there were 28 bedblocking patients at that hospital; now there are 43. Things are getting worse, not better. If the Executive wants improvements, it must examine the referrals system and the issue of co-operation.

I draw the minister's attention to the lack of co-operation and co-ordination between the NHS and social work departments. Although the situation is improving, it is still not good enough and there is far too much buck passing between departments. I also ask the minister to examine whether there should be more co-operation between prisons and communities. For example, the detoxification, rehabilitation and psychological treatments that many prisoners receive in prison are superior to the treatments that they get in the community. Indeed, when they get back into the community, they often go straight on to a waiting list. That is not good enough, because it wastes the investment that has been made in the prison treatments.

The suicide rate in Scotland is twice as high as that in Northern Ireland and 8 per cent higher than that in England. This week, we have heard about patients from psychiatric hospitals being discharged into the community. I have worked closely with families in the Highlands who have lost people to suicide; indeed, in a recent case, a suicide victim's family discovered among his belongings a letter that showed that, although he had just left Newcraigs hospital, he went straight on to a waiting list for a community psychiatric nurse. He did not live long enough to see that nurse. Such things do not cost money, but the minister has to knock heads together to make sure that the system works. Similarly, people who receive alcohol and drugs detox and rehab treatment at an NHS residential establishment do not get any help in the community when they leave those establishments.

I draw the minister's attention to depression. I am setting up a group in the Highlands for the Depression Alliance, because MSPs must not always expect the NHS to do everything. Self-help groups have been shown to work; however, although it is still easy for people to go to the doctor and get very expensive drugs for a condition, it is still very difficult to get someone to listen to them.

16:04

**Des McNulty (Clydebank and Milngavie) (Lab):** Given the document's content, this is probably one of the most important debates on the health service that we have had since the Parliament began. The minister has flagged up a significant step change that will allow us to begin to address the problems that we all know exist in the NHS. It is therefore depressing that Shona Robison had the minister on the road to perdition; that David Davidson had him on the road to Damascus; and that Carolyn Leckie had him on the road to Transylvania. I am not quite sure where Jean Turner wanted him to go, but I think that it was round in circles. However, I was interested to hear that she is in favour of the Stobhill ambulatory care and diagnostic unit, which may be news to the readers of the local newspaper in Kirkintilloch.

If the debate has been knockabout, that has played it into the hands of Duncan McNeil, the ex-shipyard bruiser. Perhaps we need to switch tack—there are genuine problems in the health service. To me, the most unacceptable problem is the 84 weeks that it takes to get orthopaedic treatment in greater Glasgow. That is not so much down to delays in accessing an orthopaedic surgeon, but to the patient journey. A person has to be referred to the orthopaedic surgeon, then get a scan, then go back to the surgeon and then eventually get the treatment. We must reduce the number of steps in the patient journey. If I understand correctly what the minister said, he proposes to establish a series of systems to fast track diagnostic screening. That is the single most effective way of ensuring that people get from the start point, which is the pain, to the end point, which is the cure, as quickly as possible. Achieving that would be a significant change in the service.

The Golden Jubilee hospital in Clydebank has state-of-the-art orthopaedic theatres. When we bought the hospital, it carried out 2,500 procedures a year; the figure is at present 9,000 procedures and 9,000 diagnostic processes. That is a substantial change, but the minister proposes to double the number of procedures next year and practically to double it again the following year. Patients in Scotland, particularly those in the west of Scotland, deserve access to the best facility, which is a terrific purpose-built tertiary hospital in Clydebank.

People want the best medics and nurses and the best support. Why should they not have that? Why do Shona Robison and Carolyn Leckie and their parties not want people to have that? Why do they want people to continue to be treated in old, outdated and derelict buildings? They want to keep those buildings going not for the sake of patients, but for the political advantage that they see in that.

**Carolyn Leckie** *rose—*

**Shona Robison:** Will the member take an intervention?

**Des McNulty:** No.

One important measure is the proposed establishment of a cardiothoracic centre at the Golden Jubilee hospital. That will be good not just for the hospital, which is the best site for such a centre, but for all the hospitals in Glasgow and Lanarkshire, because it will create space and allow them better to reconfigure services. The best-quality people will be gathered there and will be able to work efficiently, the consequence of which will be that the patients who have operations and cardiology treatment will get a much better service. Why are Shona Robison and Carolyn Leckie so ideologically opposed to that measure? Why is it unacceptable to gather together the top-quality services in the best site and to deliver a better service for patients? That is what we want to do.

**Shona Robison:** I do not disagree with a word the member has said. My only question is this: why does he believe that such services cannot be delivered within the national health service, but can be delivered only with the help of the private sector?

**Des McNulty:** The services will be delivered within the national health service—that is what the minister said. Equally important, he said that where it is appropriate, private sector or other providers will be able to supplement treatment by providing specialist or niche services, such as access to machines for scanning, so that where services are needed, we can deliver them better.

The NHS is a supertanker; it takes a long time to turn it around. I am frustrated that in the two years since we bought the Golden Jubilee hospital we have not managed to get it up to the speed that I wanted it to reach, but I welcome the minister's acknowledgment of the opportunity that exists to drive things forward.

**Carolyn Leckie:** Will the member give way?

**The Deputy Presiding Officer (Murray Tosh):** The member is in his final minute.

**Des McNulty:** There are opportunities, not just at the Golden Jubilee hospital but throughout Scotland, to do things faster and better and to be more flexible. If members stay in their ideological boltholes, stuck in their silos, the only people who will lose out are patients. I am in Parliament to sort out waiting times for patients. That is the outcome that I am interested in, so if we can deliver that better—right on.

16:10

**Ms Sandra White (Glasgow) (SNP):** As my colleague Roseanna Cunningham said, there has been a lot of hot air, but we certainly have not moved on. I want to inject a wee bit of honesty into the debate, which will be healthy for Parliament. I suggest to the minister and to members on the Labour benches that the motion was lodged for a different reason from the one that the minister gave. The motion has nothing to do with the fancy document, "Fair to All, Personal to Each". I do not know how much it cost to produce that document, but perhaps we could have employed some more doctors and nurses if less money had been spent on it. I will investigate that and find the answer. We have only just received the document and have had no time to look at it. The minister mentioned waiting times in the Glasgow area. The figures for Glasgow are among the worst in Britain, so I suggest that we are having the debate because of those waiting times and because of the closure of hospitals in Glasgow, although we are told that we are debating the document that has just been published.

**Mr Kerr:** The member talks about "the closure of hospitals in Glasgow". Will she take time to welcome the £700 million investment that the Executive is making in Glasgow?

**Ms White:** Presiding Officer, the minister was not supposed to make a statement—[*Interruption.*] I was coming on—

**The Deputy Presiding Officer:** Order.

**Ms White:** Thank you. I thought that the minister might have some manners. When he addresses someone he should do so to that person's face, not with his back to them. What more can we expect from the minister and the Labour benches?—[*Interruption.*] I will take no interruptions from Duncan McNeil.

The debate has more to do with the fact that there have been closures in Glasgow. The Lib-Lab Executive supported Greater Glasgow NHS Board's proposals to close hospitals, but the board suddenly made a miraculous U-turn and decided to keep the accident and emergency units open at Stobhill hospital and the Victoria infirmary. The SNP welcomes that, as do the people of Glasgow, who fought a hard, long and weary fight to make the board and the Executive see sense and acknowledge that we cannot do without those units. That is why we are having this debate.

There is another reason for the debate. Lo and behold, a little thing called a general election is just around the corner. I wonder whether the fact that there will be a general election in May has something to do with that miraculous U-turn. I challenge the minister to guarantee in his summing up that the units that have just had a reprieve at Stobhill hospital and the Victoria infirmary will stay open long after May 2005. Will the minister put his money where his mouth is and give us that guarantee?

As I said, NHS Greater Glasgow said that the units must be closed, but then gave the hospitals a miraculous reprieve. The facility at the Victoria infirmary was supposed to be replaced by a day centre in 2007. Indeed, in the summer the board said that the process would have to be speeded up because of a chronic lack of staff. Also in the summer, Robert Calderwood, the chief executive of the south Glasgow division of the health board, said that the closure of the unit at Stobhill hospital was imminent because of a chronic lack of staff.

I am pleased that the units will now stay open, but as I said, Glasgow has some of the worst waiting times in the UK. Where will we find the staff to work in the units? Shona Robison was right to say that we should be trying to recruit people from abroad, instead of privatising the health service. The public were right all along; we need those hospitals to stay open, with enough staff to be able to reduce waiting times in the Glasgow area. Will the minister tell us in his summing up how he will ensure that there are staff to work in the units and how he will ensure that staff are not hived off to the private sector?

One of the Labour members said that this is not privatisation and that we are not looking to any other country. I put it to the minister, however, that the proposals mirror what is happening in England, where some health professionals are worried that hospitals might have to close because they will be so unpopular that people will not work in them. That is exactly what is happening now—it is privatisation by the back door.

Duncan McNeil, Des McNulty and all the other Labour members stand there and say, "People don't care how they get their treatment as long as they get it quickly." Fair enough; people want treatment within the recommend timescale, but perhaps those members should get out and speak to their constituents about the matter. They can believe it or not, but their constituents have consciences and do not want the NHS to be privatised. It is true that they want treatment quickly, but they want that treatment kept within the NHS because they care about people. They do not want the health service to be privatised and it is about time that the Labour members learned that.

I will outline the reality of what is happening in the health service right now. A constituent of mine who has had a mastectomy was told that she had to have a check-up in September 2003. However, she was then told that she could not get that check-up until December 2003 because there were insufficient staff. That appointment was put

back again and she was told that she should have the check-up in September 2004. Now, however, she has been told that she will get her appointment in February 2005. That is the reality of the situation that faces the people in our constituencies. Labour members should listen to their consciences and believe what those people tell them. Privatisation of the health service will not help those people.

I ask the minister, where will the staff come from? He should tell us that when he sums up.

16:16

**Helen Eadie (Dunfermline East) (Lab):** I warmly welcome Andy Kerr's announcement. I support the comments of Margaret Jamieson and Mary Scanlon, who spoke about the Audit Committee and the collection of data. The point that the Audit Committee made was also made by the Health Committee.

I have been listening carefully to my colleagues' speeches. In the past week, many MSPs will have received communications from the RCN and the BMA. The conclusions of those bodies are an important contribution to our debate and I accept a great deal of what they have to say, particularly their view that waiting times are important for individual patients who have to wait for treatment. I am sure that we all agree with that. I also agree with their view that focusing on waiting times as a key measurement of NHS performance distorts priorities across the service. Most important, they say that waiting times provide only a snapshot of the performance of a small sector of the service and must be viewed against the background of the fact that 80 per cent of the work of the NHS is not easily measurable. All members accept, I hope, that it is not possible easily to measure performance in primary care and mental health services. However, waiting time figures provide an insight into the changing methods of service delivery in the NHS, such as the provision of day treatment as an alternative to elective in-patient episodes.

We politicians should remember how much the NHS has changed in the past few years, about which a number of my colleagues have talked. Many procedures that are undertaken by the acute services in our hospitals can now be performed in a day and, often, the patient can be placed back in his or her home that same day. Sometimes, a patient can be in hospital for only two or three days for a procedure that would have required them to be in for two weeks or more not many years ago.

It is important to put things in perspective. I ask members to take seriously and reflect on the information that was given to the Health Committee by Dr Andrew Walker, our budget adviser. He presented a table of information that gave members of the committee a good overall perspective on the progress that has been made in more than a decade. He took five specialties that I am sure we all agree are important and common procedures that are carried out in our hospitals. At the beginning of the period that he studied, there were 500 angioplasties a year and, in 2003, there were 2,637—a fivefold increase. In 1991, there were 10,625 cataract operations and by 2002, there were almost 23,000 cataract operations. I could go on and on, but I think that members get the drift. Dr Walker gave us extremely important information that shows the outcomes, the volume and the capacity that the health service is now delivering.

In the days of our grandparents, many of the services that are now provided simply did not exist. A person who needed to have his or her hips replaced would have become housebound or would have been consigned to spending the remainder of his or her life in a wheelchair. We need to recognise the quality of life that our wonderful NHS is beginning to give us, in spite of the warts that we all accept it has.

The BMA expressed concern that excessive emphasis on waiting time targets can mean that patients who have greater clinical need are forced to wait while non-urgent cases are given priority so that a target can be met. The BMA also said that waiting times do not reflect the overall performance of the NHS and that they are a political priority that shifts the focus away from provision of services on the basis of clinical need. We must grapple with that issue.

The BMA also said that there is an international shortage of fully trained doctors. I am sure that we all acknowledge that; the point has been made repeatedly during the debate.

**The Deputy Presiding Officer:** You have one minute left.

**Helen Eadie:** Those of us who have been privileged enough to participate in the Health Committee's workforce planning inquiry know how serious that problem is. Many Governments have failed to attract, educate and train people.

I will skip to the end of my speech, because the Presiding Officer has cut back its length. My key concluding point is about why I disagree with the BMA on the use of the private sector. I believe that the minister is right to turn to the private sector to reduce the length of time that a patient is left waiting for treatment. If one patient is left waiting for treatment, that is one patient too many.

It is instructive to all of us to learn lessons from abroad and the Parliament must do a great deal more work on that. In our health service work, we

have simply not done enough on international comparisons. Some years ago, Sweden contracted the German Government to treat Swedish patients. They were sent to Germany, where there was spare capacity, to have hip replacements. I want the Executive to examine such options and to proceed with using the private sector. Although I have concerns about the use of the private sector, I will support it if the Executive can pay for it and it allows patients to secure treatment. I cannot accept a system in which my and other members' constituents continue to wait in pain or suffering. We must be creative and have a fundamental desire to take urgent action.

16:22

**Margo MacDonald (Lothians) (Ind):** The minister started by giving an impressive list of targets, which were welcomed by my colleague Jean Turner and me. However, Mary Scanlon asked about the other waiting lists—she instanced the waiting list for podiatrists. In my view, that is one of the keys to achieving the objectives that the minister set out. I urge him to consider the less sexy side of what goes on inside our hospitals and clinics. Very often, that is the biggest part of prevention. As we know, prevention is better than cure.

Basically, we have a shortage of beds. That has been obvious in the Lothian NHS Board area over the past few months, even to members from the further reaches of the west coast. I am so sorry that Duncan McNeil, the bum, has left the chamber—that is an in-joke, but I am assured that it is okay to use that word.

**The Deputy Presiding Officer:** Not if you are being discourteous.

**Margo MacDonald:** I think that it is always discourteous to use that word.

**The Deputy Presiding Officer:** In that case, you should not use it.

**Margo MacDonald:** I am happy to have that ruling and I promise that I will not use the word again.

That was a diversion from my argument. In Lothian, the number of beds in the new royal infirmary has been reduced by a third. I can quite understand the reasoning, which was that we would have state-of-the-art theatres and all the rest of it, and that many more people would be put through much more quickly and would not need to stay in hospital. The truth of the matter is that many older people, who have more complex conditions, are going into hospital. Instead of going into hospital and neatly having just one condition seen to, they need to have a number of things seen to, which clogs up the system. That is a simple exemplification of how the bed shortage impacts on the quality of the service.

**George Lyon:** According to the Auditor General's overview report, we have more beds per head of population than has any other part of the United Kingdom. How can the member argue that there is a bed shortage, when it is clear that we are way ahead of the rest of the UK?

**Margo MacDonald:** We have more people who are sick. We know what the health stats are—

**George Lyon:** We have more beds.

**Margo MacDonald:** That is not the issue. The issue is that, because we have many older people, who have more complex conditions, beds are used for longer periods of time, which means that we need more beds. That factor was not taken into account in the calculations that were used when the RIE was planned as a seamless whole of services and equipment. I mention the point in the hope that the minister might reflect on it. The need for more beds must be seen in conjunction with the revolving-door syndrome that sees approximately 5 per cent of patients taking up 20 per cent of bed space. Those are the patients who are either chronically sick or who have a number of things wrong with them.

The introduction of PFI and the way in which resources are allocated in the system together with the recurring feature of the same people requiring more complex care—albeit that it is more sophisticated treatment—contributes to the shortage of beds. I hope that when the Executive plans new hospital buildings in future, it does not look simply at the raw data. It should do things differently and not rely on data that seem to show that more effective surgical procedures mean the need for fewer hospital beds.

General practitioners have told me that when a patient is referred to a particular consultant for, say, a cardiac consultation and the consultant says that the patient is okay, they go out of the system at that point. Instead of that happening, they should be seen by other consultants in other disciplines so that time is not lost and patients do not become more frustrated. The minister could look at the referral system, which needs to be made more sensible. At the moment, staff time is used inefficiently and patients become frustrated because of the long waits between referrals. I am happy to see that the minister is nodding.

With the objective in mind that if we treat the whole person, not only can all of their ailments be taken into account but a more efficient and effective use can be made of resources, I suggest that the minister looks at the multidisciplinary centre that I discussed with him in our meeting earlier this week. I thank the minister for that meeting, as it was most productive. We discussed

the case of a patient who has post-polio syndrome. The best way in which to treat that person would be in a multidisciplinary clinic that was specially geared to the needs of such patients. Indeed, a number of different conditions would be best served by that treatment approach.

Before I conclude, I wonder whether I might be able to answer some of the questions that were posed earlier in the debate. A member on the Labour benches posed the question why the SNP are such ideologues that they object to the use of private medicine. I would have thought that the SNP health spokesperson—her louche language aside—might have explained that the SNP has no objection to taxation, if it can be used further to enhance the health service. We will be using health service money to pay into private practice. If patients were given a choice on the subject, the minister might find that taxation for health is not all that unpopular. I see that he is shaking his head at the suggestion—indeed, I understand why—but he should reflect on it.

The Executive document's intentions are excellent. That said, I fear that the minister has set the same bear trap for himself as his predecessors did of setting so many targets that he now has to hit. What the minister needs is satisfied patients and not targets hit.

16:28

**Carolyn Leckie:** I will open by saying:

"Long term investment in the private sector will take scarce resources away from the NHS … Diverting NHS resources from the NHS and into private provider companies by entering into long term contracts is in direct opposition to the fundamental principles of the National Health Service."

Those are not my words but those of the BMA. What a turnaround we have seen since 1948: the Labour Party now advocates the private provision of health care and the BMA opposes it. I wonder what Nye Bevan would have made of Andy Kerr and Duncan McNeil's speeches or what he would have made of the complete failure to address the health inequalities that, back in 1948, Nye Bevan envisaged the NHS would address.

**Mr Kerr:** Nye Bevan would have said, "You are dealing with the big killers in your communities. It is right to do that." He would also have said, "Put more money into the health service, but let it change and modernise in order to reflect patient need."

**Carolyn Leckie:** And Nye Bevan also said that private provision of health care undermines the ethos of a national universal, comprehensive health service. The minister and Labour members should read their history.

I take exception to a specific point that Andy Kerr made on missed appointments. I am sure that he must know—if he does not, he should check with his advisers—that missed appointments are directly linked to poverty. Instead of support, the minister advocates the exclusion of the most disadvantaged people in our society. He also invoked Thatcher in his speech when he spoke of the NHS as a fossilised institution and he denigrated the NHS in the process.

The Executive's record is one of contraction of the NHS—the minister's statistics prove that—and the contracting out of services to private companies that will be vampires and suck the blood and the life of the NHS. Members might yawn, but they should come back in two years' time and see what has happened. It is clear that Andy Kerr has had a good talking-to by John Reid and was told exactly what he must do: copy the English model, or else.

What of the future? Nursing and other staff may well be poached from local NHS hospitals. That is the model of the English independent treatment centres, which are private facilities outside the NHS that cherry pick low-risk, high-margin operations and leave the complex cases to local NHS hospitals. Waiting times for common operations have certainly fallen where those facilities exist, but tales of botched surgery and poor follow-up for patients are widely reported. Surgeons whose training is not comparable to that of United Kingdom consultants are employed with no long-term responsibility for patients' welfare. Local surgeons find that their waiting lists are taken from them overnight and patients are moved across the country for surgery in strange and distant facilities, then returned after only a short follow-up. Local surgeons have no option but to manage any complications or failures that arise. Patients count only as operations to be completed and dismissed.

Duncan McNeil, who is not here, welcomes the expansion of the Golden Jubilee hospital but how does he reconcile the investment in that hospital with the threat to NHS hospitals in Argyll and Clyde? So much for devolution of health policy. I predicted that Andy Kerr's appointment would represent an increase in privatisation of the NHS in Scotland and I am not pleased to see my clairvoyance being proved right.

The uptake of and necessity for private health insurance are steadily on the increase—the threat is already there. The Government is on a trajectory of not only privatising the delivery of health care but preparing the ground for the privatisation of the funding of health care.

**Mike Rumbles:** Will the member take an intervention?

**Carolyn Leckie:** Very quickly, please.

**Mike Rumbles:** Will the member explain to me how she can say that the health service is being

privatised if the service remains completely free for patients?

**Carolyn Leckie:** The delivery of health care is being done by private companies for profit and they suck resources and staff—by the way, they do not even educate them—from the NHS for the benefit of private profit. It looks like privatisation, it walks like privatisation and it is privatisation. Mike Rumbles might like to delude himself, but that is what it is.

The threat is of the American model of health care, funding and delivery, and what a road we will go down if that becomes the case. Devolution has not protected us from the right-wing ideologues at Westminster. Gordon Brown is sharing dinners with private health care providers from America. Our system has its faults, but the United Kingdom spends £1,126 per head of population, which accounts for 7.1 per cent of gross domestic product. America spends more than £3,000 per head and 13 per cent of its GDP, yet 43 million people have no health insurance and limited access to health care. Is that what we can look forward to?

The policy shows that the devolution of health policy has not protected us from the ravages of the extreme right-wing ideologues at Westminster. We need to take total control of health policy. I ask Andy Kerr to stand up to Tony Blair and John Reid if he can find it within him to do so, although I do not have much faith that that is likely.

16:35

**George Lyon (Argyll and Bute) (LD):** I will bring the debate back from the realms of fantasy into the real world and start with some facts. According to Audit Scotland's latest report on the NHS—which I have here and which is in the Scottish Parliament information centre for anyone to see—since 1995, the number of consultants in the NHS in Scotland has increased by 31 per cent; the number of hospital doctors, by 26 per cent; the number of nurses, by 5 per cent; and the number of allied health professionals, by 37 per cent. We also have 5,000 more beds than England has and, according to the Health Department's figures, 30 per cent more doctors and nurses per head of population than England has.

The charge that we have not invested in capacity does not bear scrutiny. The facts are completely the reverse.

**Shona Robison:** What are the current vacancy rates for nurses and doctors in the NHS?

**George Lyon:** I am sorry, but the facts are in the Audit Scotland report. The investment has been made and the number of bodies working in the service and the number of beds in the system are at an all-time high. The key issue that faces us is the productivity of the service, not capacity in its own right. Although the output figures—the activity figures—in the Auditor General's report show that elective activity is declining, day-surgery activity has risen rapidly. However, there is a worry, because it peaked in 2001 and has started to flatten off and decrease slightly in the past couple of years. There needs to be a step change in the day-surgery rates in Scotland, because we are lagging well behind England in that regard, and I hope that the minister will take action on that.

I welcome the minister's decision to engage with the private sector to try to up the activity levels and productivity of the NHS in Scotland and reduce waiting times. I do not think that there are any members who do not accept that we want to drive down waiting times. We can all buy into that goal, because it is a sensible and pragmatic approach.

The most important point of all is that treatment is free at the point of delivery. Carolyn Leckie made a point about private contractors; GPs are self-employed, private contractors, so should they not be employed in the NHS? That is what she argues for.

**Carolyn Leckie:** George Lyon should know that the Scottish Socialist Party has argued consistently that GPs should indeed be NHS employees. How can he claim that the Executive is increasing capacity in the NHS when Labour has presided over a cut of 8,000 staffed beds since it came to power in 1997? I ask him to justify that.

**George Lyon:** The facts are clear if Carolyn Leckie cares to read them: in Scotland, we have twice as many beds per head of population as the English have. That is a fact, and it is time that Carolyn Leckie listened to some of the facts.

We need to go further on productivity in the system. The minister indicated in his speech that he will introduce tariffication in the spring. If we are to go down that road, that surely also requires us to think seriously about enabling the primary care sector to commission services, as happens in every other health system in the United Kingdom.

**Mary Scanlon:** Will George Lyon give way?

**George Lyon:** I am sorry, but I have taken quite a number of interventions and need to make progress.

The current primary care system's great drawback is that it is too often a referral service rather than a treatment service. We need to empower the primary care sector to maximise the number of patients who are treated locally. Patient involvement in the health service is 96 per cent with GPs and local district hospitals; it is local delivery of services, and we must incentivise those

working in primary care to increase the number of specialist services that can be delivered locally. Unless we empower the primary care providers to do that, there is a real danger that resources will be sucked into the acute sector and local services will diminish, which will lead to even greater demands being put on the acute sector. In my view, that is a vicious downward spiral, and I hope that the minister will keep an open mind on the issue. The other health services in the United Kingdom have retained the right of the primary care sector to commission services. We will have to think about that.

A further issue is the consultant contract. The basis of that contract, according to Audit Scotland's analysis, seems to be that consultants are now to be contracted to do 30 hours of NHS time, instead of 20 hours as under the current contract. In return, they have a significant pay increase. The big weakness is that, in Scotland, very few consultants work fewer than 30 hours a week anyway. As far as output levels are concerned, that means that we have bought nothing for that big increase in consultants' pay. In England, on the other hand, huge quantities of private time have been bought back, so activity levels are going up there.

There are three choices before us. First, there is the fossilisation agenda of the SNP. Shona Robison spent 12 minutes on anti-private sector ranting. It is hard to believe that she and Jim Mather are in the same party. Patients can wait as far as the SNP is concerned—"We don't care," seems to be the message. The Tories' agenda was not even mentioned today—it seemed to slip by without notice. Patient passports and an agenda of drawing down NHS budgets to subsidise well-off patients' private operations are what the Tories are really all about. The real choice is to support the next steps that are being proposed by this coalition's minister to up productivity through the use of the private sector, to deliver further radical reforms and to meet our ambitious targets on waiting times. I support the motion in the minister's name.

16:41

**Mrs Nanette Milne (North East Scotland) (Con):** This has been an interesting debate, which has clearly shown the political divide across the chamber. The Executive is still focused on running the NHS from the centre and it has been forced at last into augmenting NHS capacity by using the private sector in order to reduce waiting times for patients. The SNP and others determine that only the public sector can be involved. Only the Conservative party truly seeks to put patients at the heart of the NHS, with clinical priorities to be decided by NHS professionals and with funding going with the patient, allowing services to develop according to patient choice and need rather than political diktat.

I am glad that Labour at last accepts that providing NHS patients with treatment in the private sector does not equate to privatising the health service. Labour members did not believe us when we tried to tell them that, but I am glad that they agree with us at last. We agree that most health care can be, and is, delivered at primary care level. However, we differ in our proposals for secondary care delivery. Our policy of allowing GPs to commission services for their patients, thus opening up choice for them, was just settling in when the new Government scrapped it in 1997 and we ended up with the centrally driven, target-chasing bureaucracy that is failing patients today. It was interesting to note that, just last week, the general practitioners sub-committee of the BMA—hardly a right-wing organisation—said that it wanted a return to GP commissioning.

The Scottish Executive has set targets throughout the NHS, and we have heard many more from the minister today. Those include targets for coronary artery disease, cancer and strokes and targets for waiting lists and waiting times, which have in recent years often resulted in easily dealt with and relatively minor conditions being treated at the expense of some of the more complex, serious medical problems. Each target set spawns its own bureaucratic paper chase to ensure that it is met. Valuable resources go on funding that instead of on funding front-line services, while patients wait longer.

**Mike Rumbles:** Is the member going to tell us about the Conservatives' plans for the patient passport, where money is taken out of the national health service to subsidise private patients, or has that proposal now been abandoned by the Conservatives?

**Mrs Milne:** I am not going to speak about the patient passport. Mike Rumbles has raised the matter umpteen times since I became a member and he has had it explained to him umpteen times, yet he does not seem able to understand—so, no: I will carry on with my speech.

**Mike Rumbles:** So she is not going to explain it.

**The Deputy Presiding Officer:** Order.

**Mrs Milne:** This morning, I heard the health economist Dr Andrew Walker speaking on the radio. He was saying that it would be sensible to scrap targets, but he added that politics would not be likely to allow that to happen. He sounded as if he regretted that.

I do not deny that progress has been made in tackling mortality related to coronary artery disease, strokes and some forms of cancer.

Indeed, I welcome that. However, much of that is due to improvements in medical technology and pharmacology rather than to Government intervention. Nevertheless, as we know, we are still facing a time bomb with regard to obesity and type 2 diabetes.

Mary Scanlon was right to raise the issue of co-operation between health and social services in getting help for patients from associated health professionals. However, I do not think that that will ever really work properly until the budget for the two is unified, preferably under the umbrella of the health service.

There are umpteen patients with all sorts of medical problems who are still waiting far too long for specialist diagnosis and treatment, resulting in unnecessary pain and suffering and a significant loss of resource for the national economy. As Roseanna Cunningham described graphically, ENT waiting times are still far too long and I, too, am aware of patients who have waited well over a year to get an out-patient ENT appointment.

In Grampian, complex measures have had to be put in place to cope with the diagnosis and treatment of breast lumps. Screening for colorectal cancer is stretching a colonoscopy service that is not ready to cope with the resultant increased demand. I heard on Sunday that 390 people in Grampian are awaiting assessment of sleep apnoea with a waiting time of more than three years. Heavy goods vehicle drivers are being fast tracked to a wait of six months, during which they are at risk of falling asleep while driving on our roads and motorways. What is that costing the NHS as a result of road accidents, not to mention the distress to the individuals concerned?

Why is the Executive not doing more to tackle bedblocking in the NHS? Care homes in the independent and voluntary sectors are closing by the week because they are not receiving enough money to cover the costs of looking after residents who are not self-funding. If those homes were to be given the realistic funding that they seek, many elderly patients who no longer need medical treatment could, as David Davidson said, be released from hospital and free up their beds for patients awaiting treatment.

Back in the early 1980s Margaret Thatcher, who I am proud to mention, was the first person to question how money was being spent in the bottomless pit of the NHS. After seeing research, she decided that the service should become patient focused with money following the patient through the system. However, because that was a Tory idea, the new Labour Government scrapped the policy and instead started throwing increasing amounts of money at the system with central control of how it was spent. That clearly has not worked and it is time for reform. Patients' needs must be at the centre of the service. They should be given the choice to move anywhere within the NHS and we agree that its capacity should be supplemented, when necessary, through collaboration and partnership with the independent and voluntary sectors.

If health professionals and local managers were given the freedom locally to respond to patients' needs and the resources to commission their care, money would follow the patients and fund health care where and when the patient chose to go for it. The resultant reduction in bureaucracy, which inevitably surrounds a centrally targeted approach, would allow much more resource to be freed up for front-line care. That is the least that we can offer our dedicated and hard-working NHS staff and the long-suffering patients who wait for their care. I am therefore happy to support the amendment in David Davidson's name.

**The Deputy Presiding Officer:** I regret to note at this stage that two members who have spoken in the debate have not had the courtesy to return to the chamber for the closing speeches.

16:48

**Stewart Stevenson (Banff and Buchan) (SNP):** I start by welcoming some frank honesty on the part of the Executive. Paragraph 1.2 of "Fair to All, Personal to Each", which I received during the debate, states:

> "While health is improving for the vast majority of Scotland's people, it is improving fastest for those who are most affluent."

That is the issue on which Duncan McNeil touched when referring to his constituents. It is an issue about which, after seven years of Labour Government, we should express concern.

In paragraph 1.8, the minister states:

> "Services should be as local as possible, and as specialised as necessary."

I suspect that those sentiments will gain wide support. Whether the Executive's plans and practices deliver on them is another issue.

Paragraph 3.18 is about clearer and more consistent definitions and paragraph 3.19 states:

> "Patients who fail to turn up for an appointment or admission without prior warning will return to the start of the waiting queue".

We have heard about the welcome abolition of availability status codes, but there is a real difficulty, which I will illustrate with an example from one of my constituents. An elderly frail lady who lives in Fraserburgh was given an appointment in Aberdeen for an afternoon clinic in August. The lady had no transport of her own, so she inquired at patient transport services, only to

discover that they could not give her a return trip for an afternoon clinic. Her son—her carer—does not work and has an income in the order of £70 a week. It was suggested that they should take a taxi home and claim the cost back later. On their income, that is not possible. The effect is that, as of this date in December, we still do not know what patient transport might be offered to that lady for which she and her son would not have to pay in advance. She is now off the waiting list.

**Mr Kerr** *rose—*

**Stewart Stevenson:** I will give way, as the minister is itching to comment.

**Mr Kerr:** The situation that the member describes is unacceptable. That is why I have asked the health service to work harder on patient-focused booking systems. Good examples exist throughout the country, but they are not widespread enough. I hope that that addresses his constituent's concern.

**Stewart Stevenson:** Nonetheless, that lady has lost her place on the waiting list. That is an important point. However, I am glad to hear that the Executive is addressing the problem. I do not disregard the fact that the minister shares with many in the chamber a commitment to improve the health service. We criticise what the Executive does and ask whether it achieves improvements. [*Interruption.*] I see Mike Rumbles making some remark from a sedentary position. He should listen up.

**Mike Rumbles:** Will the member give way?

**Stewart Stevenson:** No. I do not have time, but if the member keeps listening I might take an intervention from him later.

A little Cinderella has disappeared from the document more or less altogether. Page 5 contains two references to dentistry in a table, but the rest of the document contains not a single word about it. It is a curious fact that, if someone wishes to have dental treatment, the only place where they will have it with reasonable effectiveness is Scotland's prisons, where the average wait is one week. In much of Scotland, the wait is interminable and the document says nothing much more about it.

At the end of the document, we read something of better IT for the health service, but no numbers for the investment in e-health are quoted. It was claimed that we are ahead of the rest of the UK. The health service in England and Wales is spending £8 billion to improve its IT. It is time that we considered whether we can piggyback on what colleagues that deal with many culturally similar issues in the health service are doing. They are making changes in advance, so that the health service is prepared for other initiatives. Too many initiatives that the Executive has taken have reduced the health service's efficiency. That is why we do not see a return for the money that is being provided.

**Mike Rumbles:** What would the member do?

**The Deputy Presiding Officer:** Order.

**Stewart Stevenson:** NHS 24 is an example of such an initiative. Trained nurses are sitting at phone banks to do triage. That takes on average 20 minutes. They use American software that is not even culturally appropriate for many issues here. For example, the third question that is to be asked of someone who has a sore throat—I will turn it into technical language—is whether they have recently indulged in fellatio.

**Mike Rumbles:** Will the member please tell us what the SNP wants to do?

**Stewart Stevenson:** I will. However, Mr Rumbles should remember that the debate is about the minister's announcements.

By the same token, under out-of-hours cover, we have more people going to places that have no record of their health. That reduces the health service's overall efficiency, which is why we must put money into IT. The Executive is to do that after the event, not before. It is paying the price of inefficiency when we need greater efficiency.

Private health care is a source of potential inefficiency. In a transfer from one consultant to another in the private sector, an additional consultation is involved or continuity is lost with the person to whom a patient originally presented. Alternatively, the same consultant is used in the private sector. How is that a good idea?

I will describe what we would do—as I promised Mr Rumbles—in the 40 seconds that remain for my speech. We would expand diagnostic and treatment centres. In England, 20 centres operate. It is interesting that that major contribution comes from within the health service. The private sector has made a minimal contribution of two centres so far. That shows what the health service can do.

The debate is entitled "Fair to All, Personal to Each". That is a good title. However, it is not fair to all to waste money on the private sector or personal to each to close hospitals in local communities throughout Scotland. I support the amendment lodged by my colleague Shona Robison.

**The Deputy Presiding Officer:** Before Rhona Brankin winds up the debate, I ask members to cut out their side conversations.

16:55

**The Deputy Minister for Health and Community Care (Rhona Brankin):** Members have made a wide range of points in this

Executive debate, which demonstrates the truth of something that the Executive has consistently said and that Andy Kerr has repeated today—health and health care services are vital to us all in Scotland.

I will restate some key points about the Executive's position on health and health care. First, we are committed to improving individuals' health in Scotland. We heard shocking figures in Andy Kerr's opening speech and in Duncan McNeil's passionate speech about his constituency. Whatever else has been said this afternoon must be seen in the context of life expectancy for a boy who is born in Shettleston being no more than 65 years. Everybody in Scotland wants to change that situation for the better.

It is worth restating that mortality rates from Scotland's three big killers are coming down. They have come down a long way, but they need to come down further. The new investment and the new targets that Andy Kerr has announced today will make a real contribution to that—for example, in reinforcing the NHS's efforts to tackle heart disease and cancer.

We have made it clear that patients are at the heart of our NHS. That is why we are investing more in health care services and why we will press forward with the NHS programmes of redesign and reform to improve patients' experience and to cut waiting times in accessing general practitioners and their teams, in out-patient services and diagnostics and in hospital treatment. The package of investment and reform that we have announced places patients firmly at the heart of the NHS. It is good medicine and I believe that it will be welcomed by NHS staff throughout Scotland.

No clinician wants to keep a patient waiting for months for an out-patient appointment or a diagnostic test. Our commitment to setting new diagnostic waiting times standards and to putting additional investment into diagnostic investigations will tackle the issue head on.

**Carolyn Leckie:** Will the contracts for the private sector guarantee contractors a set number of patients and a set income over a set period of time, even if the local hospital has the capacity? If patients refuse to go to an independent treatment centre, will they be punished by being put to the back of the queue?

**Rhona Brankin:** I assure Carolyn Leckie that work on the contracts is going on at the moment and that we will make absolutely sure that patients remain at the centre of everything that we do within the NHS. There is no doubt about that.

We have emphasised our absolute commitment to, and support for, the ethos of the NHS. I am talking about the ethos of equity and fairness; I am talking about services being available and accessible to everyone, regardless of their ability to pay, and free at the point of use. As someone with a Welsh father, I will take no lessons about what Nye Bevan said.

We are not prepared to turn our backs on ways of speeding up treatment for NHS patients by using capacity and expertise in the independent sector. Of course, the independent sector will never provide more than a small fraction of the total health care services that are required in Scotland but, if it can make a contribution, we should use it, which we intend to do.

It is worth reminding ourselves that the NHS is experiencing the biggest hospital building programme in history. Further major new hospitals are planned for Forth Valley and Fife and a £700 million investment programme is scheduled for Glasgow. Andy Kerr referred to £125 million going into medical equipment over the next three years. That is the context in which I will refer to key points that members have made.

Shona Robison asked why we should not recruit more staff into the NHS instead of expanding the private sector. That is exactly what the NHS is doing. It is recruiting more doctors and nurses, offering flexible working and recruiting staff who want to come back from overseas and work in Scotland. If the independent sector, which already employs some staff in Scotland, can find more staff—for example, from overseas or from England—that must be good for Scotland. Of course, anti-poaching terms will be included in any contracts.

**Shona Robison:** Will the minister give way?

**Rhona Brankin:** I want to move on and refer to some of the points that were made earlier.

John Swinney and others talked about capacity. It is important that we challenge some of the perceptions. Bed numbers will change as services change—for example, as more operations are carried out as day cases. We need more capacity in, for example, diagnostic procedures such as magnetic resonance imaging scans and endoscopy, but we do not necessarily need more beds.

Carolyn Leckie and Margo MacDonald referred to the loss of 8,000 staffed beds. Almost all those were mental health and learning disability beds in institutions that are now closed, such as the Lennox Castle and Gogarburn hospitals. Are they seriously suggesting that we should reopen those hospitals?

Carolyn Leckie made the point that the costs at the Golden Jubilee hospital are high in comparison with those at other hospitals. However, the Golden

Jubilee hospital undertakes a higher proportion of very complex procedures, such as heart bypass and major hip and knee-joint surgery. Therefore, the costs are not directly comparable. Moreover, it is important to remember that, as activity at the hospital increases, unit costs will fall.

Regarding the various amendments that have been lodged by the Opposition parties, I am disappointed that, apart from Jean Turner's, none appears to support the emphasis that we are placing on health promotion and tackling the underlying causes of ill health. I ask the Parliament to oppose the amendments and to support the motion in the name of Andy Kerr, the Minister for Health and Community Care.

# Business Motion

17:02

**The Presiding Officer (Mr George Reid):** The next item of business is consideration of business motion S2M-2169, in the name of Margaret Curran, on behalf of the Parliamentary Bureau, setting out a business programme.

*Motion moved,*

That the Parliament agrees the following programme of business—

| | |
|---|---|
| Wednesday 22 December 2004 | |
| 2.30 pm | Time for Reflection |
| *followed by* | Parliamentary Bureau Motions |
| *followed by* | Ministerial Statement on Concessionary Fares |
| *followed by* | Stage 3 of the Emergency Workers (Scotland) Bill |
| *followed by* | Motion on the Code of Practice for Ministerial Appointments to Public Bodies |
| *followed by* | Business Motion |
| *followed by* | Parliamentary Bureau Motions |
| 5.00 pm | Decision Time |
| *followed by* | Members' Business |
| Thursday 23 December 2004 | |
| 9.30 am | Parliamentary Bureau Motions |
| *followed by* | Finance Committee Debate: Stage 2 of the 2005-06 Budget Process |
| 12 noon | First Minister's Question Time |
| 2.00 pm | Question Time—Education and Young People, Tourism, Culture and Sport; Finance and Public Services and Communities; General Questions |
| *followed by* | Parliamentary Bureau Motions |
| 3.00 pm | Decision Time |
| *followed by* | Members' Business |
| Wednesday 12 January 2005 | |
| 2.30 pm | Time for Reflection |
| *followed by* | Parliamentary Bureau Motions |
| *followed by* | Executive Business |
| *followed by* | Business Motion |
| *followed by* | Parliamentary Bureau Motions |
| 5.00 pm | Decision Time |
| *followed by* | Members' Business |
| Thursday 13 January 2005 | |
| 9.30 am | Parliamentary Bureau Motions |
| *followed by* | Executive Business |
| 12 noon | First Minister's Question Time |

| | |
|---|---|
| 2.00 pm | Question Time—Environment and Rural Development; Health and Community Care; General Questions |
| 3.00 pm | Executive Business |
| *followed by* | Parliamentary Bureau Motions |
| 5.00 pm | Decision Time |
| *followed by* | Members' Business.—[*Ms Margaret Curran.*] |

*Motion agreed to.*

# Parliamentary Bureau Motions

17:02

**The Presiding Officer (Mr George Reid):** The next item of business is consideration of four Parliamentary Bureau motions. I ask Margaret Curran to move motion S2M-2159, on decision time, and motions S2M-2160 to S2M-2162, on the designation of lead committees.

*Motions moved,*

That the Parliament agrees under Rule 11.2.4 of Standing Orders that Decision Time on Thursday 23 December 2004 be taken at 3.00 pm.

That the Parliament agrees that the Justice 1 Committee be designated as lead committee in consideration of the Part 1 Land Reform (Scotland) Act 2003: Draft Guidance for Local Authorities and National Park Authorities (SE/2004/276).

That the Parliament agrees that the Justice 2 Committee be designated as lead committee in consideration of the Fire Services (Appointments and Promotion) (Scotland) Regulations 2004 (SSI 2004/527).

That the Parliament agrees that the Justice 1 Committee be designated as lead committee in consideration of the Act of Sederunt (Fees of Sheriff Officers) 2004 (SSI 2004/513).—[*Ms Margaret Curran.*]

**The Presiding Officer:** The questions on those motions will be put at decision time.

# Decision Time

17:03

**The Presiding Officer (Mr George Reid):** There are nine questions to be put as a result of today's business. The first question is, that amendment S2M-2155.3, in the name of Shona Robison, which seeks to amend motion S2M-2155, in the name of Andy Kerr, on "Fair to All, Personal to Each: The next steps for NHSScotland", be agreed to. Are we agreed?

**Members:** No.

**The Presiding Officer:** There will be a division.

**FOR**

Adam, Brian (Aberdeen North) (SNP)
Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Canavan, Dennis (Falkirk West) (Ind)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Frances (West of Scotland) (SSP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Fox, Colin (Lothians) (SSP)
Gibson, Rob (Highlands and Islands) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Lochhead, Richard (North East Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
MacDonald, Margo (Lothians) (Ind)
Martin, Campbell (West of Scotland) (Ind)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
McFee, Mr Bruce (West of Scotland) (SNP)
Neil, Alex (Central Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Sheridan, Tommy (Glasgow) (SSP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinney, Mr John (North Tayside) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)

**AGAINST**

Aitken, Bill (Glasgow) (Con)
Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Richard (North East Scotland) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Davidson, Mr David (North East Scotland) (Con)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Douglas-Hamilton, Lord James (Lothians) (Con)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Finnie, Ross (West of Scotland) (LD)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Goldie, Miss Annabel (West of Scotland) (Con)
Gorrie, Donald (Central Scotland) (LD)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Johnstone, Alex (North East Scotland) (Con)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lyon, George (Argyll and Bute) (LD)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McLetchie, David (Edinburgh Pentlands) (Con)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mundell, David (South of Scotland) (Con)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Tosh, Murray (West of Scotland) (Con)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)

Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

**ABSTENTIONS**

Swinburne, John (Central Scotland) (SSCUP)

**The Presiding Officer:** The result of the division is: For 39, Against 81, Abstentions 1.

*Amendment disagreed to.*

**The Presiding Officer:** The second question is, that amendment S2M-2155.1, in the name of David Davidson, which seeks to amend motion S2M-2155, in the name of Andy Kerr, on "Fair to All, Personal to Each: The next steps for NHSScotland", be agreed to. Are we agreed?

**Members:** No.

**The Presiding Officer:** There will be a division.

**FOR**

Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (West of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Mundell, David (South of Scotland) (Con)
Scanlon, Mary (Highlands and Islands) (Con)
Tosh, Murray (West of Scotland) (Con)

**AGAINST**

Adam, Brian (Aberdeen North) (SNP)
Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Frances (West of Scotland) (SSP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fox, Colin (Lothians) (SSP)
Gibson, Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Gorrie, Donald (Central Scotland) (LD)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kane, Rosie (Glasgow) (SSP)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Leckie, Carolyn (Central Scotland) (SSP)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lochhead, Richard (North East Scotland) (SNP)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
MacDonald, Margo (Lothians) (Ind)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Campbell (West of Scotland) (Ind)
Martin, Paul (Glasgow Springburn) (Lab)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Sheridan, Tommy (Glasgow) (SSP)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Sturgeon, Nicola (Glasgow) (SNP)
Swinney, Mr John (North Tayside) (SNP)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)

Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

**ABSTENTIONS**

Swinburne, John (Central Scotland) (SSCUP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

**The Presiding Officer:** The result of the division is: For 17, Against 103, Abstentions 2.

*Amendment disagreed to.*

**The Presiding Officer:** The third question is, that amendment S2M-2155.4, in the name of Carolyn Leckie, which seeks to amend motion S2M-2155, in the name of Andy Kerr, on "Fair to All, Personal to Each: The next steps for NHSScotland", be agreed to. Are we agreed?

**Members:** No.

**The Presiding Officer:** There will be a division.

**FOR**

Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Canavan, Dennis (Falkirk West) (Ind)
Curran, Frances (West of Scotland) (SSP)
Fox, Colin (Lothians) (SSP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
MacDonald, Margo (Lothians) (Ind)
Martin, Campbell (West of Scotland) (Ind)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Sheridan, Tommy (Glasgow) (SSP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

**AGAINST**

Aitken, Bill (Glasgow) (Con)
Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Richard (North East Scotland) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Davidson, Mr David (North East Scotland) (Con)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Douglas-Hamilton, Lord James (Lothians) (Con)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Finnie, Ross (West of Scotland) (LD)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Goldie, Miss Annabel (West of Scotland) (Con)
Gorrie, Donald (Central Scotland) (LD)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Johnstone, Alex (North East Scotland) (Con)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lyon, George (Argyll and Bute) (LD)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mundell, David (South of Scotland) (Con)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Tosh, Murray (West of Scotland) (Con)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

**ABSTENTIONS**

Adam, Brian (Aberdeen North) (SNP)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Gibson, Rob (Highlands and Islands) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Lochhead, Richard (North East Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
Marwick, Tricia (Mid Scotland and Fife) (SNP)

Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
McFee, Mr Bruce (West of Scotland) (SNP)
Neil, Alex (Central Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinburne, John (Central Scotland) (SSCUP)
Swinney, Mr John (North Tayside) (SNP)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)

**The Presiding Officer:** The result of the division is: For 17, Against 82, Abstentions 23.

*Amendment disagreed to.*

**The Presiding Officer:** The fourth question is, that amendment S2M-2155.2, in the name of Dr Jean Turner, which seeks to amend motion S2M-2155, in the name of Andy Kerr, on "Fair to All, Personal to Each: The next steps for NHSScotland", be agreed to. Are we agreed?

**Members:** No.

**The Presiding Officer:** There will be a division.

**FOR**

Adam, Brian (Aberdeen North) (SNP)
Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Canavan, Dennis (Falkirk West) (Ind)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Frances (West of Scotland) (SSP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Fox, Colin (Lothians) (SSP)
Gibson, Rob (Highlands and Islands) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Lochhead, Richard (North East Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
MacDonald, Margo (Lothians) (Ind)
Martin, Campbell (West of Scotland) (Ind)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
McFee, Mr Bruce (West of Scotland) (SNP)
Neil, Alex (Central Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Sheridan, Tommy (Glasgow) (SSP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinburne, John (Central Scotland) (SSCUP)
Swinney, Mr John (North Tayside) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)

**AGAINST**

Aitken, Bill (Glasgow) (Con)
Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Richard (North East Scotland) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Davidson, Mr David (North East Scotland) (Con)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Douglas-Hamilton, Lord James (Lothians) (Con)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Finnie, Ross (West of Scotland) (LD)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Goldie, Miss Annabel (West of Scotland) (Con)
Gorrie, Donald (Central Scotland) (LD)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Johnstone, Alex (North East Scotland) (Con)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lyon, George (Argyll and Bute) (LD)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mundell, David (South of Scotland) (Con)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)

Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Tosh, Murray (West of Scotland) (Con)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

**The Presiding Officer:** The result of the division is: For 40, Against 83, Abstentions 0.

*Amendment disagreed to.*

**The Presiding Officer:** The fifth question is, that motion S2M-2155, in the name of Andy Kerr, on "Fair to All, Personal to Each: The next steps for NHSScotland", be agreed to. Are we agreed?

**Members:** No.

**The Presiding Officer:** There will be a division.

**FOR**

Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Richard (North East Scotland) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Gorrie, Donald (Central Scotland) (LD)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lyon, George (Argyll and Bute) (LD)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Swinburne, John (Central Scotland) (SSCUP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

**AGAINST**

Adam, Brian (Aberdeen North) (SNP)
Aitken, Bill (Glasgow) (Con)
Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Canavan, Dennis (Falkirk West) (Ind)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Frances (West of Scotland) (SSP)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fox, Colin (Lothians) (SSP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Gibson, Rob (Highlands and Islands) (SNP)
Goldie, Miss Annabel (West of Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Johnstone, Alex (North East Scotland) (Con)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Lochhead, Richard (North East Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
Martin, Campbell (West of Scotland) (Ind)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
McFee, Mr Bruce (West of Scotland) (SNP)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Mundell, David (South of Scotland) (Con)
Neil, Alex (Central Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)

Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, John (Ayr) (Con)
Sheridan, Tommy (Glasgow) (SSP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinney, Mr John (North Tayside) (SNP)
Tosh, Murray (West of Scotland) (Con)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)

**ABSTENTIONS**

MacDonald, Margo (Lothians) (Ind)

**The Presiding Officer:** The result of the division is: For 67, Against 55, Abstentions 1.

*Motion agreed to.*

That the Parliament notes that continuing action is needed to turn round the poor health of many people in Scotland; supports the emphasis that the Scottish Executive has placed, across portfolios, on health promotion; agrees that the Executive is right in tackling the three big killers of coronary heart disease, cancer, and stroke and recognises the progress made to date in reducing mortality rates from these diseases; believes in putting patients first so that they are at the heart of NHS service developments and priorities, and supports the Executive's determination to target additional investment and increase capacity so that the next steps are focused on reducing waiting for out-patient appointments and hospital admissions, on speeding diagnostic tests and on extending patient choice.

**The Presiding Officer:** The sixth question is, that motion S2M-2159, in the name of Margaret Curran, on decision time, be agreed to.

*Motion agreed to.*

That the Parliament agrees under Rule 11.2.4 of Standing Orders that Decision Time on Thursday 23 December 2004 be taken at 3.00 pm.

**The Presiding Officer:** The seventh question is, that motion S2M-2160, in the name of Margaret Curran, on the designation of a lead committee, be agreed to.

*Motion agreed to.*

That the Parliament agrees that the Justice 1 Committee be designated as lead committee in consideration of the Part 1 Land Reform (Scotland) Act 2003: Draft Guidance for Local Authorities and National Park Authorities (SE/2004/276).

**The Presiding Officer:** The eighth question is, that motion S2M-2161, in the name of Margaret Curran, on the designation of a lead committee, be agreed to.

*Motion agreed to.*

That the Parliament agrees that the Justice 2 Committee be designated as lead committee in consideration of the Fire Services (Appointments and Promotion) (Scotland) Regulations 2004 (SSI 2004/527).

**The Presiding Officer:** The ninth question is, that motion S2M-2162, in the name of Margaret Curran, on the designation of a lead committee, be agreed to.

*Motion agreed to.*

That the Parliament agrees that the Justice 1 Committee be designated as lead committee in consideration of the Act of Sederunt (Fees of Sheriff Officers) 2004 (SSI 2004/513).

# Rural Abattoirs

**The Presiding Officer (Mr George Reid):** The final item of business is a members' business debate on motion S2M-1721, in the name of Eleanor Scott, on rural abattoirs. The debate will be concluded without any question being put.

*Motion debated,*

That the Parliament notes that the number of red meat abattoirs in Scotland has fallen from 79 to only 44 in the past 20 years, whereas Austria has sustained over 3,000 slaughter facilities in this period; deplores this reduction, given the detrimental impact on animal welfare that results from increased transportation times; recognises the benefits to rural livelihoods, animal welfare and local food production that more rural abattoirs would bring, and considers that the Scottish Executive should invest in, and support the establishment of, new, modern slaughterhouses throughout rural Scotland.

17:11

**Eleanor Scott (Highlands and Islands) (Green):** "Greens promote slaughterhouses" is not a headline that most people would expect, but I am grateful for the chance to raise this important issue in the Parliament. I am also grateful for the responses that I received when notice of the motion went out, almost all of which were supportive and all of which were helpful. I received responses from the Scottish Society for the Prevention of Cruelty to Animals, Advocates for Animals, the Scottish estates business group, the Scottish Rural Property and Business Association, the Scottish Federation of Meat Traders Associations, individual farmers and butchers, Highland Council, the Scottish Countryside Alliance and the Scottish Crofting Foundation. I apologise if I have left out any names.

I start with a potted history. Until 1971, local authorities were obliged to provide slaughterhouse facilities in their area. That obligation was removed by the Secretary of State for Scotland in 1971, which resulted in the closure of a large number of abattoirs that had presumably been a burden on councils. There followed a process of consolidation of slaughtering facilities into fewer abattoirs. Private butchers found it difficult to get slaughtering of a few beasts at a time done.

The livestock committee of the Scottish Federation of Meat Traders Associations supported the formation in the 1970s and 1980s of some co-operative slaughtering enterprises, which are still trading. Some butchers, such as John M Munro Ltd in Dingwall, which is responsible for slaughtering and wholesale meat provision in the Highlands, developed their own slaughtering business.

The next big change was the introduction of European Union regulations requiring the presence of a vet throughout the slaughtering process. When the regulations were introduced, they did not replace the previous Meat Hygiene Service but were simply grafted on to existing practice. That has proved very expensive for abattoirs and has a particularly strong impact on smaller ones. I have watched abattoirs in action, and it seems that there is a great deal of duplication between what vets and meat hygiene inspectors do. I believe that the service could be rationalised and made cheaper and more efficient.

Another issue is the disposal of animal waste, which is both a financial burden on slaughterhouses and a difficulty to be overcome in setting up any facility, especially if the current derogation in relation to landfilling for the islands ends. There is a feeling in all sectors of the meat industry that successive regulations have not been rural proofed when they are introduced. As a result, since 1984, the number of red-meat abattoirs in Scotland has fallen from 79 to 44, whereas Austria, which operates under the same EU regulations, still has 3,000.

**Alex Fergusson (Galloway and Upper Nithsdale) (Con):** Will the member confirm that one of the main reasons why Austria has managed to maintain a large number of rural abattoirs is that for many years it enjoyed a derogation from the European regulations?

**Eleanor Scott:** The Austrians have opted for what are called micro-abattoirs. They do not see the need for consolidation, as they value very small facilities—smaller than the facilities that I am talking about.

**Maureen Macmillan (Highlands and Islands) (Lab):** How does the Austrian Government monitor so many slaughterhouses, to ensure that they are keeping to the regulations?

**Eleanor Scott:** I do not know the answer to that question. I know only that the Austrians have gone down the road of having very small facilities. I cannot tell Maureen Macmillan about the monitoring process.

It matters if rural slaughterhouses close down. Rural abattoirs are good for animal welfare, biosecurity and rural employment and they help us to make the most of consumers' increasing demand for locally produced food. No one would deny that it is better for animal welfare if we can minimise the distance that animals must travel to slaughter. Rural abattoirs also help biosecurity. The foot-and-mouth outbreak alerted us to the inherent risk in moving animals around the country. We all hope that we never have another such incident, but keeping our food production local is one good defence against the spread of any disease that might affect our animals.

The most obvious benefit of having small local abattoirs is that they provide rural employment.

Marketing of local produce could really benefit our rural areas. Increasingly, both local people and tourists demand locally produced food whose origin they can trace. In the Western Isles, the Co-op in Stornoway has undertaken to source all its lamb from the Stornoway abattoir, so locals and tourists alike can now eat good, local produce. That is just as it should be. Unfortunately, Skye is not so lucky. Skye livestock must be transported at great cost to the east coast. As part of an effort to make the area a Mecca for good-food enthusiasts, a group in Skye and Lochalsh is trying to get an abattoir off the ground. I hope that the Scottish Executive will give every support to that group and to the people of Islay, who are trying to reopen their local abattoir.

The lifting of the over-30-months regulations provides a real opportunity for producers who specialise in the slower-maturing traditional breeds of cattle that are valued by discerning tourists and locals. We need to ensure that there are appropriate slaughter and BSE-testing facilities to make the most of that opportunity. I am aware that we are restricted in what we can do because of state-aid rules, but I believe that we could be more creative in considering what might be done under the rural development regulations. For example, marketing is included as a legitimate use of funding.

Small abattoirs are closing and the prospects for new abattoirs opening are problematic because the regulations, costs and lack of support make it difficult for small operations to be viable. If anything, the situation is likely to get worse in 2006, when the category of low-throughput abattoir is removed. I urge the minister to retain the lifeline cost capping that applies to small units under the Maclean formula.

There are models that we can learn from and build on. The community-owned and community-run facility on Mull is one such model. Another would be to help an existing operator to establish a satellite facility in a remote area. Yet another would be to support the development of a mobile abattoir. The important thing is that we start from the premise that, where possible, local slaughtering is the best option. We need to consider how we can help that to happen.

We also need to change the way in which we consider slaughterhouses. At the moment, we rightly recognise the need for slaughterhouses to conform to certain regulations and so accept that some small slaughterhouses, regrettably, will go out of business. Instead, we should start from the standpoint that we need our small rural abattoirs. As a vital part of the mix that makes up our food industry and rural economies, they should be given every possible help to meet the required standards. Small does not mean substandard. The standards of small abattoirs can be up to the mark.

I hope that the minister will affirm today his support for this important part of our food chain.

**The Presiding Officer:** The debate is substantially oversubscribed, so it will be helpful if speeches are kept as close as possible to three minutes.

17:18

**George Lyon (Argyll and Bute) (LD):** I am pleased to speak in tonight's debate. Although I support the intention behind Eleanor Scott's motion, I have not signed the motion, because I am not sure that I can support the solution that the Green party puts forward. We all agree that we need to support small rural abattoirs, but the question is how we achieve that.

I declare an interest, in that I am still a director of the Rothesay meat producers co-operative that used to operate the local slaughterhouse on Bute. The co-operative is made up of representatives of the local farming community and local butchers. The slaughterhouse operated up until about 1988, when it was completely sunk under the weight of the Meat and Hygiene Service costs that were heaped on the industry as a result of the BSE debacle. The resulting over-regulation was necessary to try to regain the trust of consumers and of the European Commission. We had to show that our regulations were robust and could not be circumvented as had happened before.

My constituency of Argyll and Bute has three abattoirs. Unfortunately, only two of them—the one on Tiree and the one on Mull to which Eleanor Scott referred—are in operation at present. Although the abattoir on Islay is bankrupt, we hope that it will start up again.

Those abattoirs survive not only because they slaughter cattle but because they are supported by the butchers' businesses that are attached to them. Clearly, that model works. Indeed, the weakness with the abattoir in Rothesay on the Isle of Bute was that the butchers did not operate and run it. Because it was run by other employed staff, the costs could not be shared and, at the end of the day, the enterprise could not wash its face.

The key point is that abattoirs should be owned by the business that is also responsible for the retail side. Such businesses have a tremendous future and we must support them.

Again, the issue comes down to sustainability. There are no abattoirs in the north and west partly because there is very little finished stock. Indeed, the only available finished stock is light lambs, which are bound for Spanish and southern European markets, as we all know. There is simply no Scottish trade for small light lambs, so anyone who thinks that someone would buy that

stock if they set up an abattoir to process it has got things the wrong way round. The demand is not there.

**Eleanor Scott:** Will the member give way?

**George Lyon:** I do not want—

**The Presiding Officer:** We are very tight for time.

**George Lyon:** In summary, the key issues are sustainability and the need to ensure a project's viability by attaching a butcher's shop to it. I know that the processing and marketing grant supports the start-up of small rural abattoirs; indeed, that is how the Mull abattoir began. There is a tremendous opportunity to set up abattoirs in other areas of Argyll and Bute and I hope that the Kintyre community will come forward with a proposal that the Executive will support.

17:21

**Jim Mather (Highlands and Islands) (SNP):** I, too, congratulate Eleanor Scott on securing this debate and should tell her that, in lodging this motion, she is the toast of Islay.

I want to build on some of George Lyon's practical and positive suggestions. As he pointed out, this worthy motion has been strongly shaped by the recent experience on Mull, which has an abattoir, a butcher's shop and small-scale specialist meat producers. In that regard, I should mention Aeneas and Minty MacKay, who run an organic farm at Ardalanish near Bunessan that produces quality meat. A visit to their farm is a stimulating experience. People can see the animals, watch the sheep being sheared and the wool being woven, buy organic meat that is as good as any in Scotland and appreciate the biodiversity—in the form of bird life—that has been created as a result of the MacKays' careful organic husbandry of the land.

Putting that approach into practice at Ardalanish has produced nothing less than a little economic miracle. However, as George Lyon said, that miracle is totally dependent on the crucial presence of the local abattoir and the co-op butcher's shop in Tobermory, which has allowed the MacKays to build a strong, viable and—I believe—replicable business model that maximises the retention of value from local produce and improves the value of the visitor experience. Such a virtuous circle and success story would fail if the abattoir were not there. It would simply not be possible for the MacKays to remain viable if they had to bear the cost of transporting live animals from the island and bringing back carcases or butchered meat.

Ardalanish farm has an unsurpassed view of Jura and Islay, neither of which has an operating abattoir. Both islands had such a shared amenity and are currently feeling the loss of it. In fact, I have received more letters and e-mails about this debate from Islay and Jura than I have from anywhere else. That makes Eleanor Scott the toast of those distillery-rich islands and makes the economic and animal welfare case for reopening the abattoir. The correspondence that I have received spells out in great detail the beneficial impact that such a move would have, particularly in producing more local jobs; reducing costs; capturing the full value of the finished beasts; increasing added value by making it easier for local people, hotels and restaurants to access local meat; bolstering the visitor experience and the premium nature of the finished meat; and keeping much more money in local communities. It would also be a key component in triggering and sustaining repeat visits to the island and repeat sales of differentiated, premium meat.

The solid example of the Mull experience bolsters the cases for Islay and Skye, which might be described as latent Mulls that are waiting to retain more of the value of their produce and to enrich the visitor experience. I encourage the Executive to do more to resuscitate abattoirs in such locations, given that they offer a great return on investment in both economic and community terms.

17:25

**Alex Fergusson (Galloway and Upper Nithsdale) (Con):** I join other members in congratulating Eleanor Scott on bringing the subject to the Parliament for debate. I also welcome the fact that the Green party has embraced the Scottish Conservative party's manifesto commitment to explore every possibility that might encourage the reinstatement and reinvigoration of rural abattoirs. As the motion rightly points out, the number of such abattoirs has nearly halved in 20 years.

The pressure is on-going. Earlier this year, in my constituency, one of the last true rural abattoirs in the south of Scotland, the one in Castle Douglas, announced that it would have to close. It has enjoyed a chequered career, including a spell when the local council owned and managed it in a valiant effort to keep it afloat, despite the fact that it no longer had to do so. Everybody in the area hoped that its future was secured when it was taken over by Buccleuch Scotch Beef, an attached downstream business that is a local co-operative that specialises in absolutely top-quality beef and which has proved to be a tremendous success.

That arrangement, which was similar to the one that George Lyon mentioned, encapsulated everything that I believe about how local produce should be dealt with in a perfect world. My belief

applies as much to timber, milk, lamb and other primary produce as it does to beef. Buccleuch Scotch Beef took a product that was born and reared locally, slaughtered and packaged it locally, and distributed it to the wider world only when the last ounce of added economic benefit had been wrung from it. That is what the debate is really about: maximising the beneficial economic impact of local primary produce before it leaves the area and ensuring that local job opportunities are given the highest priority so that the economic trickle-down impacts on the whole community and does not stop at the farm gate. The good news is that Buccleuch Scotch Beef is closing the abattoir only because it is too small to accommodate the required throughput, but the tragedy is that nobody is queuing up to take it over.

Unfortunately, the Green party makes something of an art form out of lodging motions with which I very nearly agree, but which always have something that makes me stop. Like George Lyon, I did not sign the motion, because I cannot agree with the argument about the

"impact on animal welfare that results from increased transportation times".

Eleanor Scott said that nobody would disagree with that point, but I do. The argument is a fallacy and falls into the same category as saying that if something is organic, it is healthier than other products or that an animal that is organically reared has been better treated than other animals have been.

**Chris Ballance (South of Scotland) (Green):** Will the member take an intervention?

**Alex Fergusson:** I am sorry, but I have only three minutes.

Abundant research exists to show beyond any doubt that journey times do not have a detrimental impact, if regulations are adhered to, and that any impact comes during loading and unloading. I do not accept the basic tenet that the journey time has a negative welfare impact. However, I agree that local abattoirs have a wider benefit to the local community and I accept the desirability of slaughtering farm stock as close to the point of production as possible.

If we were to have a vote on the motion, I would support it if the distance/welfare equation were amended out. As it is, I encourage the Executive to endorse the Conservative's policy of exploring every possibility to reinvigorate and encourage the rebirth of local abattoirs. I suspect that the plea to invest in them directly will fall foul of the European state-aid rules, but no doubt the minister will deal with that issue.

I welcome the opportunity to debate the issue, but I am sorry that, even at this time of good will to all men, women and, no doubt, political parties, I cannot give the motion my full support.

17:28

**Maureen Macmillan (Highlands and Islands) (Lab):** This issue is raised constantly with rural MSPs and was raised with me at the weekend when I was down in Kintyre, where the farmers were bemoaning the fact that they do not have a local abattoir and have to haul their animals right up the peninsula and down the other side again to have them slaughtered. The issue raises animal welfare issues. Transporting animals on a nice smooth motorway might not be terribly stressful for them, but going along twisty Highland roads is something else entirely. However, I realise that a balance must be struck between possible animal welfare issues and the costs that are associated with hauling beasts by land and sea.

Another factor is the European Union food safety and animal welfare standards, to which slaughterhouses must adhere. If we had 3,000 slaughterhouses in Scotland, I wonder how difficult it would be to monitor whether they were all doing their job properly. I have an idea that the procedure might be the gun at the back door of the farm, rather than the procedure that we would like to happen.

Like other members, I think that there is an issue about community enterprises that include an abattoir. Jim Mather mentioned the Mull community venture, which is extremely interesting. I have visited the abattoir on Mull and considered the food chain. There is a dairy industry—indeed there is a world-famous cheese factory—and the dairy farmer uses the factory's by-products to feed pigs, which are sent to the local slaughterhouse and on to the community butcher's shop. We must support such ventures and promote new ventures that are based on that model, which is ideal for islands such as Skye, Islay and the Western Isles. The model deserves all the support that the Executive can give it through the enterprise agencies and money that is made available from rural development funds and as a result of common agricultural policy reform. If the Mull model is copied elsewhere in Scotland, it should be supported.

The EU document, "Healthy food for Europe's citizens: The European Union and food quality", aims to promote employment opportunities in rural areas, to help farmers to

"upgrade the quality of their production"

and

"to develop markets for niche products".

Healthy eating for Europe's citizens is part of what we want to achieve through rural abattoirs,

local hotels, local butchers' shops and local facilities for farmers to use. There is a case to be made for high-quality produce, such as prime beef, being slaughtered locally, given a label of origin and made available on the menus of local hotels and restaurants as an added tourist attraction. The success of seafood festivals attests to the importance of food tourism.

It is difficult for small abattoirs such as the one on Mull to keep their heads above water. It is cripplingly expensive for such abattoirs to meet and maintain the new EU standards and it is crucial that they are supported when they are at the heart of truly innovative community schemes such as the one on Mull. I hope that the Executive will promote similar schemes.

17:32

**Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP):** I congratulate Eleanor Scott on securing the debate. The principle behind the motion is desirable in theory, although in practice what it calls for would be extremely difficult to achieve.

Lochaber, which is in my constituency, has no killing facilities. Four or five years ago, the Scottish Crofters Union considered a proposal for an abattoir there, but the proposal was deemed unviable, not because the capital could not be raised—it could—but for two other reasons. Those reasons were the difficulty in sustaining revenue and the difficulty in sustaining volume. Those problems will not go away and would not be solved by state aid, even if that were legal. I am not sure how the proposition in the final part of the motion could be achieved, because the granting of direct subsidies to create slaughterhouse facilities would place existing slaughterhouses at a competitive disadvantage.

There might well be a special case for islands, as Maureen Macmillan and George Lyon suggested, but I cannot see how such support could easily be given without unfairly disadvantaging slaughterhouses such as Raymond Miller Ltd in Grantown-on-Spey. I spoke to the company today and was told that it faces a serious problem. Eleanor Scott alluded to the problem, which is the huge bureaucracy and hassle of running a slaughterhouse. I have invoices from the Meat Hygiene Service inspectors for £4,000 one month and £5,000 the following month. Apparently one of the bureaucratic difficulties that slaughterhouses face is that they must pay inspectors for the whole day, even if the inspectors finish early. What can the minister do about that? I suspect that the matter is reserved and that the answer will be that he can do nothing.

There is a serious problem that has not been mentioned. Although people who run abattoirs are becoming increasingly involved in direct sales and retail in order to try to cut out middlemen and increase their revenues, what will happen if there is a continued flood of meat from South America? The minister will no doubt correct me if I am wrong, but I understand that the United Kingdom Government wants to make it easier to import meat from South America. I believe that the UK Government seeks to increase the quota by 100,000 tonnes; because the United Kingdom wants access to South American financial markets for UK financial businesses, such as banks and City firms, it is arguing that the limits be increased. That means that the current tariffs of 40 per cent would go. What effect would that have on abattoirs? It would put them out of business. In this debate, we are considering the overall viability of abattoirs. I hope that the minister will at least let us know whether the Scottish Executive agrees with me that the current quota system should be maintained and not liberalised. If it is not maintained, it will become extremely difficult to establish new facilities.

17:35

**John Farquhar Munro (Ross, Skye and Inverness West) (LD):** I am sure that there are many people in the agricultural community in rural Scotland who would be delighted to support the concept of small rural slaughterhouses if that were a practical and viable proposition. To be frank, however, the facts are all too evident. Small slaughterhouses are neither practical nor profitable, which has led to a reduction in the past 20 years in the number of approved and registered slaughterhouses by some 35 units, which represents nearly 50 per cent of the abattoirs in Scotland.

There are many reasons for that steady decline. The abattoirs have had to comply with regulations that govern the inspection of animals before and after slaughter and have had to ensure stringent inspection of carcases to comply with food and hygiene standards. Inspection is undertaken by qualified professional veterinary surgeons who are assisted regularly by equally qualified meat inspectors. That all adds to the cost of attempting to maintain an abattoir service in Scotland.

The regulations that govern the function and operation of existing slaughterhouses will most certainly guarantee that the facilities and functions are of the highest standards and quality, which is essential if the general public are to have complete confidence in them. After all, they are the end customers and, without their confidence in the product, we will lose the battle.

Many people in rural communities would wish their local abattoir to be retained. No doubt, that would bring a financial benefit in that they would

not have to meet the cost of transport over long distances. However, the bare fact is that if we comply with health and safety legal requirements and with food standards regulations on hygiene so that we ensure that quality, acceptable products reach the market, it becomes obvious that we must direct our efforts and resources toward abattoirs that are properly operated and regulated. After all, we want confidence in the product; we do not want a situation to develop again like the one in which we currently find ourselves, in which the sale of British beef produce is restricted because of problems we have had in the past with animal welfare and disease.

17:38

**Mr Mark Ruskell (Mid Scotland and Fife) (Green):** I thank Eleanor Scott for securing this debate on an important topic. Abattoirs are a neglected part of our food supply chain. They are extremely important, not only in terms of animal welfare but in relation to developing something that a lot of members have talked about—vibrant and healthy circular local food economies.

The local abattoir in Dunblane is a small to medium-sized abattoir. It, too, is having difficulty surviving. That is the case not least because, since the foot-and-mouth outbreak, the cost of insurance has gone up by 663 per cent. The question is this: what will happen if this small to medium-sized abattoir goes? It supplies 38 small butchers in central Scotland, many of which are struggling. The danger is that, if our small to medium-sized abattoirs disappear, we will be left only with the bigger abattoirs, many of which are tied to supermarkets. The result of that will be that the small independent retailers will find it harder to source produce locally. There are producers in the Stirling area who want to support the local food economy and who want their meat to be reared, slaughtered, butchered and sold locally, whether through a farmers market or a butcher's shop. We need to ensure that the appropriate facilities exist to support that integral part of the local food economy.

I turn to organic slaughtering and organic production. Unfortunately, only 13 of the 44 slaughterhouses in Scotland are certified for organic production. The fewer organic slaughterhouses we have, the more the organic sector's costs go up and the more organic producers' important premiums start to dissolve.

I say to Alex Fergusson that organic standards acknowledge the importance of minimising animal transport to ensure welfare and the integrity of the organic product. Slaughterhouses are extremely important to the organic sector. I would like to know what the minister's approach to slaughterhouses is, given that one of the action points in the organic action plan that was developed in response to Mr Harper's bill in the Parliament's first session was

"The development of local processing facilities for meat products (too much Scottish organic livestock is slaughtered and processed in England)."

Slaughtering is as important as processing, so I would be interested to hear how we are making progress on that in Scotland.

It is clear that there are no instant solutions, but it is necessary that the Executive understand the role of slaughterhouses in developing local food economies. There needs to be dialogue with the industry and communities about the problems and there needs to be creative thinking about how to develop solutions that can fit in with EU rules. I look forward to hearing what the minister has to say about that.

17:42

**Dr Sylvia Jackson (Stirling) (Lab):** I will speak in the debate from an SSPCA point of view. I am chair of the cross-party group in the Scottish Parliament on animal welfare, on behalf of which, as members will be aware, I lodged a motion on animal transport. Quite a bit of my speech will deal with that.

I thank Eleanor Scott for lodging her motion, which raises many issues besides animal transport. The briefing that we got from the SSPCA and the other material that Eleanor Scott outlined list the problems that are the cause of the demise of rural abattoirs. Much has been said about EU rules and their effect, but it is important that we balance that against the difficulties that were faced in the aftermath of BSE and foot-and-mouth disease. As George Lyon said, it was reasonable to try to restore public-arena trust by ensuring that specified risk material was dealt with correctly. That was why higher standards came about. However, that does not answer Eleanor Scott's questions.

The SSPCA has raised funding issues. As Maureen Macmillan and George Lyon both said, we must consider ways of providing more support. The minister might like to comment on that; it is obviously a matter on which we can make progress.

As Eleanor Scott pointed out, the increase in the use of large commercial abattoirs is cause for concern, not only because transportation of animals over long distances means that there is a greater risk that disease will be spread a long way—as happened during the foot-and-mouth outbreak—but because of the animal welfare implications. The SSPCA briefing states:

"according to European Union legislation, animals can travel for journeys up to 30 hours with only one hour's rest, often in cramped and uncomfortable conditions."

Alex Fergusson asked whether taking animals out and putting them back into lorries causes them difficulty. Given that he is also a member of the cross-party group on animal welfare, one can see that the issue has been yet another contentious subject of debate.

The European Union has consistently tried and failed to reach consensus on improvements to journey times; the latest talks on the subject broke down in April this year. The newest regulations on live animal transport, which date from November 2004, do not touch on the issue but focus on what was agreed to be the best way forward, which is enforcement.

If we look—

**The Presiding Officer:** The member must wind up.

**Dr Jackson:** I welcome what has been said about, for example, transportation of young and pregnant animals and training of drivers. That debate moves us in the right direction.

Finally, I turn to a question that must be asked. How have European countries such as Austria been able to obtain derogations to keep their abattoirs open?

I welcome Eleanor Scott's motion. As she always does, she has raised issues of sustainability that are of interest not only to rural communities but—as Mark Ruskell said in his reference to the abattoir in Dunblane—to communities throughout Scotland.

**The Presiding Officer:** Although most members have been very good with their timekeeping, I will not get everyone in. As the minister has indicated that he is in agreement, I am minded to accept a motion without notice that the debate be extended. That should comfortably do it.

*Motion moved,*

That, under Rule 8.14.3 of Standing Orders, the debate be extended to 6.14 pm.—[*Mark Ballard.*]

*Motion agreed to.*

17:47

**Ms Rosemary Byrne (South of Scotland) (SSP):** I thank Eleanor Scott for bringing the debate to the chamber tonight. I believe that it is crucial to rural livelihoods, animal welfare and the provision of locally produced, high-quality meat.

In 1991, an EU directive was introduced that called for greater levels of inspection and hygiene in abattoirs and, in 1995, the Meat Hygiene Service was established. However, those improvements in hygiene levels meant higher running costs for small and medium-sized abattoirs. Despite the implications for public health, the Government refused to make any grants available to help those businesses comply, which meant that many small and medium-sized abattoirs went out of business.

The numbers of animals that are slaughtered in UK abattoirs has not declined. That has meant an increase in the number of large, commercial abattoirs and, of course, a decline in smaller, rural abattoirs, which has had huge implications for animal welfare. A revival of rural abattoirs would resolve the situation. The SSPCA has said:

"The Society is opposed to the extended transport of live food animals for slaughter. The Society advocates slaughter as close as possible to the point of rearing. This should ultimately lead to a 'carcase only' trade over long distances".

I hope that some sense can be brought into the situation by the management of animal welfare being considered alongside the increase in the number of rural jobs that would result from bringing back the small, rural abattoirs. People want locally produced food that they know has come from a certain farm or area. Small, local abattoirs also serve to minimise disease—indeed, they have many other advantages for rural communities.

My colleagues laughed about the fact that I was to speak in the debate, given that I am a vegetarian. It is probably a bit unusual for a vegetarian to speak in such a debate. I do not impose my values on other people, however, and I care deeply about the quality of food that people eat and about animal welfare.

The advantages of local abattoirs are many: local jobs; reduced travelling time for animals, which leads to better animal welfare; less stressed animals, which leads to better-quality meat; a reduction in the mixing of animals, which leads to less opportunity for the spread of disease; and reduced dangers for abattoir workers, with improvements in health and safety. A reduction in travelling also means less pollution emissions from lorries.

More local abattoirs would mean more locally produced food, which would lead to better development of farmers markets, which is another key issue for rural communities and for our market towns and bigger towns. We want to know where our food is coming from. In conclusion, the Environment and Rural Development Committee today discussed its proposed inquiry into rural development. The re-establishment of rural abattoirs in farming towns should be considered as part of that inquiry.

17:50

**Mr Jamie McGrigor (Highlands and Islands) (Con):** I declare an interest in that I still run a

sheep and cattle farm in Argyll. I congratulate Eleanor Scott on securing this debate, which is important to farmers and crofters throughout the Highlands and Islands.

I remember hearing the Minister for Environment and Rural Development, Ross Finnie, urging the agricultural sector in the Highlands and Islands to add more value to their products. I heartily agree with that aim, and here is an opportunity for Lewis Macdonald to do something about it by encouraging more modern abattoir facilities in rural Scotland.

It has been difficult to maintain abattoirs because of huge rises in water rates and in the cost of offal disposal, specified risk material disposal and veterinary attendance. State-aid rules and worries about competition displacement make councils cagey about investing in new facilities or improvements to existing ones, but if Austria can work within the rules, why cannot we?

The abattoir in Stornoway in Lewis, which Eleanor Scott mentioned, is open only from August to December, which means that after December the supermarkets and shops have no local meat to sell. They need an all-year-round abattoir service. In Skye, animals have to be taken 120 miles to Dingwall and the cost of killing a sheep works out at £24. An enterprising group of farmers and crofters is trying to set up an abattoir in Broadford, which would cover Skye and much of the adjacent mainland. In Argyll, animals have to be sent across the Clyde to Paisley for slaughter, which is a huge disadvantage.

Highland meat is healthy, nutritious and free range. Its use should be encouraged in schools and hospitals to support healthy eating guidelines. Lamb burgers can be delicious and are popular with children. The local enterprise companies have financed reviews and they should now be supportive by helping to finance abattoirs, which will undoubtedly benefit the rural economy. Many farmers and crofters will take advantage of the opportunities that are afforded by the single farm payment by keeping less stock, but aiming for better finished quality. It is probable that many sheep farmers will keep wedders to a later age, as they used to in pre-subsidy days, rather than selling all the lambs at a young age.

Niche marketing of local meat is important and I call on Quality Meat Scotland to highlight the meat from different regions as well as advertising the overall Scottish product. Areas such as Shetland would benefit enormously from that because they have the product. The tiny Shetland chops disappear like gold dust from butchers' slabs and we need an increased supply. There is an example of good practice in Mull, where there is a community-run abattoir that includes a butcher's shop. Tiree has an abattoir linked to a butcher, which sells fabulous meat and the best potatoes that I have ever eaten. Such models point the way to more prosperity for livestock farmers.

To sum up, accessible local abattoirs give farmers and crofters the freedom to farm and the freedom to finish their product, thereby gaining the added value that is often lost if lambs and calves have to be sold in the store markets. Local enterprise companies can facilitate local abattoirs and provide a real boost to the agriculture and food retailing sectors in local areas throughout the Highlands and Islands.

17:53

**Rob Gibson (Highlands and Islands) (SNP):** I declare an interest as a member of the Scottish Crofting Foundation, and I thank Eleanor Scott for launching this debate.

I take up where Jamie McGrigor left off. It is important to recognise the question about Austria that was posed at the beginning of the debate. Austria has a derogation from the European Union in order to run abattoirs in the way that it does. That is a form of subsidy. I am glad that the Conservatives support that in Opposition, but I wish that they would support it in Government—not that they are likely to be in Government in the future.

There is a dichotomy here: we have a Government that says, in its forward strategy for agriculture, that shortening the food chain is recognised as a good thing. At the same time, it says that consumers will pay only a certain amount and that it cannot interfere at the level at which consumers buy cheaper product from abroad. We are aware that the quality of meat that is produced in local abattoirs is generally far better. On "Rick Stein's Food Heroes" programme on television the other night, he pointed out that meat from contented local animals that are killed locally is more tender. That is what people demand at the level of the farmers market, but what most people are offered is not at that level or of that quality. Indeed, we have a Government that seems to have thrown in the towel on dealing with the fact that we are not able to feed the majority of the population from the produce of their local areas.

I give the example of Caithness. In 2002, the red-meat survey for the Highlands and Islands showed that there was a beef supply of 10,388 one and two-year-old beasts, but the local demand was 2,224. Much of the beef that can be produced in Caithness has to be sold outwith the county, but the fact is that, unless it can be branded as Caithness meat, it is unlikely to sell at premium price. We must be able to brand produce, not only from the islands, as Maureen Macmillan

suggested, but from local areas throughout the country so as to attract a market. The local abattoir—which was closed and has now reopened to serve local butchers—could be doing much more if we could invest in local branding. We will be interested to hear what the minister has to say about that.

The Orkney brand clearly works well, but we are fundamentally interested not only in trying to give a new lease of life to areas that have been struggling economically, but in founding a new means of operating whereby people can have secure and sustainable futures. I suggest that we must cut the costs of running abattoirs if we have any means to do so. The meat inspection charges and the veterinary contracts must be reconsidered to ensure that we are not gold plating the European regulations.

17:56

**Dr Elaine Murray (Dumfries) (Lab):** I congratulate Eleanor Scott on securing the debate. I concur particularly with the remarks that she made about the role that the transportation of animals up and down the country played in the spread of foot-and-mouth disease. That in itself, not only animal welfare, is a reason to consider more local slaughtering.

I will make two points that have been made to me recently. I bring them to the debate and to the minister's attention. There may or may not be much that the Executive can do about them, but they could do with being aired.

The first point concerns the problems that small abattoirs have. A local farmer and constituent raised the point that small abattoirs with small numbers of staff have particular problems in coping with red tape, which puts them at a competitive disadvantage to the larger abattoirs. I ask the minister whether there is some way in which regulation and bureaucracy can be streamlined so that small abattoirs are not disadvantaged.

The second point was made to me by the British Horse Society Scotland, which pointed out that the matter is also an equine issue. When horse passports were introduced earlier this year, many of us wondered why. A horse passport is not for taking a horse on holiday, but is a record of all the medication that the horse has taken, and whether that horse will enter the food chain, to ensure that animal medicines do not get into the food chain. To my surprise, 200 Scottish horses are slaughtered for meat every year, and there are only two specialist equine abattoirs in the United Kingdom. They are in Cheshire and Essex, which means that the horses have to travel for at least eight hours before they are able to get to their place of slaughter.

The British Horse Society and the International League for the Protection of Horses have been campaigning for a Scottish abattoir to be fitted out for equine use—perhaps monthly or quarterly—to prevent the horses from having to go through those long journeys. Alex Fergusson made the point that it is loading and unloading that cause distress to animals. That is true, but although some horses, such as race horses, become used to long journeys, not all horses are used to travelling for long distances. If members ever inspect the interior of a horse box that has been inhabited by a horse that is not used to travelling, they will see that there is evidence that horses find that quite stressful—I hope that that is not too indelicate.

I do not know whether there is an awful lot that the Executive can do about equipping an abattoir in Scotland for horse use—there would clearly have to be discussion with the specialists who are involved in processing and chilling horse meat for export—but if it could be done, it might help to sustain one of the smaller Scottish abattoirs by enabling it to diversify into a different market. I leave that thought in the debate as a point that might be worthy of comment or further consideration.

17:59

**David Mundell (South of Scotland) (Con):** I am grateful for the extension of the debate, which has allowed all members to contribute. While I was listening to what Elaine Murray and other members were saying about foot-and-mouth disease, I thought about the importance of not having a knee-jerk reaction to the crisis. People at the time highlighted the issue of moving livestock. My colleague Alex Fergusson and I had to argue robustly for markets to continue operating. A significant body of opinion suddenly came to the view that markets and the market system were themselves part of the reason for the spread of the disease and that, therefore, if we stopped markets and had internet trading instead, that would be the solution.

I did not sign Eleanor Scott's motion for the same reason that Alex Fergusson gave. Although travel issues can always be highlighted, we cannot accept that all travel by livestock is bad. If we go down that line, we are being unrealistic—we are entering a world of motherhood and apple pie where people can somehow have meat to eat without it having to travel or without animals even having to be slaughtered. That is a ridiculous concept.

I am wholly supportive of abattoirs. In the context of this debate, I would like further abattoirs to be developed. I welcome the fact that Scottish Enterprise is now much more interested in the

rural and farming sector than it has been in the past. It could be supportive of abattoirs. Partly because of the actions of people such as Eleanor Scott, public attitudes have changed.

When I grew up in the community of Lockerbie, there was an abattoir right in the centre of the town. It was taken as a given. People who worked there could regularly be seen out and about in the town during their lunch hour. A number of attempts were made to reopen Lockerbie abattoir, but the change in public attitudes was clear: the public in communities such as Lockerbie simply would not accept an abattoir in the centre of their town now in the way that they did in the past. We must be realistic about that. If we are to have more abattoirs, they will have to be new and state of the art. Such abattoirs will bring with them the costs to which John Farquhar Munro referred. Although opening new abattoirs is a positive aspiration, we must be realistic about it.

We must be realistic, too, about people's consumption of food, an issue that has been referred to in the Parliament many times. Although many of us may seek out organic produce—even I do that—and go to our local butcher, the public tend to want to seek out and acquire cheap food. That is a reality and, no matter how much motherhood and apple pie we have, we cannot get round it.

18:03

**The Deputy Minister for Environment and Rural Development (Lewis Macdonald):** Eleanor Scott is to be congratulated on raising this important issue for debate. Rural communities like to have key services on their doorsteps, as has been said before, but it is important to recognise—as has also been said before—that there needs to be enough business for abattoirs to do. We must recognise that abattoirs provide a business service; we have to view the issue in that light. The setting up or closing down of an abattoir is a commercial decision for a commercial operator. It is clearly not for ministers to get into the business of directing such commercial decisions, not least because of the issue of EU state aid, which a number of members have mentioned.

It is important to set the debate in its commercial context. A new abattoir means a large investment. The view of many potential investors is that the density of stocking in many parts of Scotland simply does not justify the considerable capital expenditure that is required for even the most modest of plants. In many areas, there is not the necessary throughput of animals for slaughter to allow processing to be done profitably in the longer term. For those reasons, a new abattoir of any size is simply not an economic option in many areas.

History has shown that the pressures on abattoirs are significant. A number of those pressures have been mentioned this evening, including competition for the supply of animals and the need for investment to meet required hygiene standards without wiping out producer returns. Clearly, for smaller abattoirs, those pressures tend to be proportionately greater.

It is worth noting that the decline in numbers has slowed considerably in recent years. I was struck by Jamie McGrigor's party-political approach to the issue. I thought it worth drawing to his attention the fact that the number of slaughterhouses fell by 31 between 1984 and 1997 and has fallen by only a further six since then—the rate of loss of slaughterhouses in the Tory years was two and a half times more.

On the bigger picture throughout Scotland, the challenge for operators does not seem to be a need to increase slaughter capacity; it seems to be a problem of overcapacity, particularly with beef. The larger plants in Scotland are operating at roughly 70 per cent capacity and they account for more than three quarters of all cattle slaughtered. Therefore, any proposition to increase slaughter facilities has to be considered carefully in the context of that commercial reality.

There is clearly an issue about support for rural abattoirs, which ministers recognise.

**Eleanor Scott:** Does the minister accept that the opening of a small abattoir in a rural area will not dent significantly the throughput of a large abattoir, but might make all the difference to an area such as Assynt, where the north-west cattle producers are trying to get something going and return to the cattle culture that they once had?

**Lewis Macdonald:** I accept that and I accept that the issues for small and remote communities are different from those for Scotland as a whole. However, the motion is drafted in terms of Scotland as a whole and it is important for anyone who would advocate a return to farm-based slaughtering to recognise the commercial realities within which the slaughtering industry operates today.

We recognise the value of increasing the availability of locally produced and processed food and the benefits that that has for producers, consumers, health, the environment and local employment. For that reason, we have processing and marketing grants, through which operators can seek support with both capital and non-capital projects for construction, upgrading and the purchase of plant and equipment. That applies to large and small projects alike. Since 2001, we have committed more than £20 million in grant assistance through those schemes, of which £6 million is for meat processing and animal

slaughtering facilities, including the development of the Orkney abattoir and the extension and upgrade of processing facilities at the abattoir on Barra. On some of the specifics that were mentioned this evening, we have also supported the Islay Fine Food Company through a number of projects involving the local processing and packing of beef, and we have had approaches from the abattoir on Mull, seeking assistance. Those will be considered on the same basis as other such applications. Significant public funds have already been committed and will continue to be so.

Clearly, applicants must be able to demonstrate a number of things. First, as with any public grant scheme, they must be able to demonstrate that the project requires the funding in order to proceed. They must also show that the project is economically viable, that there is an identified market outlet for the product and that the project will also deliver an adequate and lasting share of the benefits to the primary producer. I think members of all parties would support those objectives. We acknowledge the difference that those types of project make. We have plans to invest a further £18 million in the food-processing sector over the next four years, but it is for individual operators to make decisions about the investments that they would require to make for such projects to go ahead.

**Fergus Ewing:** I do not disagree with a great deal of the minister's analysis, but will he respond to the point that I raised about the wider threat to beef production as a whole, in which abattoirs play a significant part, which is the possible influx of huge extra quantities of beef from South America—perhaps an extra 100,000 tonnes? Does the Executive have a view on that? If so, what is it?

**Lewis Macdonald:** Fergus Ewing raises an issue that is on the table. The continuing general agreement on tariffs and trade talks concern such issues. No decisions have been made and no firm proposals have been agreed. It is important not to disadvantage the Scottish industry, but we are also clear that we will compete with Argentina not on quantity, but on quality. That is why the emphasis on Scotch beef is important, because the quality of Scottish produce is our strongest asset in the marketplace.

Animal welfare reasons have been given as justification for a different concentration or spread of slaughter facilities throughout Scotland. It is important to recognise that although issues arose during the foot-and-mouth outbreak with the transportation of animals, they typically related to animals that were being transported for further fattening and finishing; they did not particularly concern animals that were going to slaughterhouses, which did not spread the disease.

We must recognise that some of the greatest stress that animals face on their way to slaughter is from loading and unloading, rather than from the distance or time that is involved in a journey. Strict rules govern journey times and that is appropriate. Those rules should be maintained and respected. As long as those time limitations are adhered to, the quality of the route and the type of journey that the animals must make matter more than the distance, as Maureen Macmillan said.

I will respond to the suggestions that smaller abattoirs somehow invariably deliver a better service and that dispersing the slaughter of animals among a larger number of small units has no potential risks. Consumers want and expect safe food. That is why hygiene standards exist. The record of units in Scotland—including large units—is very good and we want to maintain that.

Given the food hygiene regulations that will come into force on 1 January 2006, it will be important to maintain those standards. It was said that the distinction that exists between full-throughput and low-throughput abattoirs will cease at that time, but it is also worth noting the other change that will happen at that time. The regulations that apply to slaughterhouses of all sizes will be risk based and risk related and will no longer be as inflexible as some regulatory requirements have been. That means that no slaughterhouse will be required to adhere to standards that do not relate to the hygiene risks in that unit. The standards as implemented and enforced will relate to the position in that unit.

The legislation will apply directly in all member states, so gold plating will not be an issue, as has been suggested. All plants—large and small—will require to meet the same standards throughout the European Union. That is the right direction in which to move.

The slaughter of horses was mentioned. The requirements to which Elaine Murray referred relate to the slaughter of horses for human consumption and do not apply to the slaughter of horses when the meat is not to be used for human food.

Through our grant schemes, which comply with European requirements, the Executive wants to maintain support for economically viable projects that have due regard to food hygiene standards, animal welfare, working conditions for staff—they were not mentioned, but they are important—and the commercial realities in which all sorts of businesses must work. We recognise the importance of such services to communities and to Scotland as a whole.

*Meeting closed at 18:14.*

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, Scottish Parliament, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

**Wednesday 22 December 2004**

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

*Single copies: £5.00*
*Meetings of the Parliament annual subscriptions: £350.00*

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committes will be published on CD-ROM.

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

*Single copies: £3.75*
*Annual subscriptions: £150.00*

Standing orders will be accepted at the Astron Print Room.

Published in Edinburgh by Astron and available from:

**Blackwell's Bookshop**
**53 South Bridge**
**Edinburgh EH1 1YS**
**0131 622 8222**

**Blackwell's Bookshops:**
243-244 High Holborn
London WC1 7DZ
Tel 020 7831 9501

All trade orders for Scottish Parliament documents should be placed through Blackwell's Edinburgh

**Blackwell's Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:**

**Telephone orders and inquiries**
**0131 622 8283 or**
**0131 622 8258**

**Fax orders**
**0131 557 8149**

**E-mail orders**
**business.edinburgh@blackwell.co.uk**

**Subscriptions & Standing Orders**
**business.edinburgh@blackwell.co.uk**

**RNID Typetalk calls welcome on**
**18001 0131 348 5412**
**Textphone 0845 270 0152**

sp.info@scottish.parliament.uk

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

**Accredited Agents**
(see Yellow Pages)

and through good booksellers

Printed in Scotland by Astron