MEETING OF THE PARLIAMENT

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Scottish Parliament

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

Time for Reflection

The Presiding Officer (Mr George Reid): Good afternoon. The first item of business today, as it is every Wednesday, is time for reflection. Our time for reflection leader today is Mrs Alison Twaddle, general secretary of the Church of Scotland Guild.

Mrs Alison Twaddle (Church of Scotland Guild): Today is my birthday. It is one that I share, of course, with our national poet, Robert Burns. It is also the date on which the Christian church remembers the conversion of St Paul. They are two very different men, but both have a great deal to say about women, some of which has got them a pretty bad press—particularly in these enlightened, post-feminist times.

However, I do not come to criticise either of those men today, for I think that they are two examples of the glory that is our humanity—with all its flaws and failings. In Burns we have the artistic genius who struggled with his passions in circumstances that demanded more practical application to the economics of survival than he was able to give. When he let his passions rule, he wrote sublime verse but broke hearts and neglected his responsibilities.

Struggles of another kind faced Paul, the new convert to Christianity. He was on fire with zeal for the gospel, but Jesus was not around for him as he had been for Peter and John. Paul was left to work out, somehow, a modus operandi for the infant church. How were the truths of Jesus to be interpreted and applied in the mundane business of living and working in the complex society of first century Palestine? How was the church to be governed? What should its attitude be to the Roman authorities? What was to be the status of marriage and the relationship between the sexes?

They were two men of their time trying to figure out the right thing to do: one on a personal level, tortured by longings and regrets; and one as a leader weighed down by the expectations of others and the awesome implications of the decisions that had to be made.

Some may call me naive, but I am prepared to believe that most politicians are women and men who are trying to figure out the right thing to do. They have their personal weaknesses and their ethical struggles, whatever their religious belief or value system. I can imagine the hard choices and compromises that have to be made in terms of priorities and conflicting loyalties. I want to give you a word of encouragement today, to tell you that we who put you here should not expect you to be perfect. The electorate have placed you in positions of trust and we expect you to struggle to do the right thing, to try, to keep on trying and—above all—to hope. We have the right and the duty to call you to account, but we have no right to expect miracles or saints.

Point of Order

14:34

The Presiding Officer (Mr George Reid): I expect a point of order to be raised at this stage.

Margo MacDonald (Lothians) (Ind): I raise my point of order with reference to rule 6.2.2(b) of standing orders. The rule refers to the responsibility of the committees of this Parliament.

My point of order rests on whether the Health Committee was remiss in not anticipating, in the year during which it considered the Abolition of NHS Prescription Charges (Scotland) Bill and took evidence from expert witnesses, that the Government would not be able to produce its own consultation paper in time for the committee to consider it under rule 6.2.2(b). I concede that there may be a perfectly reasonable explanation for why the Government could only provide its consultation two weeks after the committee reported. I refer, of course, to the need to ensure that no Westminster minister makes a policy decision on free prescriptions for all.

I seek guidance on whether the committee was remiss in not anticipating that the Executive was going to produce such a late consultation document when it had had a year in which to do so.

The Presiding Officer: I do not think that that is for me to say. The Health Committee is master of its own workload. I had expected something a little more substantial as a point of order. In the circumstances, we will just continue with business.

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

The Presiding Officer (Mr George Reid): The next item of business is a debate on motion S2M-3808, in the name of Colin Fox, that the Parliament agrees the general principles of the Abolition of NHS Prescription Charges (Scotland) Bill. Members who wish to contribute to the debate should press their request-to-speak buttons now. I call Colin Fox to speak to and move the motion. You have 14 minutes.

14:35

Colin Fox (Lothians) (SSP): Today, I have great pleasure in introducing this stage 1 debate on the Abolition of NHS Prescription Charges (Scotland) Bill. It is a proud moment for me and for the Scottish Socialist Party. I thank those MSPs, particularly in the Green party and the independent group, who were the original sponsors of the bill. I am grateful for the support of all my colleagues in the SSP and the SSP team in Parliament. I am also grateful for the support outside Parliament of the Scottish campaign to remove all prescription charges, whose members are in the public gallery today. I particularly thank David Cullum and Claire Menzies Smith from the non-Executive bills unit, whose efforts have been immense. I express my gratitude for the work of the clerking teams on the Health Committee and the Finance Committee in bringing those committees' reports on the bill before the Parliament. I am particularly pleased that my bill comes before members on the anniversary of Robert Burns's death. It is a significant day.

I am disappointed however that the speech that I prepared yesterday has had to be substantially rewritten in the light of this morning's announcement that the Scottish Executive has conceded many of the arguments that it previously used in the debate about the bill and has announced a raft of new proposals to go out to consultation. It appears to me that, with its new propositions, the Executive has conceded entirely two lines of argument. The first is that only the rich currently pay prescription charges; the second is that the £44.4 million income from prescription charges is vital for the funding of the national health service in Scotland.

In trying to pull a rabbit out of a hat this morning, the Executive has presented us with another rabbit—one that is half-cooked and inedible. In my view, the Executive has shown in its announcement disdain for the Parliament. The bill has been before the Parliament for nearly two and a half years and before the Health Committee for a year, but the Executive waited until just three hours before this debate to come forward with its

proposals. I think that that shows disdain for the Parliament and the Health Committee. In addition, as the sponsor of the bill, I did not get to see the Executive's report until two hours ago.

So what is in the report? I must say that it appears to me to be a proposal/consultation document that has been put together very quickly. It tries to replace one dog's dinner with another, with the ability-to-pay approach contradicted throughout. The Executive puts in question the continuing exemption of the over-60s, which it says is anomalous with its proposals. In effect, the Executive proposes to consult exactly the same people who were consulted on my bill and exactly the same people who were consulted on the Health Committee's proposals. The Executive gives with one hand and takes away with the other.

I will focus my remarks on the case for the abolition of prescription charges in principle. Martin Luther King was fond of borrowing a saying of the Scottish author, Thomas Carlyle:

"No lie can last forever."

King used that in the context of the civil rights struggle in America to highlight the way in which millions of African-Americans were being denied equality under the law.

For me, prescription charges are a lie that will not last forever. They show that medical justice and equal access to health care are denied to people in Scotland today, irrespective of their class, background or income. The founding principle of the national health service was universal free health care, paid for out of people's taxes. The NHS's high ideals have been compromised by prescription charges.

The Deputy Minister for Health and Community Care told us at the Health Committee that prescription charges represent a co-payment contract between patients and the NHS. I have to say that there is no concept of co-payment in the founding principles of the NHS—that should be made clear. The Parliament has the opportunity today to make a profound and very welcome difference to the lives of the 2.5 million Scots who currently do not qualify for free prescriptions. That statistic alone should lay to rest any claims that members would like to make in this debate that the rich alone pay for prescriptions.

The bill concerns the kind of improvement that the people of Scotland wanted from the Parliament when they set it up. In the most recent test of public opinion, 82 per cent of Scots supported the abolition of prescription charges because they see that the charges deny poor people the medicines that they need. That conclusion is based not on sentiment but on hard facts and sound reason. The Wanless report, which was commissioned by Her Majesty's Treasury to consider all the available international evidence, concluded that every 10 per cent increase in health charges leads to a 3 per cent fall in the numbers taking up that care.

It is telling that, as the first part of its consultation, the Scottish Executive's review examined all the available international research literature. That review was completed seven months ago, yet the Executive still refuses to publish it. Why could that be? Could it be because all the studies conclude that prescription charges act as a disincentive to accessing health care and the Scottish Executive wants to avoid the conclusion that the Health Committee and others have drawn? The evidence from the National Consumer Council, Citizens Advice Scotland, the Social Market Foundation and the King's Fund is that the current system of prescription charges is a complete dog's dinner and lacks any basis in fairness or logic.

The bill that is before the Parliament today has the backing of the Health Committee. That committee heard not one piece of evidence backing the status quo. However, the Executive has rejected the committee's working conclusions. I have to say that the Executive gave a slap in the face to the committee system of this Parliament when it delivered its verdict. For the first time, it has rejected the positive recommendation of a lead committee.

The Health Committee recommended the bill because it accepts that the current system is an indefensible dog's dinner. Everyone over 60 is exempt, irrespective of income. Every pregnant woman, new mother and patient with diabetes, epilepsy or an underactive thyroid gets free prescriptions, regardless of income. At the same time, however, only some people on state benefits qualify for free prescriptions.

The reality is that the Queen gets free prescriptions while people on disability living allowance do not. Some 30 members of this Parliament get free prescriptions but people on incapacity benefit do not. J K Rowling, as a new mum, gets free prescriptions, but a low-paid woman worker in the Scottish Parliament must pay in full. That is the reality of the dog's dinner of a system that currently exists.

The Scottish Executive argues that, since 92 per cent of prescriptions go to people who are exempt, only the well-off pay. Unfortunately, however, that picture is simply not supported by the facts. Some 75 per cent of all prescriptions are repeat prescriptions, mostly for people over 60. The reality is that half the population of this country are not entitled to free prescriptions at the moment. That means that the exemption could be extended to 2.5 million people for a small sum of money. We

might expect the Executive to say, "Never look a gift horse in the mouth," yet it looks the other way and decides that it does not want 100 per cent exemption, saying that it prefers to target the benefit. The Deputy Minister for Health and Community Care is nodding. He is quite right to nod. However, all the evidence shows that the system is about as effective at targeting as poor old Charlie Kennedy was when he tried to bowl those balls in that old people's home. It is precisely the abject failure of targeting that means that those who need the benefit the most—such as 300,000 people on disability living allowance, 219,000 people on incapacity benefit and 850,000 low-paid people—are left behind. That is the reality of targeting and it is why the current system of targeting was not attractive to any of the witnesses who came before the Health Committee.

However, the Executive goes further and says, "We want to bring forward proposals to increase the number of sufferers of chronic conditions who will be exempt," and that it intends to introduce exemptions for as yet unspecified chronic conditions, pointing out that the list of chronic conditions has not been changed since 1968 and is, therefore, worthy of review. The fact of the matter is that the list of chronic conditions has been looked at 13 times since 1968. Every review concluded that we should leave well alone, because it is a Pandora's box. The National Assembly for Wales decided that it was

"not practically possible to rank chronic conditions in terms of clinical need for medication."

In other words, all chronic conditions should be covered, or none. That is the reality of the sheer folly of the Executive's suggestion of ranking the suffering of cancer patients against that of asthmatics, or the suffering of people with Parkinson's disease against that of people with cystic fibrosis or Crohn's disease. What an unattractive proposition.

The second, and perhaps weakest, argument from the Scottish Executive is that abolition of prescription charges would lose the national health service £45 million of vital income and lead to cuts elsewhere. That raises two questions. Who pays the £45 million and where does it come from? As I have already illustrated, it comes from people who can ill afford to pay those charges. It comes from the 300,000 people who are on disability living allowance, from people on incapacity benefit and from the 850,000 people who are on low pay. They are the people who run the risk of not getting the treatment that they need.

The Executive says that the £45 million could not be absorbed into the budget and would lead to cuts elsewhere. Let us look at the evidence: £45 million represents 0.5 per cent of the national health service budget in Scotland. In Scotland, 99.5 per cent of the NHS's income comes from taxes, but it is the 0.5 per cent that comes from prescription charges that we cannot do without. The NHS's income is £9,000 million a year, but £45 million cannot be absorbed. I remind the minister of the background: the United Kingdom Department of Health at Westminster pledged a 7 per cent increase in health expenditure year by year until 2009. That gives the real context of the £45 million.

Two years ago, the former Secretary of State for Health, John Reid, renegotiated—to his credit, and I applaud him for it—the contract between the drugs companies and the national health service to the advantage of the service of £1.8 billion over the next five years. The financial claims of the Scottish Executive in the matter are just not credible.

The evidence in front of us today makes it absolutely clear that there would be savings for the national health service from the abolition of prescription charges: the £2 million that it costs to run the system. I see that the minister is now nodding in agreement after shaking his head; it always pays to listen to the end of a sentence. It is also clear that other parts of the national health service must pick up the tab for those who are denied their prescriptions. If they present themselves at hospital, the cost is £1,800 a week for a stay in a general hospital or £7,000 a week for a stay in a high-dependency or intensive care unit. That is the reality of people going without prescriptions. Considerable savings are to be made from the £45 million.

Finally, I want to touch on the party politicking that is going on in the chamber on the question of prescription charges. Scottish Socialist Party policy is to support the abolition of prescription charges and to support the bill, and that is the position of the Greens and the Scottish National Party. The Liberal Democrats will go into the 2007 Holyrood election calling for the abolition of prescription charges, but they will not vote for it today. The Labour Party policy in Wales was to abolish prescription charges, which, much to its credit, it did in 2003. However, the Labour Party in Scotland refuses to abolish charges—it hasnae got the bottle.

Some cynics have suggested that Labour would back the bill if it had come from a Labour member, but I could not possibly comment. Labour MSPs intend to vote against the bill, while the Labour Party in Wales championed the abolition of prescription charges. The Scottish Executive offers vague propositions in a consultation that begins today, yet there is a bill before the Parliament that would abolish prescription charges and introduce fairness and equality in the national

health service. That is the choice for Labour back benchers. Members should support the bill, which I have pleasure in commending to the Parliament.

I move,

That the Parliament agrees to the general principles of the Abolition of NHS Prescription Charges (Scotland) Bill.

14:50

The Minister for Health and Community Care (Mr Andy Kerr): My opening line was to be: "Colin Fox has just outlined the rationale for his bill." However, I may have to rewrite that part of my speech, because he did not do so. We acknowledge that the existing system is in need of reform but, in our view, the bill is not the way forward.

Before I address the extensive flaws in the bill, I will take a few minutes to lay out the strengths of the current system. We commissioned a review of prescription charges in 16 countries from throughout the world, the conclusion of which was that Scotland's system is already one of the most generous in the world. For example, of those countries, only the Netherlands provides free medication for all, and it is in the process of introducing charges. Only four of the countries have, as we do, a flat-rate charge. In the other 12, patients who require high-cost medication face substantially higher charges than they would face in Scotland. Although some of the countries provide reductions in charges for older people, none of them provides complete exemptions for the over-60s, as we do here, and only Germany and Sweden can match the complete exemption arrangements that we have for children.

Colin Fox: Will the minister take an intervention?

Mr Kerr: No, I will not.

Fewer than half the countries that were surveyed exempt fully people with certain medical conditions, while three of the 16 have no concessions at all for medical conditions or high usage. Uniquely, only Scotland and the UK exempt all prescriptions for people who have specified medical conditions. In other countries, only drugs that are related to such conditions are exempt. Only three of the countries offer full exemption on low-income grounds, while seven offer no concessions at all.

Colin Fox: On a point of order, Presiding Officer. I am sorry to interrupt the minister, but he is referring to a review that the Scottish Executive has carried out but, thus far, refused to present to the Parliament. He is talking about something that the Parliament has not been afforded the opportunity to see.

The Presiding Officer: That is more of a debating point. I think that the minister wishes to respond to it.

Mr Kerr: The findings are summarised in the consultation document, but I am more than happy to provide Mr Fox with a full copy of the review, if he wants it.

Let us remember that, under the present arrangements, about 92 per cent of items are dispensed free of charge to people who qualify for exemptions. That covers around 50 per cent of our people. We also have pre-payment certificates that, in effect, cap the charges that patients with on-going conditions have to pay. Further details are given in the consultation paper. Altogether, there can be no doubt that Scotland's existing prescription-charging regime is one of the most generous to patients in the world.

I make no attempt to defend the anomalies in the existing system. Before the bill was introduced, we had already accepted the need to review the situation for people with chronic conditions and for young people in full-time education—hence the partnership agreement commitment on that. The Executive is committed to reform of prescription charges to make them fairer, simpler and affordable to all—patients and the wider NHS alike.

Carolyn Leckie (Central Scotland) (SSP) *rose—*

Mr Kerr: That is why we want to consider extending the existing exemption arrangements for people on low incomes and for those in full-time education and training and why we want to review the arrangements for people with chronic medical conditions, an issue which has been mentioned.

Colin Fox's ill-thought-through approach would take away resources from the very group that he claims his proposal would help and, in so doing, would benefit financially people such as me and, I expect, most other members. That cannot be right. What is right is that those who can afford to contribute towards NHS dispensing costs should do so. That system helps to reduce less urgent demands on general practitioners' time, places a value on the medicines that patients require and makes a worthwhile contribution to NHS funds. Colin Fox made great play of the fact that patients will save £44 million a year. He also dismissed the sum as a drop in the ocean, which it is not, and ignored the fact—although we all know it—that the eventual cost of abolition may be much greater. Some say that it may be as high as £100 million a year, while the Royal Pharmaceutical Society of Great Britain has estimated that the additional cost to the NHS in Scotland could be as much as £245 million per year.

The Health Committee's report on the bill acknowledges those points. I thank the committee for its report and for its analysis, which we have taken into account in preparing our consultation. We found the evidence that was presented to be extremely helpful. It informed our thinking on the issues that need to be addressed, as a result of which we have widened the scope of the review.

Roseanna Cunningham (Perth) (SNP): Given that the minister says that he is presenting evidence to us and that he has known about it for eight months, I respectfully ask why that evidence was not put before the Health Committee during its stage 1 deliberations. [*Interruption.*]

Mr Kerr: Lewis Macdonald has reminded me that the Executive stated clearly its position to the committee on every point.

Let me look at where we agree with the committee. The committee said that

"the status quo is not an option."

We agree. It said that

"there is scope to improve the effectiveness"

of the current system, which has anomalies. We agree. It said that there is a need for thorough consultation on reform of the system. We agree. It said that it is difficult to develop

"an equitable charging scheme … by identifying exemption categories."

We agree.

Carolyn Leckie *rose—*

Mr Kerr: The committee said that the bill would

"provide financial benefits to those on higher incomes who … can afford to pay for prescriptions".

We agree. It said that there is concern that people on low incomes who suffer from chronic illnesses should not face

"a financial barrier to receiving treatment"

and that such a barrier might be detrimental to their health. We agree. The Health Committee was unconvinced by Colin Fox's claims that free prescriptions

"would correlate with fewer hospital stays".

We agree with the committee on that, too.

Carolyn Leckie *rose—*

Mr Kerr: The bill is not good for the NHS; it would take services from the poor and give those services to the benefit of the rich.

The committee said that the bill would lead to an increase in the number of prescriptions that were issued, with clear financial consequences. We agree. The committee expressed concern that there would be

"a significant additional cost of abolition, resulting from an increased demand for prescriptions".

We agree.

The only significant point on which we disagree with the committee is its conclusion, from which many members dissented.

Carolyn Leckie: Will the minister take an intervention?

Mr Kerr: Its conclusion was that the most equitable solution is to "abolish prescription charges entirely." We do not agree with that point.

Carolyn Leckie: Fantastic. At last.

If the minister agrees with so much of the bill, and given that no other bill that has come before the Parliament with committee approval to agree the general principles has ever been opposed by the Executive, will he tell us why he will not just amend it?

Mr Kerr: I will tell Ms Leckie why. We believe that the bill would be unfair on the NHS and unfair on the patients. In effect, it would rob the poor and the unwell to give to the rich. I will illustrate the £45 million that is such a drop in the ocean. The cost of almost all the hip and knee replacements carried out throughout Scotland annually comes to that amount of money. Almost the entire annual running costs of the Perth royal infirmary amount to £45 million. The £45 million would pay for more than 1,600 additional nurses, or 50 new magnetic resonance imaging scanners, or 2,000 neonatal incubators, or 1,800 dialysis units, or 900 lung ventilators. That is the drop in the ocean. That would be the real effect of the bill if it were to proceed. In practice, we know that the cost of the bill would be significantly higher.

The alternative is set out in our consultation: a simpler, fairer system that is affordable to patients and the NHS. Our consultation will consider whether exemptions for people on low incomes might be extended; how the medical exemption arrangements might be reformed to be fairer for all; whether exemptions should be extended to people in full-time education and training; and whether payment arrangements for high users should be reformed. I am confident that what will result from that consultation will be an even better system: a fairer, simpler system that is affordable to the patient and the NHS alike. Members can choose between that or Colin Fox's alternative, which takes from the poor to benefit the rich. As the Minister for Health and Community Care, I am not prepared to see those resources spent in that way. I am confident that, following our consultation, we will agree that new system, which will provide a solution that will result in many more patients on low incomes being completely exempt from prescription charges, reform the

arrangements for patients who require frequent or multiple prescriptions and extend concessionary arrangements for full-time students and trainees.

Faced with the choices before us and the responsibilities that were referred to at the start of the meeting by our time for reflection speaker, I therefore urge members to make the difficult, hard but, at the end of the day, sensible choice to support the consultation, not Colin Fox's flawed bill.

14:59

Shona Robison (Dundee East) (SNP): Today, we have yet another example of the Executive's disrespect for the Parliament. After a two-year delay in moving forward with the reform of prescription charges, and the minister being unable to provide the Health Committee with any details only a few weeks ago, a tabloid newspaper gets to know, through an exclusive briefing, the Executive's long-awaited thoughts on the matter before Scotland's democratically elected Parliament.

The Deputy Minister for Health and Community Care (Lewis Macdonald) *rose—*

Shona Robison: If the minister would like to defend his position, he is welcome to do so.

Lewis Macdonald: I am sure that Shona Robison, having been present at the Health Committee, will accept that the committee asked that we bring forward this consultation at this time. We have done so to fulfil the commitments that we gave to the convener on 7 December.

Shona Robison: It is a pity that the minister said that he did not have any information to give to the Health Committee when he appeared in front of it. He clearly had the information, but he was just not willing to share it with us. Reading today's *Daily Record* headline—"We'll scrap script charge"—makes me wonder whether we are in the same debate, because what it says is far from the case.

I will return to the long-awaited consultation document in a minute, but before I do I will outline why the Scottish National Party is supporting the bill at stage 1. There is a fundamental principle that if someone falls ill, they should not be financially penalised for it. The health service is based on the principle that treatment should be free at the point of need, no matter what the patient's income is. We regard the provision of medication as an intrinsic part of the health service, and it should be based on the same principle as the rest of the health service—it should be funded through general taxation.

The bill should be allowed to progress to stage 2, when it can be amended. The SNP will seek to amend it to phase in abolition to reduce any likelihood of additional pressures and demands being placed on general practitioners, pharmacists and the public purse. Other parties might wish to amend it in other ways.

Lewis Macdonald: Shona Robison is presenting the abolition of prescription charges as her party's position. Has she estimated the cost of that policy?

Shona Robison: I will come to that, because I am about to move on to the key objections to the bill. Cost is cited as one of those. I would never argue that the cost of abolition is a "drop in the ocean", because it is not, but the Executive's costings are exaggerated for its own ends. It will be interesting to hear the costs of the complicated bureaucratic system that it proposes as the alternative. I ask the minister: where in the consultation paper can the detailed costs of that system be found? We wait to see them.

John Swinburne (Central Scotland) (SSCUP): Does Shona Robison agree with my interpretation of the consultation document, which is that it will lead to pensioners being means tested to obtain prescriptions?

Shona Robison: There is a real danger of that.

Where there is a political will, resources can be found. The Executive has shown that by finding £295 million over three years for dental services, which is welcome. The question is whether there is sufficient political demand in the Parliament to make the abolition of prescription charges a reality. Cost is not the key objection. During the debate, we will hear from Labour members speeches that will masquerade as principled stances, and which will state that the abolition of prescription charges will help only the better-off, rather than their poorest constituents. Although a principled argument can be made along those lines, it does not apply to prescription charges.

In the *Daily Record* article, someone—I think that it was a source close to Labour ministers—said:

> "This is getting back to good old Labour values, making sure support and exemptions are there for those who need them."

Anyone who uses that argument in this debate will have to explain why those good old Labour values did not apply to free eye checks, free dental checks, concessionary travel or free personal care. Where, in those instances, were the good old Labour values that said that it should be about income, and that those who could afford to pay should pay?

Margaret Smith (Edinburgh West) (LD): Does Shona Robison agree that the analogy for free eye and dental checks is the free visit to the GP? We

did not scrap the cost of glasses or anything else that resulted from those checks.

Shona Robison: The phrase "angels dancing on the head of a pin" comes to mind. The principle that Labour and, I assume, the Liberal Democrats are trying out is that those who can afford to pay should pay. The Labour Party did not apply that criterion to a raft of policies when it did not suit its coalition agreement with the Liberal Democrats. It is more about political expediency than any point of principle—and Labour members know it. They are kidding themselves if they think that it has anything to do with principle.

It is the same old thing: the Executive wants to have it both ways. If the *Daily Record* is to be believed, full-time students will be exempted from prescription charges. What about the better-off full-time students? They are to be exempted as well. It is supposed to be all about those who can afford to pay, but it is not about them, is it? It is about the coalition agreement between Labour and the Lib Dems, and principle has nothing to do with it whatsoever. A bit of honesty from those members would not go amiss today.

I return to the consultation paper. We would support moves to extend exemptions to those on lower incomes, because it would be an improvement on the current position, but that would still lead to unfairness for those who are just above the line, wherever it is drawn. The commitment to review the list of chronic conditions has been around for more than two years. All that we have in front of us today are more limited options to add to that list, which will create more winners and losers.

The alternative that has been advanced is to link exemptions to the drug, not the condition, which would mean that drugs that were not linked directly to a condition would be subject to a charge. Who would decide on the definition of "linked directly"? What would it mean? What if someone had a chest infection that, on the face of it, was not directly linked to their chronic condition? In reality, their poor health might make them more susceptible to such infections. Would they be charged for the drugs for that infection?

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): We did not hear a word from Shona Robison at the committee meetings.

Shona Robison: Well, I look forward to Duncan McNeil's explanation of what it is that the Executive is actually proposing. Its proposals are a minefield, and could lead to further unfairness in the system. Let us keep it simple and do the right thing. I urge members to support the bill and allow it to proceed to stage 2.

15:06

Mrs Nanette Milne (North East Scotland) (Con): Whether we agree with it or not, Colin Fox's proposal to abolish NHS prescription charges has forced a long-overdue debate up the agenda. We should be grateful to him for that. I have little doubt that, without the Abolition of NHS Prescription Charges (Scotland) Bill, we would not have seen the Executive's consultation document this morning, with its proposals to change the current system. The Executive's partnership commitment to review exemptions for people with chronic conditions and young people in full-time education is, indeed, welcome, but we are disappointed that it has taken the Executive so long to bring forward an options paper, and that it has done so only just ahead of the debate. Nevertheless, we look forward to studying the detail of the consultation document closely, and to responding to it in due course. I will not do so this afternoon, however.

There is no doubt—and there is no disagreement about this among the parties—that the present system of prescription charging is illogical and inequitable. The current exemptions are based neither on need nor on people's ability to pay. Instead, they depend on age, the receipt of certain benefits and pensions, and a very limited number of chronic medical conditions. The criteria for exemption have not been reviewed since 1968, and there are now many more people on regular long-term medication for chronic conditions who are not exempt from paying for their prescriptions.

Frances Curran (West of Scotland) (SSP): Will the member take an intervention?

Mrs Milne: No, not at the moment.

For example, there are people with asthma, HIV/AIDS, cancer or Parkinson's disease, people who require immunosuppressive therapy following organ transplantation, and many others who are on long-term medication that was not available in 1968.

Prescriptions are often for multiple drugs. At £6.50 per item dispensed, costs soon mount up, even with the pre-payment certificates that are currently available. For people on low incomes, such costs can be very significant, and I accept that, at times, they might result in patients not taking all the medicines that are prescribed to them.

Some exemptions are based on income. People on income support, jobseekers allowance and war pensions qualify, but those on incapacity benefit and other benefits do not. There are further anomalies. A person with a qualifying chronic condition may be relieved of all prescription charges, whether or not the prescription relates to that chronic condition. Prescriptions that are

issued at genito-urinary medicine and minor ailment clinics are free, whereas the same illnesses do not qualify if they are diagnosed in a GP's surgery.

We acknowledge the unfairness and anomalies of the present system, and the fact that 92 per cent of NHS prescriptions go to the half of the population who qualify for one or more of the exemption categories, so members might ask why we do not support the proposal to abolish prescription charges altogether. We agree with the Health Committee that

"the abolition of charges would provide financial benefits to those on higher incomes who currently can afford to pay for prescriptions"

and who do pay for them. That is probably right. We also agree that, in addition to the direct loss to the NHS of about £45 million of revenue from prescription charges, it is likely that abolition would result in significant additional costs that have not been taken into account in the financial memorandum to the bill.

Alex Neil (Central Scotland) (SNP): Will the left-wing Tories explain why it is right in principle to provide free personal care to rich people but not to provide free prescriptions? What is the difference?

Mrs Milne: Those are different issues. I will not enter that debate with the member at the moment.

The extra costs of abolition that I mentioned were of concern to both the Finance Committee and the Health Committee. The direct loss of £45 million might seem small in the context of the NHS budget, but, as the minister pointed out, several NHS functions would be affected. For example, one of the NHS Confederation in Scotland's member boards pointed out that its share of the lost income would equate to 175 whole-time equivalent nurses or allied health professionals. The loss of revenue would impact badly on NHS boards, many of which already struggle to function within their budgets.

Frances Curran: Will the member take an intervention?

Mrs Milne: No. I will not take any more interventions.

Colin Fox claims that an increase in the number of patients who receive free prescriptions would lead to fewer hospital admissions, and that that, together with the savings to be made on running the current system, would achieve savings that would entirely offset the cost of abolition. However, neither the Finance Committee nor the Health Committee is convinced that those indirect savings would be achieved. Also, there has been no estimate of the costs that would arise from the increased demand for prescriptions, which is likely to be significant.

The implications of abolition for the workload of GPs, nurses and pharmacists are of concern. At present, patients purchase many medicines over the counter more cheaply than if they were prescribed. If those over-the-counter preparations became free on prescription, the increased demand—estimated to be at least 22 per cent—would have a significant effect on GPs' workload.

The implications of abolition or substantial reform of the system are considerable. In particular, any NHS income that was lost would have to be replaced from other sources or made up from savings elsewhere. Removal or reduction of the price barrier would lead to the greater uptake of prescriptions and greater claims on the time of GPs and other professionals. There would also be a significant impact on the delivery of the minor ailment schemes that are being rolled out throughout Scotland.

Prescription charging has been a feature of the NHS throughout most of its existence. The Labour Government that removed charges in 1965 reintroduced them three years later due to financial pressure. The National Assembly for Wales's move towards phased abolition, which is based purely on a political decision, is as yet unjudged. I am told that the Italian Government is considering the reintroduction of charges.

The abolition of prescription charges is not the panacea that it may seem to be. We cannot support Colin Fox's bill, but neither do we regard the status quo as tenable. We will seriously consider the Executive's alternative options before we draw our conclusions on the best way to ensure equity of access to NHS prescription drugs for patients in Scotland.

15:13

Euan Robson (Roxburgh and Berwickshire) (LD): As Nanette Milne said, consideration of the Abolition of NHS Prescription Charges (Scotland) Bill has raised some particularly important issues.

First, I point out that abolition of prescription charges was not mentioned in the Liberal Democrat manifesto for the 2003 elections. At that time, we said that we would review health charges, including prescription charges, to ensure a consistent approach. In particular, we supported exemptions for full-time students. Subsequently, the partnership agreement, which set out the Scottish Executive's policy objectives, included a commitment to set up a review of prescription charges for people who have chronic health conditions and young people in full-time education or training. As has been said, the first stage of the review examined the literature. We welcome the consultation document that has been published today, which is another step in the process. Our

manifesto commitments and the partnership agreement commitments are being met. The consultation is an important development and I hope that everyone who has an interest in the matter will engage in it. It is good that the consultation will be open until the end of April because that will allow the Executive to publish its response and to take action to implement the necessary changes progressively soon thereafter.

The case has not been made for outright abolition of prescription charges. As we have heard, about 92 per cent of prescriptions are currently free. The health board in my area—the Scottish Borders—pays, in round figures, £20 million per year for prescriptions and collects just under £1 million in charges. Whatever way one looks at abolition, its major problem is that it is effectively an open-ended spending commitment. Evidence to the Health Committee identified a cost of £45.5 million, although other short to medium-term transitional costs, minus the savings that the member in charge of the bill identified in the financial memorandum, would need to be added.

The Health Committee was entirely right to point out that there had been no consideration of additional costs that might result from increased take-up, or of the cost of the time that GPs would spend coping with additional consultations. The deputy minister has suggested that those costs could be up to £32 million, although it is fair to say that no one can provide anything other than an estimate at this stage. Indeed, the committee recommended that should prescription charges be abolished, the Scottish Executive would have to ensure that the financial impact on the policy was closely monitored in order to ascertain

"the real cost of abolition to the NHS in Scotland".

To be frank, I find it hard to see how policy can be based on that.

Members have suggested that such costs are marginal to the health budget. Of course, in overall percentage terms the charges are small, but they are significant. Where is the additional resource to be found? We have not heard. If charges are to be abolished, would boards that face deficits have to cope with the additional cost? Alternatively, would the global health budget need to expand? If so, at the expense of what other services in the Scottish Executive budgets would it be expanded?

Shona Robison: Will the member give way?

Euan Robson: In a minute.

If the national health budget were not expanded, what areas of existing expenditure would need to be curtailed or reduced?

If £45 million—or indeed any higher figure—of additional expenditure were made available, the Liberal Democrats would look to use that resource for health promotion. We have emphasised free eye and dental checks because they are essential components in the promotion of good health. However, there is an undoubted case for reforming the present system. I have no time to detail the deficiencies in that system; the Health Committee has more than adequately covered them in its own report, and they have been covered in evidence from a number of organisations, which the minister has acknowledged. Accordingly, it is right to consult on the efficacy of a number of changes that are set out in the consultation document. As the consultation has an open character, individuals or organisations are free to suggest options. I am sure that the minister will confirm that in his concluding remarks.

A clear principle should underlie any future necessary changes. As the minister stated, the status quo is unacceptable, so we need to ensure that affordability is addressed and that there is not prohibitive pricing that means that medication is unavailable to people who are less well-off or who earn low pay. Exemptions should be extended to students and people who are in training. Section 4 of the Executive document sets out several alternatives, and it is clear that the eventual outcome must include a combination of measures to ensure that the general principle is met.

There are two related areas that the Executive should examine when it considers the outcome of the consultation. The first relates to the use of medicines; it is important that the right quantity of medicine is prescribed and that courses are taken as prescribed. Any new system must ensure that changes do not worsen the situation in respect of unused medicines. Secondly, the Executive will need to ensure that any changes to prescription charges will not impact on the numbers of people who are currently admitted to hospital as a result of their prescriptions not suiting their medical conditions. There are issues about getting information to, and training, people who prescribe medicines. It would be advantageous to address those matters simultaneously with the new charging regime.

It has been said that there is a risk that abolition of prescription charges will lead to increased queues at GPs' surgeries. It should be the objective of the system to ensure that GPs' precious time is not devoted to minor ailments. Also, the bill would put at risk the minor ailments scheme and prescription by pharmacists. The network of community pharmacists throughout Scotland could face a threat that would be severely disadvantageous to patients and consumers.

Mr Fox made great play of the Health Committee's vote on the bill, but he failed to

mention what the Finance Committee said about his bill. I presume that when Parliament debates Mr Sheridan's Council Tax Abolition and Service Tax Introduction (Scotland) Bill next week, Mr Fox will apply that principle—that the committee report should be accepted, which would mean that Mr Sheridan's bill should not proceed. He made a bogus debating point among other bogus remarks.

The Liberal Democrats will vote against the bill, but we welcome the consultation that has been launched today and we look to the Executive for a swift response to it.

The Presiding Officer: We move to the open debate. The debate is heavily oversubscribed, so I ask members to stick to their allotted times.

15:21

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): As Colin Fox said, this is a special day. It is a day for celebration when six Scottish Socialist Party members are in the Parliament building, never mind in the chamber.

The event of the day must have been Shona Robison's speech. Anyone who took time to read the evidence would find no hint of the passionate support for abolition that she talked about today. There is no doubt that a lot of politicking is going on.

Colin Fox claimed in evidence that the bill is a popular measure and complained today that politics is interfering with the bill's progress. I suggest that he is enthusiastic about the measure only because the politics suits his failing party and his failing leadership.

An e-mail from Colin Fox to his SSP activists states:

"Opinion polls put support for abolition at 4 to 1 in favour among the population at large. There are literally hundreds of health organisations, patients groups … who support this Bill."

He asks

"the local SSP branches and regions to help by campaigning and building the party around this issue"

and says that he is sure that they

"will agree that this is just the kind of opening to 2006 we need."

No luck at all, Colin.

The reality is that the bill would cost a lot of money and that it would benefit well-off people at the expense of the poor.

Tommy Sheridan (Glasgow) (SSP): Will the member take an intervention?

Mr McNeil: No—we have been told that there is no time and that we need to let other members speak.

Shona Robison *rose—*

Mr McNeil: Just sit tight, Shona—you will be getting it in a minute.

The Deputy Presiding Officer (Trish Godman): Order.

Mr McNeil: Shona Robison agreed to the Health Committee's report, which says:

"The Committee acknowledges that the abolition of charges would provide financial benefits to those on higher incomes who currently can afford to pay for prescriptions and therefore the removal of charges is unlikely to have a significant impact on the health of this proportion of the population."

She knows that the bill would serve those people and she agreed to that statement, so there is no hiding place for her.

Tommy Sheridan: Will the member take an intervention?

Shona Robison: Will the member give way?

Mr McNeil: People who can afford to pay will undoubtedly benefit. It is not possible to fix a system that hammers at a maximum of 500,000 people—if all the arguments in favour of abolition are accepted—by giving 2.5 million people a benefit that they do not need.

Tommy Sheridan: Will the member take a quick intervention?

The Deputy Presiding Officer: Mr McNeil is not taking interventions.

Mr McNeil: The bill would give an even greater share of the health budget to the people who have the greatest access to the health budget, to drugs, to medicines, to GP's time and to consultant appointments. Let us cut the spin and let us hear no more nonsense—not in the name of the poor. The bill may be to the SSP's political advantage, but it is not to the advantage of the poor.

Colin Fox claimed that the bill had great support from the Health Committee. For members who have not had the opportunity to read the committee's report, I will read the committee's statement of support. It says:

"On the basis of the evidence received, and taking into account some of the reservations expressed, the majority of the members of the Committee"—

excluding me, thankfully—

"recommend that the Parliament approves the general principles of the bill."

That is hardly a ringing endorsement.

The member in charge of the bill wants us to follow the example of Wales. Let us look at the evidence from there—or, rather, let us try to find some, because the committee found no evidence on its trip to Wales. There was little hard evidence—

Colin Fox: The Executive has shot your fox, Duncan.

Mr McNeil: SSP members should listen—they obviously have not read the report.

There was little hard evidence from Wales about the political and financial impact of the measures. Janis Hughes—who visited Wales—said:

"it was difficult to find any evidence."

Jean Turner expressed her surprise that

"the decision had not been based on any evidence"

and Mike Rumbles stated:

"It was clear that the abolition of charges was a political decision".—[*Official Report*, *Health Committee*, 29 November 2005; c 2390.]

The convener of the Health Committee, Roseanna Cunningham, said:

"It quickly became clear that we were not going to get the cast-iron evidence that we were looking for and—to be fair—expected."—[*Official Report*, *Health Committee*, 29 November 2005; c 2391.]

Only now, after three years, is the Welsh Government monitoring the impact of the abolition of prescription charges. Let us not make the same mistake. We should not, however, worry just because Wales could not give us evidence to support the bill. What about the evidence that we did gather? During our evidence-taking sessions, the convener asked various witnesses for their positions on the bill. There have been claims that there is great support for the bill, but what were the responses?

Tommy Sheridan: Will the member take an intervention?

Mr McNeil: No.

The patient partnership and practice organisations, Macmillan Cancer Relief and NHS National Services Scotland were neutral about the bill, while the Scottish Association for Mental Health supported it. The Royal College of General Practitioners Scotland was neutral and Lothian NHS Board had no official view. Greater Glasgow NHS Board and the Scottish Pharmaceutical Federation were against the bill, while the Royal Pharmaceutical Society of Great Britain and the Highland area pharmaceutical committee were neutral. The suggested widespread support for the measure does not exist. [*Interruption.*] Members might howl, but widespread support does not exist. We could go on and on.

We should not proceed with the bill. The Health Committee and the Finance Committee were seriously concerned about costs and the impact on front-line services. The case for abolition has not been made, but the case for reform has. Let us get ahead and reform the system for the benefit of the people of Scotland.

15:27

Roseanna Cunningham (Perth) (SNP): As usual, Duncan McNeil was passionate, but his Labour Party colleagues in Wales were equally passionate and used precisely the same language to argue in support of the abolition of prescription charges. The gulf between the two positions is quite extraordinary.

There were major areas of agreement in the committee on many aspects of the bill. Those areas have already been mentioned. For reasons that have been discussed, there was unanimity that the status quo was not an option. About 50 per cent of the population are eligible to receive free prescriptions and those who make up that 50 per cent receive about 92 per cent of prescriptions that are issued. Most people on low incomes are exempt, but by no means all of them are. Incapacity benefit, for example, is not an automatic qualification for free prescriptions, so some people who receive that benefit pay for their prescriptions. That is a major irony because, notwithstanding the current debate, I presume that a person will not receive incapacity benefit unless they have long-standing ill health that means that they are likely to be more reliant on prescriptions.

People who suffer from certain chronic ailments receive free prescriptions while those who suffer from other ailments do not. Diabetics receive free prescriptions, but asthmatics do not. The people who receive any free prescriptions get all their prescriptions free, even if those prescriptions are not related to their exempting condition. It is worrying that anecdotal evidence suggests that some people have to choose between prescriptions because they cannot afford them all.

Furthermore, it is a major failure that the existence of pre-payment is not widely known. That involves a lot of money for people who have very little money.

There was unanimity about the paucity of evidence. Duncan McNeil argued about the lack of evidence on one side, but there was a lack of evidence on both sides, so the committee had serious difficulties in that respect. Procedurally, stage 1 is the phase of a bill's consideration during which evidence is gathered—which suggests that there is evidence to gather. Consideration would have been easy had there been a lack of evidence on only one side of the argument, but that was not

the case. I mentioned anecdotal evidence—we received anecdotal evidence from all sides.

Absent from the Executive's evidence was any mention of the international comparators that it clearly knows about, and that the Minister for Health and Community Care clearly knew about when he came before the committee. I am aggrieved that evidence that the Executive is now putting forward to support its case was deliberately held back from the committee. Presiding Officer, I suggest that that is an unacceptable way of doing things.

We were left with a lot of "Yes it is", "No it isn't" evidence, none of which seemed to be based on any factual reports or surveys. Citizens Advice Scotland was the exception; its evidence included a survey of clients in England and Wales, which suggested clearly that people are making choices about which prescriptions to take and which not to take.

The committee had high hopes of our Welsh visit and it was indeed informative, but not from an evidence point of view, because the Welsh members had no evidence either. It was clear that they had simply taken a political decision and were implementing it, albeit that abolition is to be phased in over four years. I think that I am right in saying that the committee was unanimous in its view that if the bill were to be passed, abolition in Scotland should also be phased in, along the same lines as in Wales.

The Health Committee was also unanimous that the Finance Committee's concerns were well founded and that the financial information that was given by Colin Fox was insufficient. It was clear that the only figure regarding costs that was not in dispute was the current income from prescription charges of about £45 million a year. That was the only incontrovertible bit of financial information that we got. That income would disappear on the abolition of charges. Whether there would be other costs from increased uptake because prescriptions had become free, or benefits in longer-term savings because people were now taking all their medication instead of picking and choosing, was extremely difficult to quantify. I am sorry that Colin Fox did not do more work on that aspect of the bill.

Comparisons are available. Charges were abolished in the UK in the late 60s and early 70s and Italy has abolished prescription charges. Both comparisons are interesting, but carry health warnings: Italy has a different health culture and the late 60s were a very long time ago. The Welsh Assembly has been undertaking monitoring exercises for some time, but has not yet reported, so the information is not yet available to us.

Again, I say that I am sorry that the Executive saw fit to conceal other evidence on which it based its arguments.

Lewis Macdonald: What evidence does the member believe we concealed?

Roseanna Cunningham: The Executive concealed international comparator evidence, which it did not make available to the committee.

This morning, the Executive—coincidentally—published its plans to review the prescriptions system, which was promised for the week beginning 23 January. I am sorry that if I had read the *Daily Record* this morning I would have had rather longer to consider what the consultation paper said. I cannot agree with the assertion that was made in that paper that the case against abolition was strengthened by the evidence that was presented to the committee. That was not the view of the majority of the committee and I hope that it will not be the view of Parliament. Parliament is rightly proud of its committee system; I hope that members will bear that in mind as they consider the difference of opinion between the Executive and the committee.

It has been important to emphasise the areas of agreement because of the unusually narrow majority on the committee. I am not sure that there has previously been such a split view of a bill. However, I do not believe that that narrow majority detracts from the validity of the report's conclusions. In truth, the committee did what the Welsh Assembly did: in the absence of incontrovertible evidence one way or the other, it made a political decision. That is what we are here to do and I do not shrink from that. I ask Parliament to approve the general principles of the bill.

15:33

Mary Scanlon (Highlands and Islands) (Con): As other members have said, there is no doubt that the bill would increase demand for prescriptions. I find it incredible to listen to the Scottish Socialist Party proposing that there should be huge increases in the profits of pharmaceutical companies when, not so long ago, SSP members were talking about nationalising them.

It is also incredible that the socialists advocate free prescriptions for all those who can afford to pay. Not one single pensioner on a fixed income in Scotland will benefit from the measures that are before us today. What cannot be measured in the financial memorandum or elsewhere is the change in consumer behaviour when something becomes free. The stated saving of £45.4 million to individuals has to be measured against the potential increase in demand for prescriptions. It

will increase the demand for GPs' time, the demand for diagnoses and it will increase paperwork for GPs. We should also remember that the annual increase in the drugs budget for NHS Scotland is currently about 10 or 12 per cent per annum.

Colin Fox: Will the member take an intervention?

Mary Scanlon: No. I am sorry, but I have limited time; Colin Fox had at least double the time that I have.

The bill is also likely to reduce the demand for over-the-counter medicines, more of which have become available in recent years. Why would people pay for such medicines when they could get them free?

The most dangerous message from the Scottish socialists today is that there is a pill for every ill. If one talks to mental health patients and the many people in Scotland who suffer from depression, one finds that they start with one pill, which often has serious side effects. They then get another pill to counter those side effects. Before they know it, they are on a cocktail of drugs, when all they wanted was someone to listen to them—not a pill, and not free prescriptions. That general theme runs through many cases of suicide in the Highlands. Legal prescription drugs are readily available, but there is no one for people to talk to about their problems.

For years the Conservatives, Labour and most MSPs have been trying to encourage people in Scotland to change their diets, their smoking habits, their lifestyles and their health and exercise regimes so that they lead healthier lives. The abolition of prescription charges would not affect lifestyle issues one bit, but that is Scotland's biggest problem. If more free drugs were available, what incentive would that give to people who are looking to make changes to their lifestyles?

We should consider providing free podiatry care, rather than more free drugs, for pensioners and others who would benefit from being more mobile. We need more physiotherapists, rather than more free drugs. We need more psychiatric and psychological support, rather than more free drugs. More NHS dentists would also be very welcome. There should be much more support and advice for patients who self-manage conditions such as asthma and diabetes, rather than more free drugs. I say to the minister that we also need greater access to complementary and alternative therapies, rather than more free drugs.

The exemption list needs more scrutiny. I had a quick look at the paper that the Executive has issued today. I notice that the options that are being considered include extending the exemptions under the low-income scheme and extending exemptions for full-time students and others. That is the debate that we need to have—not a debate about more free drugs. Extending exemptions for conditions such as Parkinson's disease should undoubtedly be examined urgently.

Removing prescription charges would not alter Scotland's main health problem, which is based on lifestyle, not on the case for free drugs. Quite often, free drugs lead to problems instead of solving them. I agree with the Health Committee that the status quo is not an option, but I do not think that the answer is the abolition of prescription charges. I rest my case.

15:38

Helen Eadie (Dunfermline East) (Lab): I am pleased to support the Executive in today's debate. For me, the quote of the day was from Dr Jean Turner, who said in committee that the debate

"seemed to be more of a walk in the dark"

and that

"we were left with no evidence at all."—[*Official Report*, *Health Committee*, 29 November 2005; c 2390.]

The Scottish socialists are inviting us to take a walk in the dark and to have the Scottish Executive write blank cheques.

In urging MSPs to vote in favour of the bill to abolish prescription charges, Colin Fox claims that the bill would reduce inequalities in health because people on lower incomes will no longer have to pay prescription charges. In fact, those who will gain the most are people like me and other members, who can afford to pay but would get free drugs. There is no evidence to suggest that the bill would achieve any of its objectives.

Labour is committed to tackling the inequalities in health that dictate that life expectancy is based on how much people earn and where they live. Striking at the heart of those inequalities was at the centre of the new approach that we outlined last year in "Delivering for Health". Action includes preventive anticipatory care, especially in the most deprived communities—some of which I represent—a more proactive approach to encouraging healthier lifestyles and better self-management of conditions, wider roles for nurses and allied health professionals, and targeted resources through programmes such as prevention 2010.

Although I did not get a chance to participate in the Health Committee's visit to Wales, I read with interest the comments by the convener and other members who are not currently in the chamber. The committee reported that the visit was not

particularly fruitful because it provided no evidence base for the abolition of prescription charges or for the potential impacts, be they positive or negative.

Mike Rumbles said of the Welsh visit:

"It was clear that the abolition of charges was a political decision that had been not so much made after consideration of a great deal of evidence as motivated by the election results"—[*Official Report*, Health Committee, 29 November 2005; c 2390.]

As I said, Dr Jean Turner said that the visit had been a "walk in the dark". It is important to underline that point.

Roseanna Cunningham said:

"People could relate anecdotal evidence of one kind or another … but very little of the negative or positive impacts that they identified could be backed up by hard evidence."—[*Official Report*, Health Committee, 29 November 2005; c 2391.]

Colin Fox said:

"The one thing that you can say has surely been found in Wales is that the measure is popular."—[*Official Report*, Health Committee, 29 November 2005; c 2419.]

That is the only thing on which I agree with him. [*Interruption.*] I hear Colin Fox crowing that the Health Committee has backed his bill and he chastises the Executive for not following suit. I tell him that the Health Committee is not whole-heartedly behind his bill; four of us did not support it. However, we agree that the status quo is not an option, as ministers have said clearly.

We note that there are serious questions about the cost of Colin Fox's bill. We are definitely not happy to throw away £45 million when that money could be spent in some of the most deprived communities. Colin Fox should admit that he has provided inadequate costings for his proposals. The Health Committee and the Finance Committee agreed that the cost could be significantly higher than has been estimated.

Colin Fox dressed up as Robin Hood a couple of years ago—I suggest that he is now reversing that role because his proposals would rob the poor to give to the rich.

The Deputy Presiding Officer: I call Margaret Smith to be followed by Frank McAveety. You have six minutes, Ms Smith.

John Swinburne: On a point of order, Presiding Officer. I seek clarification rather than anything else. Can you explain to me why, when there are very few people in the chamber who are competent to speak in the debate, Jean Turner—one of my colleagues in the independent group—has been refused the opportunity to speak? That is shocking. Can you remedy the situation?

The Deputy Presiding Officer: The debate is oversubscribed and it is a matter for me whom I call. I have called Mary Smith—I apologise; I have called Margaret Smith, who will be followed by Frank McAveety, who will have four minutes.

15:42

Margaret Smith (Edinburgh West) (LD): I welcome the opportunity to speak in this important debate. I welcome the work that has been done by the Health Committee, Colin Fox's bill—which has engendered this spirited debate—and the consultation that was unveiled by the Executive this morning.

The key points at the heart of the argument include the prevention of ill health and how we approach that—I concur heartily with Mary Scanlon's points about lifestyle and ensuring that we do not rely totally on the idea that there is a drug for every ailment. If we go down that road, we will create serious problems.

The other key point concerns affordability for the individual and the NHS as a whole; I will return to that in detail. The Health Committee's report said that many who would benefit from the bill would be people who can afford to pay for their prescriptions.

Whichever way the vote on the bill goes, the key message that we should take from today is that all members agree that the status quo is not acceptable. Anybody who has read the committee report or heard the anecdotal evidence will have seen clearly that the status quo is no longer acceptable because the system is totally inequitable. The list of chronic conditions that are exempt from charges is inadequate. On the other hand, people who are exempt from charges because they are diabetes patients are exempt from paying for any other prescriptions—if they break their leg, or whatever. That is unfair. Patients who are aged 16 to 19 who are in full-time education are exempt, but full-time higher education students and trainees are not. Surely mature students are more likely to find themselves in greater economic difficulty by going into full-time education.

The proposed system has a number of anomalies. For example, the income exemption would create anomalies with regard to disability living allowance and incapacity benefit. Roseanna Cunningham made some valid points on that matter, which also concerned many people who gave evidence to the Health Committee.

Whatever way we vote at the end of this debate, each of us has accepted that the current system must change. Because of their cost, patients sometimes choose not to take prescriptions, although like much of the evidence, the evidence on that is merely anecdotal. The consultation document that the Executive has published today

contains a range of options, including extending exemptions and ensuring that people know about pre-payment certificates, which can cap their payments for prescriptions. In an intervention, Alex Neil mentioned free personal care. I make it clear that prescription charges can be capped if we make people aware of the difference that pre-payment certificates can make in what they pay over a year.

My main concerns centre on the impact of abolishing charges and the greater needs of NHS Scotland. As the Health Committee has made clear in its report, the £45 million of revenue that would be lost is only part of the issue. It is true that that money could be used to meet various other priorities that the minister highlighted, but other impacts must also be borne in mind. For example, according to the Executive's best estimate, the increased demand for prescriptions under the bill would increase costs by 20 per cent; £17.5 million more would have to be spent on drugs and there would be knock-on effects on GPs' and pharmacists' time. The impacts on a wide range of workforce issues would add about £15 million to overall costs and the cost of filling prescriptions for over-the-counter drugs would increase, with a corresponding impact not only on GPs' and pharmacists' time but on the use of drugs.

Various members mentioned Italy. I was concerned to discover that, when Italy abolished prescription charges, demand increased by 44 per cent. The Italians are wondering whether they should change their minds.

I am also very concerned that, when we are trying not only to keep down the cost of drugs—which is currently growing at 10 per cent a year—but to reduce wherever possible the use of drugs by patients, the bill would have the opposite effect. It is wrong in its proposals on preventing ill-health, wrong about how it would affect people's lifestyle choices, wrong about the principle of individual affordability, in which rich and poor people should pay what they can afford, wrong about the costs that it will incur for the NHS and wrong about its impact on NHS priorities and the way forward.

The case for abolition has not been made, although there is certainly a case for reforming the system. Parties across the chamber—and the Executive—have accepted that point. I applaud the Executive on its consultation document and hope that, instead of supporting the removal of all charges with all the anomalies that that would create and all the impacts that that would have on the health service, people will take this opportunity to construct a system that is fairer, that will benefit the poor rather than the rich and which will improve the NHS in Scotland. Let us now grapple with reform and ensure that we create a system that is fairer and better for all.

15:48

Mr Frank McAveety (Glasgow Shettleston) (Lab): At time for reflection, Alison Twaddle from the Church of Scotland Guild said that a Parliament was about

"women and men trying to figure out the right thing to do."

Despite all the heat and the—occasionally rather fake—anger and indignation that we have witnessed in the chamber this afternoon, the debate is about how we use a finite amount of health resources most effectively to meet the needs of the people of Scotland.

The bill is another in a series of uncosted and often unsustainable demands that have been made primarily by the SSP. Even if some of its points about the impact of the present charging policy contain a grain of truth, the issue is much more complex than it has made out and cannot be addressed merely by simplistic slogans. However, we are talking about a party 90 per cent of whose manifesto commitments at the previous election were uncosted, unidentified and in some cases not legally enforceable under the Scotland Act 1998. Given that manifesto, how can we believe that there has been any real examination by the SSP of the proposal put forward by Colin Fox?

Tommy Sheridan: Will the member take an intervention?

Mr McAveety: No. I read the manifesto. That was enough of fantasy land for me.

Opposition spokespersons have conceded today that any figure that we talk about is not a "drop in the ocean"; I accept that and I think that they do too—in fact, those are Shona Robison's words.

What the Health Committee said in its report is central to how we should approach the debate. It said that a serious review of prescription charges is required. We have had that discussion and there has been a response from the minister. The convener of the Health Committee asked questions about the overall cost and eventual impact of removing all charges. There was anecdotal evidence about whether charges discourage people from looking after their health. More important, there was concern that people were not taking up the annual passport for prescriptions. The *Daily Record* has been mentioned as one of the sources of information; the cost of buying the *Daily Record* every day of the year is more than it would cost to have a pre-payment certificate for the whole year.

Tommy Sheridan: Will the member take an intervention?

Mr McAveety: No. I want to address a point that Mr Sheridan and the other SSP members have raised. They have articulated in the debate that

some members of the Parliament are entitled to free prescriptions. I thought that the SSP's starting point was that everybody should get a free prescription. I am morally offended that the SSP should question those members' right to have a free prescription if that is allowed under the current rules and regulations. As someone who, like Mr Sheridan, can afford to pay, I have no worry about saying that I have an obligation to ensure that those who need the help most should have the prescription charge paid for them at the time that they need the prescription. Instead of subscribing to the politics of envy and criticising those members, the SSP should recognise that they are legitimate recipients of a service that it would like to extend, although it will not tell me the cost of the extension.

Tommy Sheridan: It is called redistribution of wealth—Frank McAveety used to believe in it.

Mr McAveety: In respect of the redistribution of wealth, there is obviously a debate about what the National Assembly for Wales did. It is an Assembly, not a Parliament—I would like members to reflect on that point.

The Deputy Presiding Officer: You have one minute left.

Mr McAveety: It is a devolved Assembly that makes such decisions based on the health needs of constituents in Wales. That is right and proper, but that is not the debate in Scotland.

A great Welshman, Nye Bevan, said—[*Interruption.*] A question has been asked about people's socialist past, so I am pointing out that Nye Bevan said:

"the language of priorities is the religion of socialism."

What we have had today is a legitimate debate—strong as it has been—about how we best allocate resources. Unlike Mr Fox, I do not make it a priority to pontificate about helping the poor while ensuring that we pamper the protected and the privileged. If those are the SSP's politics, they are entitled to do that, but they should not lecture anyone else on the matter.

I will conclude by saying that the debate is not about reform or revolution; it is about abolition versus reform. The right and legitimate approach is reform. I hope that the consultation—

The Deputy Presiding Officer: You must finish now, Mr McAveety.

Mr McAveety: Members would perhaps like to hear my final sentence. [*Interruption.*] Sorry, Presiding Officer, but I cannot hear you.

The Deputy Presiding Officer: You must finish now.

Mr McAveety: Thank you. I could not hear you because of the rabble at the side.

The Deputy Presiding Officer: Alex Neil has six minutes.

15:53

Alex Neil (Central Scotland) (SNP): I say right away that I fully respect that it is the Presiding Officer's decision whom to call in the debate. However, I am willing to cut my time by two minutes to enable Dr Jean Turner to speak because I would like to hear from her later in the debate. I fully—

The Deputy Presiding Officer: You are right. It is my decision. I point out that I have had to tell other members who were on the list before Dr Jean Turner that they would not be called. It is a matter for me or the other Presiding Officers. Carry on, Mr Neil.

Alex Neil: Absolutely. I am trying to facilitate the process.

I found it incredible that Frank McAveety had the cheek and audacity to quote Nye Bevan. If Nye Bevan had been sitting in the public gallery listening to the speeches that have been made by the new Labour members in the debate, he would have been disgusted. It was Nye Bevan, a Labour minister, who introduced the principle of free prescription charges. If those new Labour people had been in the House of Commons in 1945 they would have said to Nye, "You cannae introduce a free health service, because it will help the rich." Is the logic of that that the rich should not get access to a free hospital bed, a general practitioner service, a free operation or child benefit because they are rich? Have Labour MSPs never heard of the principle of universality for certain key services so that we can create a society not just in Scotland but in the rest of the United Kingdom in which we have genuine equality?

Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD): Will the member take an intervention?

Alex Neil: No; sit doon, Jeremy.

It is no surprise that, in the eight years of this so-called Labour Government, inequality in Scotland has got greater, not smaller, because of its pursuit of policies that create inequality rather than solve it.

Mr McAveety: The most recent reports on child poverty have shown progress being made in Scotland to address that systemic issue, so how accurate are Mr Neil's claims about universality? While we are on the point, can Mr Neil tell members what would be the cost of extending universality to all the areas that he identified?

Alex Neil: It is not a great boast for a Labour member to say that after eight years of a Labour Government a quarter of our children are still living on or near the poverty line. If Mr McAveety thinks that that is progress, he is no socialist and, in fact, he has no right to the title "Labour" and to the traditions of the labour movement.

We have heard a lot in the debate about costs and about the £45 million, but the Executive has not told us its costing for dealing with the anomalies. It has criticised everybody else for not having any figures for costs. The Executive has stated that it will get rid of the anomalies; what is the cost of doing that? I want the Deputy Minister for Health and Community Care to give us the number.

Lewis Macdonald: I wonder whether Alex Neil welcomes the fact that we are consulting on precisely how we will deal with the anomalies and that one of the purposes of our consultation is to assess the cost.

The Deputy Presiding Officer: Just a moment, Mr Neil. There is far too much noise from members in sedentary positions. There is a method of intervening and if the member does not take an intervention, members should sit quietly and listen.

Alex Neil: The bottom line is that Mr Macdonald does not have a clue about the costs, but the Executive is criticising everybody else because they do not have figures for the costs. The fact of life is that if the Executive gets rid of the anomalies, it will not have £45 million of revenue. If it gives people on incapacity benefit and disability living allowance entitlement to a free prescription, as it should, and covers all the chronic diseases for exemption, as it should, by definition the cost of the final step of abolition cannot be £45 million. The net cost will be substantially lower than that.

I heard somebody refer to the 44 per cent increase in demand for prescriptions in Italy. Does it not occur to members that perhaps that increase in demand is genuine and that those people could not afford their prescriptions when they had to pay for them? Are members saying that all those people in Italy are at it? The fact of life is that we do not know, as Roseanna Cunningham said. What I find incredible is that it has taken the Executive three years to get round to tackling this problem. If the bill has done nothing else, it has at least forced the Executive to take some, albeit inadequate, action.

I will stop now in the hope that we hear from Jean Turner.

The Deputy Presiding Officer: Des McNulty, to be followed by Carolyn Leckie. You have four minutes, Mr McNulty.

15:59

Des McNulty (Clydebank and Milngavie) (Lab): I suppose that the task for the Scottish socialists, given their unpopularity, the unrealistic nature of their overall politics and their lack of support, is to try to find some item on which they can make themselves popular and appeal to people who do not look into the issue too seriously. The role of the Parliament, particularly the parliamentary committees, is to consider carefully the basis on which legislation is introduced. I believe that the Abolition of NHS Prescription Charges (Scotland) Bill is based on four false premises.

The first false claim is that the bill would substantially benefit poor people. That is manifestly untrue. All those on income support and those on an equivalent income are already exempt from prescription charges. The gainers would be primarily those on middle and upper incomes. The best debating point on that subject was made by Colin Fox. He said that 30 MSPs get free prescriptions. However, his bill would mean that 129 MSPs would get free prescriptions—100 beneficiaries, none of whom is poor. That would be replicated across Scotland.

The second false claim is that the removal of prescription charges would make a substantial difference to people with serious illness who are above the benefits threshold. The reality is that most people who have chronic illness already qualify for free prescriptions. Further, the Executive is going to review the categories of illness in order to deal with some of the anomalies. The maximum payment for those who have to pay is £92 a year. There is an issue about the basis on which the SSP is putting its argument, because most of the beneficiaries will be those without chronic conditions who are better off and who currently pay for occasional medicines.

The third false claim is that the removal of prescription charges will cost £45 million. When it completely demolished that argument, the Finance Committee was clear that the cash involved would be significantly more than Colin Fox claimed that it would be. Even Colin Fox accepted that position. We do not know how much the increased uptake from the 50 per cent who are not currently entitled to free prescriptions will be. It has not been quantified. I ask Roseanna Cunningham why the Health Committee—or any other committee of this Parliament—should pass a piece of legislation whose cost basis is manifestly untrue. We have to be responsible and serious on this matter. The reality is that it would be the better-off rather than the poor who would gain yet again and that it would be the sick and the poor who would stand to lose most.

Tommy Sheridan: Will the member give way?

Des McNulty: No, the member has had his chance.

The final lie is that the reduction in the money that is available to the health service—even if we say that it is £45 million—is somehow inconsequential. As the minister said, that is the equivalent of the amount needed each year to run Perth general hospital. Of course, we would not shut a hospital in Perth or anywhere else in Scotland. What would happen is that there would be a reduction in the money that is going into health improvement across Scotland. It would be the poor people, those who are sick and those whose health needs the greatest support who would lose out as a result of this money being diverted to support the better-off occasional users of prescriptions. It is a perverse logic that has no basis in reality.

If we were to agree to the bill, we might make friends or find that this person or that person who is adversely affected by the existing system will come up to us and say, "That was a good thing that you did," but, in reality, we would have given to the rich and taken away from the poor and the sick, which is exactly the opposite of what the Trotskyists say that they are trying to do. Of course, that is the reality of Trotskyist politics: what they say is the opposite of what they do.

16:03

Carolyn Leckie (Central Scotland) (SSP): Well, well, well. Today, Frank McAveety was left quoting Nye Bevan as he united with the Tories to deny the principle of universality. Coming from a guy who represents a constituency where the life expectancy is 57, that is a cheek.

Let us get back to the human arguments in the debate. As has been ably demonstrated by a number of members—apparently, there is agreement across the chamber on this point—the current system is ridiculous and iniquitous. Take the case of Jackie, a young mum who is a local authority worker in East Kilbride and who suffers from coeliac disease. Due to her condition, she needs bread on prescription. If she does not have that, she will become extremely ill. Until recently, her general practitioner would prescribe only one loaf per prescription, which meant that she was paying £6.50 for a loaf. That is how ridiculous the system is. Unless Labour members live up to their professed support for reform of the system by supporting the principles of the bill and taking the opportunity to amend it at stage 2, that is the ridiculous system that they are prepared to defend in the chamber today.

This regressive tax on the sick comes from the same political school as the poll tax, and Labour used to understand that. All the evidence—and evidence has been presented, much to the disdain of those who oppose the bill—shows that 7 per cent of people do not pick up prescriptions due to the cost. People who are sick go without prescriptions and many of them have to be admitted to hospital, which puts an increased cost on the NHS.

Voting against the bill will set members against the people of Scotland, 82 per cent of whom support the abolition of prescription charges—some of them might still be voters in 2007. Members will be setting themselves against 36,500 nurses and 150,000 Unison members, who know better than the likes of Duncan McNeil, and they will be setting themselves against Citizens Advice Scotland. Those people and organisations know the reality of prescription charges and their impact on the poor, on people on incapacity benefit and on people on low incomes, which is that they must go without their vital medicines. They are the people to whom we should be listening.

The Executive has an absolute cheek. It has been prepared to hand £280 million to business to cut business rates, but it is not prepared to fork out £45 million for the sick. Under Labour, billions of pounds have been transferred from the poor to the wealthy, so we will take no lectures from Labour about poverty. The Executive is not interested in making the rich pay—£80 billion of tax revenues from the rich remain uncollected. It is so mean spirited that it will not spare £44 million to deliver medicine to the sick, but it is prepared to spend more than £5 billion bombing, invading and occupying Iraq.

Aneurin Bevan—a real custodian of Labour values—promised the post-war and subsequent generations free prescriptions and the principle of universality. Therefore, it is primarily to Labour members that I turn. Kate Maclean, who is unfortunately not in the chamber, and Elaine Smith have had the courage of their convictions, and I admire them for that. I know that the rest of the Labour back benchers are embarrassed about defending the indefensible—I see them squirming in their seats. I know that at least one of them planned to introduce this very bill themselves, but Labour members' narrow-minded fear of the Scottish Socialist Party is such that they are prepared to condemn the sick to unfair and punitive charges rather than support anything that the SSP brings to Parliament. What a shame. Labour members should bear Rabbie Burns's words in mind about seeing oursels as ithers see us.

Surely, some Labour members are bigger than that and will put what is right and fair and what is in the great tradition of Aneurin Bevan ahead of any pressure that they are under from the Labour

whips. They should take the chance to match their colleagues in Wales; they should take the chance to put the needs of the vulnerable, the sick, the poor and the excluded ahead of narrow, sectarian party-political interests. Members have an opportunity to give people such as Jackie and thousands of others something to celebrate.

The argument that the abolition of prescription charges is a benefit to the rich rings hollow. The idea that there are 2.5 million rich people in Scotland makes me laugh. If there are, they are better at hiding than Osama bin Laden.

It is fitting to quote Burns on Burns's birthday—it is his birthday, not the day that he died. I have a very prescient and pertinent Rabbie quote. I ask Labour members to

"dare to be honest and fear no labor"

whips.

16:09

Eleanor Scott (Highlands and Islands) (Green): As other members have done, I will try to be brief in the hope that Dr Jean Turner can have some speaking time. As she is a member of the Health Committee and a former general practitioner, her voice should be heard in the debate.

I support the bill, because I support the principle of an NHS that is free at the point of need. If that is a political statement, I make no apologies for it. I will speak entirely about the bill and the Health Committee's response to it. I will not refer to the Executive's consultation, as I was unaware of its existence until today. I was not party to the political thinking at the time of the introduction of prescription charges in 1952, as I was just one year old then. However, it seems arbitrary that this one aspect of health care has, since then—with a brief exception of three years in the 1960s—carried a charge, while other forms of health care have been free at the point of need. We would not think of introducing payment for X-rays or for other forms of care, as that would be equally arbitrary.

The list of exemptions that the Executive appears to intend to consider dates from 1968. Issues of the list's current suitability arise—it is no longer fit for practice and it clearly never was, as it had anomalies from day one. I remember that being mentioned when I was a medical student in 1968. A lecturer talked about the anomaly whereby somebody who had an underactive thyroid and who was receiving thyroid replacement treatment could also receive a free elastic stocking, whereas someone who was on lifelong treatment with digitalis for a heart condition had to pay for all the prescriptions. The list has never made any sense and I question the possibility of ever achieving a list that makes any sense. As has been said, conditions that have not been amenable to treatment but which become amenable to treatment would therefore have to be added to the list. If the system of having a list that is based on clinical grounds is to continue, we will be condemned to review and re-review it constantly, which would involve a cost and take up a lot of professional time spent agonising about the matter.

There are two classes of exemptions: those which are based on clinical need and those which are based on personal circumstances, such as income. As has been pointed out, the second class of exemptions also raises many anomalies. For example, people who receive incapacity benefit or disability living allowance are missed out. I welcome the opportunity to review the exemptions, but we should go one better, because there will always be anomalies.

The cost of the proposals is a major factor and is, I presume, the one issue that prevents all members from supporting the bill. We have talked a lot about the upfront cost to the NHS of £45 million a year. Alex Neil made the good point that some of that £45 million will have to be paid out anyway if a review takes place and people who are not currently exempt are found to merit exemption. Therefore, that £45 million will not all be kept for other spending purposes in the NHS. I also wonder whether the figure is net or gross, as we must take into account the cost of administering the system. Any system that depends on people being exempted from a charge must be policed and administered. Colin Fox said that the cost is £2 million a year; I do not know whether that is right, but there is definitely a cost.

It has been claimed that there could be increased costs as a result of people taking up prescriptions that they do not at present take up or of people demanding prescriptions for drugs that could be bought over the counter. I wonder about that argument. If somebody needs a preparation that is available over the counter, they will pay for it if they can afford it. If they cannot afford it but still need it, it is not unreasonable that they should get it on prescription. If they can afford it, they will not wait three days for a doctor's appointment to get it—they will just buy it. That argument is a red herring.

The existing system may have hidden costs that could be saved by introducing free prescriptions and increasing the uptake of necessary medication. However, as has been said, there is a lack of study on the matter. A briefing that we have received refers to an example in the United States. It is difficult to translate from the US to the UK, but the study showed that, when the amount of reimbursement that people with schizophrenia

could claim was capped, that led to increased hospital admissions, with a cost that was 17 times the amount that was saved.

There are other ways of making savings in the NHS. Roseanna Cunningham said that the Parliament should not be afraid of making political decisions. We have made courageous political decisions, for example on free personal care for the elderly. We cannot ignore the advice of bodies such as Citizens Advice Scotland, which shows that some people are slipping through the net and suffering under the present system. This is a time to make a brave political decision. I support the bill.

16:15

Elaine Smith (Coatbridge and Chryston) (Lab): I record my registered interest with regard to Unison, which supports the abolition of prescription charges.

We should remember that the debate is about sick people and people who, I am sure, would prefer not to be reliant on prescriptions, free or otherwise. We all agree that the current system is a mess and that, while certain chronic conditions get free prescriptions, many do not. Certain people on low incomes get free prescriptions; many do not. New mothers get access to free medicine for the first year, after which they do not. In Coatbridge and Chryston, there are nearly 8,000 people on incapacity benefit. Most of those claimants do not get free prescriptions; nor do those on DLA, despite the fact that their need for medicines and appliances is likely to be greater than that of people in other sections of society. It is likely that the working poor and people on the minimum wage have to pay for their medicines.

Obviously, a few well-off individuals might benefit if we abolished charges, but they are already getting free prescriptions for their children—or themselves if they are over 60 or have a particular chronic condition. On the latter point, it is less likely that such individuals will need prescriptions, because the wealthy are statistically less vulnerable to ill health. They might also attend a private GP, who can write them private prescriptions, which can allow them cheaper access to medicines.

I support the general principles of the bill for a number of reasons, most important of which is that it will be of benefit to the vast majority of the people I represent, when they take ill.

Prescription charges have proved problematic for the Labour Party over the years. Nye Bevan famously resigned his ministerial post, outraged by the way in which prescription charges compromised the fundamental principles of the NHS. Labour's 1974 manifesto pledged:

"The Labour Government … will continue the progressive elimination of prescription charges".

Subsequent manifestos have essentially sustained that position, although perhaps in subtler language. However, in the intervening 32 years, only the Welsh Labour Party has delivered on it.

How would we pay for the abolition of prescription charges? Is the cost too high? I contend that the cost that is too high to pay is the cost of the continued worsening health of people with chronic conditions and sickness who cannot afford their prescriptions; people who are too poor to buy their prescriptions; and those who have to make a dangerous and humiliating choice about which bits of their prescription to buy, such as whether to buy the brown inhaler or the blue one. I would not want to have to make that choice. If costs increase because sick people are taking their medicine, surely that is a good thing.

How do we pay for it? What about savings on the price of drugs? Drug companies make a lucrative income from the NHS. Unison suggests that the excess cost could be met by taking a radical approach to tackling the escalating costs of drugs and suggests that the procurement of drugs could be included in the Scottish Executive drive to secure a streamlined procurement strategy. Alternatively, the Chancellor of the Exchequer could adjust the upper earnings limit on national insurance contributions, which is currently £645 a week. That might help to reassure those who worry that we might somehow advantage the seriously rich sick people. We could vary taxes.

There are many ways of finding the costs if we are serious about sorting out the prescription fiasco. However, perhaps we could just implement abolition gradually, as the Welsh have done. It is ridiculous to argue that GPs' surgeries will suddenly become so inundated with the wealthy looking for free prescriptions that GPs will be unable to see their poorer patients. Will people suddenly start making themselves ill? No. Do better-off parents run to the doctor when they want paracetemol for their child, who is entitled to free prescriptions? I do not think so; they buy it in the chemist. Do the better-off with chronic illnesses demand that they get every cough medicine bottle and headache pill free? Frankly, it is quite insulting to accuse them of that. On the whole, the better-off will continue to buy over-the-counter medicines, because that is much more convenient.

What removing charges would do is to ensure that no one experiences a barrier to medicine because of cost and financial hardship. We should abolish prescription charges. The Scottish Executive has not come up with anything better. Universal benefits are paid by those who can pay and are shared by everyone, to the ultimate benefit of society as a whole.

16:20

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I thank everybody who has supported my being given the opportunity to speak. I appreciate it, because 25 years in general practice led me to believe—before I ever thought about politics—that the abolition of prescription charges was the only way to go.

Much has been made in the debate of GPs' time. Every week of every year when I was a GP, much of my time was taken up trying to explain to patients how to take drugs and the importance of getting them even if there was a cost. Many people cannot afford their prescriptions because they are on low incomes and do not come into any of the categories for exemption from the charges. I got fed up trying to explain why there was a cost, because the cost of the prescription did not relate to the cost of the drug and many people—even those who could afford to pay—did not understand that, so it took up a lot of my consulting time.

Asthma is a good example. There is a side of the equation in asthma treatment that has not been calculated. Over the years, general practitioners have done their job well and have looked after asthma sufferers better. With the help of practice nurses and asthma clinics, they have ensured that asthma patients take their drugs properly so that they do not end up going into hospital, as used to happen when I went into general practice. In 1975, I would be called out urgently to prevent somebody from dying from an asthma attack. People still die from asthma, which is sad. They will continue to die, because they frequently do not take their preventers—I can tell members that for certain, although it did not come out in the evidence that the Health Committee gathered. Patients will use the blue inhaler—the Ventolin—because they know that that helps them that instant, but they are scared to spend money on the other inhaler. However, the cost does not stop at two inhalers. Some asthma patients are on three treatments and, occasionally, when there are acute exacerbations, GPs throw in steroid tablets, so that means four—or, if an antibiotic is necessary, even five—times £6.50 for people who pay.

If we control pain, we save money. The McEwen report said that pain clinics might save us £1,000 per patient. Many sufferers of osteoporosis are in the younger age group, perhaps because they happened to have an early menopause or a family history of the disease. If we do not treat their osteoporosis, we end up treating fractures, which costs more. There is another side to the accounts that is never seen: we would save money if we treated people correctly.

Some people are on hormone replacement therapy. They can never understand why a combination treatment is twice the cost—it is two times £6.50 for HRT.

Over the years, the invention of new drugs for ulcer treatment has prevented patients from needing to go into hospital to have surgery. That has made a saving that has never been costed, because research has never been done to find out how much the treatment that was saved on would have cost.

We must also consider transplant patients. When they are in hospital, they get their treatment free, but when they come out of hospital, their GP writes a prescription and they have to pay for it. I overheard a clinical conversation regarding a transplant patient who was having financial difficulty in paying for the treatments that would prevent rejection. Members should consider the cost of that, which is enormous and would never appear on a balance sheet. Somebody gave a precious kidney, but it was rejected because the recipient could not afford to take the drugs to prevent rejection. That kidney transplant patient was spreading out their treatment, which many general practice patients do because they think that it will fill the month better.

Many times a patient would ask me whether I would put a treatment on the prescription of somebody else who would get it free. I had to tell them that, although I would love to do that, I could not, because it was fraud. People were being forced to contemplate fraud.

We could save money if drugs that are out of patent were manufactured in the UK, making the drugs cheaper for the NHS. It would be nice if drugs cost the same in primary care as they do in hospitals, because they are cheaper in hospital. I used to be hassled sometimes about the cost of the prescriptions that I wrote. I was writing them in general practice whereas, many years ago, they would have been taken over by the hospital. The practice of pushing everybody into the community faster and of trying to keep people out of hospital puts up the drugs bill.

The debate has thrown up many anomalies in the system. Experience tells me that the only fair way is to abolish payments for all. Let income tax take it. We need only think about fuel allowances and free travel for the elderly.

The Deputy Presiding Officer (Murray Tosh): We now come to closing speeches. A number of members have accepted a reduction in time.

16:25

Euan Robson: I was interested to hear Jean Turner's speech and pleased to be able to assist her in making a contribution.

This has been a significant and, at times, passionate debate, and rightly so. With all due respect, I do not think that the case for the bill has been made, but the case for reform has undoubtedly been demonstrated. However, there are certain inescapable facts. With all due respect to the member in charge, the bill's financial memorandum is inadequate. I appreciate the difficulties for a member in introducing a complicated financial proposal.

Carolyn Leckie: Will the member take an intervention?

Euan Robson: In a minute.

The financial memorandum omitted to refer to all the additional costs. We have heard copious evidence of that today. We have heard a great deal about where the actual cost will lie, but the truth is that no one can be sure. It is like taking a leap into the dark. The Royal Pharmaceutical Society of Great Britain has stated that the cost to the Scottish Executive of total abolition could be an additional £245 million

"if the Italian experience was replicated in Scotland".

Colin Fox: Does the member accept that the Royal Pharmaceutical Society of Great Britain supports abolition, and did so in evidence before the Health Committee?

Euan Robson: I am not clear that that is in fact the case. I will accept the member's view, but it does not detract from the fact that the society says that the costs could be that high if things develop in a certain way.

I was interested in Alex Neil's contribution. He seemed to suggest that universality is indivisible. If that is the absolute case that he was advancing—and he is perfectly entitled to hold that view—how could we possibly afford the consequences? How could any Government afford the consequences? We needed to hear more from him on that. Perhaps Stewart Maxwell will be able to explain it to us when he winds up for the SNP.

Shona Robison: Does the member accept that exactly the same arguments were used against free personal care for the elderly, which the member supported at the time, which he is now turning around to use against the policy that we are debating now? Is that not hypocritical?

Euan Robson: I am not turning the argument around to use it against the proposals. In effect, what I am saying is that there are practical limitations to the concept, which even Shona Robison must understand. If she is advancing the concept in her programme for government, I would love to hear how she will pay for it.

One important point that has been made is that the Executive will have to identify the cost of its proposals and how it intends to find the resources. What is sauce for the goose is sauce for the gander. That is a task ahead.

On the consultation, it is relevant to point out that there should be an opportunity to identify cost reductions through streamlining administration of the system. I am sure that the Executive will wish to take that on board in preparing the options that it will eventually propose.

Roseanna Cunningham made a particularly important point about the lack of awareness of the existing pre-payment scheme. It is not well known. The Executive will need to address that, too.

During the debate, nothing was said about the risk to community pharmacies. That is a very relevant consideration, and perhaps the minister could address that issue in his reply and suggest the scale of the risk to community pharmacies of total abolition, as he envisages it.

The tone and balance of the Health Committee's report—which is a thorough, good report—and of the evidence that is provided with it suggest an alternative conclusion to the one that was reached by majority decision. That is the impression that I and many impartial observers have been left with. The fact that the committee decided to agree to the bill at stage 1 is fair enough, and we respect that point of view. As Duncan McNeil mentioned, we also respect the point of view that the Welsh have come to on the issue. However, it is clear that there is little hard evidence on why Wales went down that particular route. It is perfectly reasonable to make a political decision of that nature, but devolution means that different decisions will be made in different parts of the United Kingdom. It is equally reasonable for Scotland and Wales to choose different courses of action.

16:30

Mr David Davidson (North East Scotland) (Con): This has been an emotional debate, although there has been some humour in it. There is a lot of agreement about certain core issues. The fact is that the status quo is untenable. In the past three years, the Conservatives and others have asked for a review of the chronic condition exemption scheme. I welcome the consultation document that the Executive published today, late as it is. It is a shame that it was not published in time for the Health Committee to take it into account, but I suppose that we do not want to rush things just for the sake of having a political answer. I would rather wait for a real consultation paper to be produced and examined properly not only by the Health Committee but by others in the Parliament, including the Finance Committee.

I should have declared that I am still a registered pharmacist although I do not practise and I have no shares in anything to do with community pharmacy. I remember being a guinea pig for the sale of pre-payment certificates in pharmacies, which aimed to make things easier for people. The health authority was staggered by the number of times we phoned during the first week to request more papers and by the number of payments that we received. The authority did not believe that the demand was genuine so it set up another trial and the same thing happened elsewhere in the area. That demonstrated that people were prepared to make a contribution but wanted it to be affordable. Under the current system, pre-payment certificates cover four months or 12 months. The system is not a clever one because some people cannot afford to pay for a full year in one go. I hope that the minister will review the ways in which people can pay and the regularity and scale of payments.

The Finance Committee criticised the financial expertise that went into producing the information on costs. That was also mentioned by Roseanna Cunningham from the Health Committee. It is incumbent on anyone who introduces a bill to the Parliament, including the Executive, to propose pragmatic legislation that is affordable and deliverable. Whatever we decide to do about prescription charges, I do not believe that the model that Colin Fox has proposed is pragmatic. It might seem pragmatic to some people, but it is certainly not affordable and he has not provided evidence to demonstrate that it would be deliverable. We have not seen enough research that compares the approaches that are taken in different parts of the world, although there is some research in the Executive's consultation paper.

Even if we increase the number of exemptions, we must accept that the £45 million figure that has been bandied about will not be the true figure. If we double the number of exemptions, there will not be an income of £45 million—that is a fact of life. We must be fair and honest about these things. I believe that the Royal Pharmaceutical Society's figure for the additional costs—around £250 million—is not wrong.

In response to Elaine Smith, I say that the Treasury negotiates with the drug companies twice a year and the pharmaceutical price regulation scheme sets the price of the branded prescription drugs that are used in the health service. We can use more generic drugs to cut the overall cost, but that will not help the patient: the treatment will be the same.

We do not do enough work on medicines management to ensure that people use their medicines correctly. Sometimes, I think that GPs could do with more prescribing guidance, which might reduce the number of prescriptions.

I hear anecdotal evidence of people saying to pharmacists, "I can only afford two out of my three prescriptions. Which ones do I need?" The odds are that those are people with chronic conditions rather than one-offs. We need to reconsider the exemptions carefully.

A number of members made interesting points during the debate. I agree with Margaret Smith's point about the workforce. There is going to be a shortage of pharmacists regardless of whether there is an increased volume of prescriptions for them to deal with. There is also a shortage of GPs coming up.

Frank McAveety was right to say that the debate is about either abolition or reform. From my perspective, there has never been any argument about the fact that there needs to be reform of the prescription charging system, but I have yet to be persuaded that abolition is the solution. If there is an increased demand on the budget, should more Executive money be spent or should services be cut somewhere else? Those are the hard choices that medics have to make and that GP fundholders used to have to make. Money can be spent only once, and people must ensure that it is spent appropriately.

The Scottish National Party talked about political expediency. That is a fact of life; it is what politics is about. Governments are elected to use their political power to deliver results. The Opposition's job is to ensure that it scrutinises what the Government puts on the table. I look forward to reviewing what the Executive has to offer.

As far as the Conservatives are concerned, Mr Fox has not made the case for his bill. It is poorly analysed. I have said that to him from the beginning, so that is not news to him. We will not support the bill.

16:36

Mr Stewart Maxwell (West of Scotland) (SNP): As Mr Davidson has just said, the debate has been interesting. Others have said that it has been emotional. Clearly, those on both sides of the argument have some deeply held views. It is healthy that we thrash out the arguments in this kind of debate. However, several members have suggested a series of false choices. I am afraid to say that that happens all the time. The Minister for Health and Community Care, Mary Scanlon and Des McNulty all did that. People ask, "If prescription charges are abolished, which kidney machines will we stop funding to cover the £45 million that people currently spend on prescriptions?" and "Which hospitals should be closed?" Perth got a mention. Those are all false choices. If they are real choices, the Executive must tell us which ones it would make. If, when its

consultation concludes, it intends to expand the list of exemptions to include those with extra chronic conditions and those in full-time education, costs will increase. Which kidney machines will the Executive cut to pay for that? Which services will be closed down? The Executive will face exactly the same choices. Frankly, it has not answered that question, so it is unreasonable and unfair to accuse others of not doing so.

Mr Kerr: If the member looks at the *Official Report*, he will see that I was demonstrating that £45 million is hardly a drop in the ocean.

Mr Maxwell: Nobody argues with that. However, your deputy discussed the choices, as have others, and I am saying that those are false choices. The minister will have to make choices about the services that he will cut if he intends to extend the system. He knows that he will not do that, and neither would we if we abolished prescription charges.

Euan Robson said that he opposed open-ended spending commitments. I do not disagree. It is strange continually to talk about open-ended spending commitments. However, the Liberal Democrats did that when they supported free personal care, free eye care and free dental checks. The Liberal Democrats are happy to make open-ended spending commitments when it suits them, but they totally oppose them when it does not suit them and the Labour Party. That is the bottom line.

In his opening remarks, the Minister for Health and Community Care stated that the Executive had looked at something like 16 other countries and that we should not adopt the policy because it has not been adopted in those countries, which is a rather bizarre argument. The minister then said that he will extend exemptions to students and those who are in full-time training despite the fact that the Executive's document states:

"There is little evidence from other countries of exemption policies for students and people in training".

If what happens in other countries is his example and reason for opposing the bill, he should not say that he will extend exemptions even though there is no evidence that any other country has done that. Frankly, he cannot have it both ways.

I was not going to mention Duncan McNeil's rather strange rant, but I surely must. He spent his time attacking the lack of evidence from the bill's supporters. However, Roseanna Cunningham made it clear that no solid evidence was provided on either side. Duncan McNeil was utterly selective with what he used and he is frankly—I will not use the word that I was going to use. He should argue on the basis of the evidence for both sides and not just the evidence for one side. The Deputy Minister for Health and Community Care could not say how much it would cost to implement his proposals. The evidence is limited on both sides.

Roseanna Cunningham answered the question for the committee. It is clear that the evidence is not available, but political principle must come into play. There is no political principle among Labour members; the political principle lies with the SNP. Labour members have completely abandoned their principles.

Mary Scanlon's speech showed an incredible lack of faith in our doctors. She suggested that doctors would just prescribe willy-nilly. If she has a problem with the prescribing policy, she should deal with that rather than use it as a reason to oppose the abolition of a tax on sickness.

I very much enjoyed Elaine Smith's speech. She is right to ridicule the idea that people will rush to their GPs just because prescriptions are free. They will go to their GPs because they are sick and not because prescriptions are free.

The Deputy Presiding Officer: You must close.

Mr Maxwell: If people can afford it, they will go to their local chemists to buy medicine, because they can do that quickly.

The Executive's consultation is on a new system that looks, at best, even more complicated than the current system.

The Deputy Presiding Officer: You must close.

Mr Maxwell: We should reject that nonsense and support free prescriptions for all. That is the right thing to do.

16:42

The Deputy Minister for Health and Community Care (Lewis Macdonald): We started with Colin Fox's speech, in which he asserted that 30 MSPs qualify for exemption from prescription charges because they are over 60, have a chronic condition, are pregnant or are nursing mothers. That is an example of the anomalies in the present system, which we recognise.

However, Colin Fox's bill is not designed to limit exemptions to those who are on low pay. He said that it is unjust that one in four members is exempt from paying charges but, as Des McNulty said, his solution is to extend exemption to the other three in four members. That is hardly a blueprint for social justice and it is more than a debating point—it goes to the heart of the SSP's proposal.

Because the system has anomalies and because some people who are on low incomes are not exempted, the SSP proposes not to reform the system or to exempt the people who have

been missed out, but to give tens of millions of pounds back to everyone who pays, including those who can afford to do so.

Tommy Sheridan: I ask the minister to clarify paragraph 4.3.7 of the Executive's consultation document. Does the Executive intend to means test pensioners for prescription charges?

Lewis Macdonald: No. I am glad that Mr Sheridan has given me the opportunity to make that clear and to respond to points that have been made about free personal care. It might not have occurred to SNP members that free personal care applies to people who are over 60 in the same way as the exemption from prescription charges does. People ask whether we are consistent. We recognise that people over 60—even those who are on good incomes—have particular health and care challenges that younger people in general do not have.

I will be absolutely clear. Some policy objectives are involved—[*Interruption.*] Shona Robison refers to dental checks from a sedentary position, so I will address them. Free dental and eye checks relate to our policy and priority of preventive care and of tackling illness before it happens. That is completely different from the proposition that drugs should be made free.

Shona Robison *rose—*

Lewis Macdonald: I will move on.

Concern is felt about people who are on low incomes and who do not qualify for an exemption. Like Elaine Smith, we make it clear that we want to ensure that nobody is deterred from taking their medicine because they cannot afford to pay a prescription charge. As Margaret Smith and Roseanna Cunningham said, the extent of that problem is unclear and Colin Fox has not provided substantive evidence of that.

However, we know that more than 20,000 people qualify for help for some medical costs on the ground of low income, but not for free prescriptions. We think that we can do something about that, which is why the issue was included in the consultation paper. We know that students and trainees are often at the lower end of the income spectrum, and we think that we can do something about that too. We recognise that some of the people who would benefit most from an annual season ticket system that would cover all their prescriptions for a year can struggle to find £93 up front to get that benefit. We want to explore how we can do something to enable people to receive that up-front benefit in the context of technological change in the next couple of years.

Shona Robison: How will exempting better-off students help the poorest in our communities?

Lewis Macdonald: Students and trainees receive relatively low cash incomes. I agree that there are exceptions to that rule, but we have a policy priority. We recognise the specific needs of older people and we want to increase access to higher education. I am disappointed that the Scottish National Party does not share that objective. [*Interruption.*]

The Deputy Presiding Officer: Order.

Lewis Macdonald: We believe that our proposals are sensible and affordable in trying to meet the objective of widening access.

We simply cannot accept the idea that additional support can be provided to people on low incomes only by providing free prescriptions to everyone else. That would not be a good use of NHS resources. It has been said that nearly £45 million a year comes into NHS boards' budgets as a result of prescription charges. That is a serious sum of money.

Mary Scanlon asked about NHS dentistry. In Elgin on Friday, I announced the allocation of £30 million of additional investment in NHS board dental premises. In Fife on Monday, I announced a further £15 million for high street dentists to improve their premises. Such sums, which are not insignificant, will make a real difference to dental patients throughout Scotland.

This week, we have committed £45 million to health priorities. We certainly want to invest in priority areas, but we do not believe that free prescriptions for those who can afford to pay are a priority. Not only would £45 million of revenue be lost to NHS boards, but—as has been said—demand for additional prescriptions and prescribing time would increase costs by millions of pounds. Of course, we cannot tell members today how many millions of pounds that increase would be, and we do not want to find out. There is a difference between reforming the system in order to extend exemptions to more people who ought to be exempted and removing all charges and generating unlimited demand. The Royal Pharmaceutical Society of Great Britain has said that there would be up to £245 million of extra costs. I do not want to find out from experience that the NHS is losing £245 million to fund a scheme whose benefits go to better-off members of our society.

It has been said that we know in advance the conclusions that we will draw, but that is not true. The point of consulting is to draw out the evidence and to reach conclusions, which is what we intend to do. However, we are clear that we are not looking to spend money in the way that Alex Neil suggested. We are looking to target our resources on the most important health challenges, in the areas in which we can make the most difference.

That is why we are consulting on exempt chronic conditions and on people who receive low

incomes, and why we are consulting across the board. We want to ensure that the reform of prescription charges that we propose is well founded on an adequate evidence base and that it will stand the test of time. We want a fairer, simpler and more affordable system, and we believe that abolition would give most of the benefits to people who can afford to pay; that it would impose unpredictable new costs on the NHS; and that it would divert precious resources away from the areas of highest priority. There are no pots of gold at the end of the rainbow. Choices must be made and reform, not abolition, is the right choice. I urge members to reject the bill.

16:49

Colin Fox: The debate has been interesting and passions have certainly been roused. Members have attempted to throw light on the issues, but there has often been more heat than light, especially from Labour and Liberal members. On the anniversary of the birth of Burns, the Burns words that spring most readily to mind about the debate and the Executive's presentation are "wee", "sleeket", "cowran" and "tim'rous".

What a stramash the Labour members in particular have got themselves into. Today the Executive produces proposals in the consultation, which the minister was good enough to mention to us, to extend exemptions to the low-paid, poor students and chronic users and to extend pre-payment certificates. The Executive has made that clear and I suspect that Labour members have known about those proposals and the consultation for a little bit longer than most of us.

Nevertheless, in a rational debate, I would have expected more of Des McNulty than for him to say that poor people will not be helped if the charges are abolished for them. The Executive intends to abolish the charges for people who are on disability living allowance and those who are on benefits, but Des McNulty thinks that those people would not be helped by the bill. The Executive says that it will consider extending exemptions to cover more chronic conditions, but Des McNulty is able to say that all people with chronic conditions already get free prescriptions. That is a completely irrational point of view that is not backed up by the facts—we have heard a lot of those today.

Having listened to the debate, I am more convinced now of the case for abolition than I ever was before. Anybody watching the debate from the gallery, on the television or anywhere else will surely conclude that the case for abolition has been made a thousand times over and that we have been presented with a series of spurious arguments by the Executive, in the main, against it.

The minister says that the Executive has no plans to roll back the exemptions. When the minister came to the Health Committee, he was asked to explain what chronic conditions would be added to the current list. He avoided the question by saying that the Executive was not going to consider that, but that it might consider the current exemptions for chronic conditions; the example was given of diabetics getting help with prescriptions for their asthma. However, asthma is not currently covered by the exemptions.

Paragraph 4.3.7 of the consultation document states:

> "the Executive's policy position remains that patients who can afford to pay should make a contribution to the costs of prescribing and dispensing – on the basis that exemption arrangements are in place for those most likely to have difficulty paying."

However, it continues:

> "A straightforward age exemption is, therefore, anomalous in terms of this policy."

In other words, the Executive will bring in means testing for pensioners who currently get this benefit. The Executive has to answer that point.

Another point about the consultation document that the Executive has yet to answer—remember that it has taken three years to get to this point—

Lewis Macdonald: Will the member give way?

Colin Fox: I am tempted not to let the minister in, seeing as he did not let me in.

Lewis Macdonald: Had I been aware that Colin Fox wanted to intervene, I would have been happy to let him in.

I challenge the member's proposition that, because we point out that it is an anomaly that pensioners who have good incomes get free prescriptions, we intend to change that.

Colin Fox: The minister and the deputy minister have both argued that there is a series of anomalies, but they then suggest that the way to get rid of them is not to abolish charges. The Executive is trying to make a silk purse out of a sow's ear. No matter how we look at the current exemption system, it remains a sow's ear. The Executive suggests adding conditions, but no matter how it changes the system, it will not make a silk purse out of it.

I feel sorry for Duncan McNeil, Helen Eadie, Frank McAveety and Euan Robson, because the Scottish Executive has shot their fox. The Executive has accepted the case that poor people do not get their prescriptions, yet each and every Labour member still contends that the bill would help only the rich. Their leadership has abandoned them; it no longer puts forward their argument.

Prescription charges were introduced in 1951. Frank McAveety was good enough to remind us that Aneurin Bevan thought that that was a bad idea and he resigned from the Cabinet over it. He said that the introduction of prescription charges—at a shilling for the entire prescription—was done to offset the cost of the Korean war. Fifty years later, I have to say two things: first, surely we have paid for that war by now and secondly, is it not the case that the Executive wants £45 million out of poor people to pay for the war in Iraq? Labour presents a continuing theme in this debate.

The minister refers to a review—a policy to examine all the international evidence, from Italy and elsewhere, and to reach a conclusion on whether prescription charges and charges for health have prevented people from getting the treatment that they need. What happens? The Executive carries out a review over six months, reaches conclusions and does not tell anyone about them. Instead, it holds on to them for seven months, because they undermine its case. The minister does Parliament a disservice today by talking about the evidence that is contained in a review that no one has seen. In my opinion, that is an insult to the Parliament. The evidence must be put before the Parliament.

I come to the insurmountable problem of the £45 million. If we take at face value what the Executive says—although it is dangerous to do that—and it implements the proposals in its consultation document, the income from prescription charges will be reduced from £45 million to less than £10 million. If free prescriptions are extended to everyone who is on benefit, to people who receive eye tests, to students and so on, prescription charges will yield a piddling sum. That reduces the debate to its real tenor.

Some Labour, Liberal Democrat and Conservative members are worried that there will be increased costs to the health service because people will get more prescriptions from their GP, but Lothian NHS Board supports the abolition of prescription charges. Duncan McNeil is wrong about that—one would expect him to be able to read the evidence that is put in front of him. He can look it up while I am speaking and tell us whether it is not the case that the board supports the abolition of prescription charges. The evidence of Dr Philip Rutledge from Lothian NHS Board was that those people who are worried about the frivolous use of the health service and more people going to their GPs for drugs should consider that the way forward is to ensure that there are better prescribing practices and better management of medicines. That is how to stop the run on GPs that Labour members are apparently frightened about.

Hundreds of health organisations and patients associations, and 82 per cent of Scots, support the bill. What on earth are that 82 per cent of Scots and, in particular, the 75,000 people in Scotland who were forced to go without their prescriptions last year because they could not afford it, to make of the patronising attitude of Mary Scanlon, and Margaret Smith of the Liberal Democrats, who tell them that there is not a drug for every ill? Those 75,000 people could not get the drugs that their GPs recommended for them, but Mary Scanlon and Margaret Smith say that they should be patronised into not having drugs. That is the reality of the debate.

Like Labour back benchers, the Liberal Democrats twist and turn and tell us that it is not their policy to abolish prescription charges. They are on record as saying that they will go into the 2007 Holyrood elections in favour of abolition, but tonight they intend to vote against it. They are hypocrites, one and all. In the same way, Labour members say that they do not support abolition and that it is not Labour policy, whereas their colleagues in Wales stand proud at their decision in 2003 to abolish prescription charges there.

The Executive has presented a proposal that will do nothing fundamentally to address the problem that is before the Parliament today. Poor people are going without their medicines because of the charges. The Executive's consultation document remains intact, even though it tries to make a silk purse out of a sow's ear. People in Scotland will not forgive the political hypocrisy on the Labour and Liberal benches, in particular. I urge members to support the Abolition of NHS Prescription Charges (Scotland) Bill.

Mr McNeil: On a point of order, Presiding Officer. Colin Fox suggested that I had intentionally misled the chamber. In my speech, I said that Lothian NHS Board was neutral on the bill. I quote Dr Philip Rutledge, who said:

"Lothian NHS Board does not have an official view on the matter, because it has not carried out an official consultation. I am here wearing my professional advisory hat. In that respect, the answer is yes and no: yes in principle and no because we need to sort out the finances before we say yes."—[*Official Report*, *Health Committee*, 1 November 2005; c 2332.]

The Presiding Officer (Mr George Reid): That was not really a point of order, but I accept it as a point of clarification.

Business Motion

17:00

The Presiding Officer (Mr George Reid): The next item of business is consideration of business motion S2M-3871, 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 1 February 2006

2.15 pm	Time for Reflection
followed by	Scottish Parliamentary Corporate Body Question Time
followed by	Parliamentary Bureau Motions
followed by	Stage 1 Debate: Council Tax Abolition and Service Tax Introduction (Scotland) Bill
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Thursday 2 February 2006

9.15 am	Parliamentary Bureau Motions
followed by	Stage 3 Proceedings: Human Tissue (Scotland) Bill
11.40 am	General Question Time
12 noon	First Minister's Question Time
2.15 pm	Themed Question Time— Health and Community Care; Environment and Rural Development
2.55 pm	Stage 1 Debate: Police, Public Order and Criminal Justice (Scotland) Bill
followed by	Financial Resolution: Police, Public Order and Criminal Justice (Scotland) Bill
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Wednesday 8 February 2006

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 9 February 2006

9.15 am	Parliamentary Bureau Motions
followed by	Stage 3 Proceedings: Budget (Scotland) (No.3) Bill
11.40 am	General Question Time
12 noon	First Minister's Question Time
2.15 pm	Themed Question Time— Enterprise, Transport and Lifelong Learning; Justice and Law Officers
2.55 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

17:01

The Presiding Officer (Mr George Reid): The next item of business is consideration of two Parliamentary Bureau motions. I ask Margaret Curran to move motions S2M-3864 and S2M-3865, on the approval of Scottish statutory instruments.

Motions moved,

That the Parliament agrees that the draft Scotland Act 1998 (Transfer of Functions to the Scottish Ministers etc.) Order 2006 be approved.

That the Parliament agrees that the draft Civic Government (Scotland) Act 1982 (Licensing of Skin Piercing and Tattooing) Order 2006 be approved.—[*Ms Margaret Curran*.]

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

Decision Time

17:01

The Presiding Officer (Mr George Reid): There are three questions to be put as a result of today's business. The first question is, that motion S2M-3808, in the name of Colin Fox, that the Parliament agrees to the general principles of the Abolition of NHS Prescription Charges (Scotland) Bill, 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)
Ewing, Mrs Margaret (Moray) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Fox, Colin (Lothians) (SSP)
Gibson, Rob (Highlands and Islands) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Hyslop, Fiona (Lothians) (SNP)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Lochhead, Richard (North East Scotland) (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)
Maxwell, Mr Stewart (West of Scotland) (SNP)
McFee, Mr Bruce (West of Scotland) (SNP)
Morgan, Alasdair (South 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)
Smith, Elaine (Coatbridge and Chryston) (Lab)
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)
Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
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)
Brownlee, Derek (South of Scotland) (Con)
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)
Gordon, Mr Charlie (Glasgow Cathcart) (Lab)
Gorrie, Donald (Central Scotland) (LD)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, 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)
McNulty, Des (Clydebank and Milngavie) (Lab)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Murray, Dr Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland) (LD)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (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)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

ABSTENTIONS

Munro, John Farquhar (Ross, Skye and Inverness West) (LD)

The Presiding Officer: The result of the division is: For 40, Against 77, Abstentions 1.

Motion disagreed to.

The Presiding Officer: The next question is, that motion S2M-3864, in the name of Margaret Curran, on the approval of a Scottish statutory instrument, be agreed to.

Motion agreed to,

That the Parliament agrees that the draft Scotland Act 1998 (Transfer of Functions to the Scottish Ministers etc.) Order 2006 be approved.

The Presiding Officer: The final question is that motion S2M-3865, in the name of Margaret Curran, on the approval of an SSI, be agreed to.

Motion agreed to,

That the Parliament agrees that the draft Civic Government (Scotland) Act 1982 (Licensing of Skin Piercing and Tattooing) Order 2006 be approved.

NHS Fife (Cancer Waiting Times)

The Deputy Presiding Officer (Murray Tosh): The final item of business today is a members' business debate on motion S2M-3825, in the name of Iain Smith, on NHS Fife waiting times. The debate will be concluded without any question being put.

Motion debated,

That the Parliament welcomes progress made on the reduction in waiting times for treatment of cancer patients in Scotland but notes with concern that 40% of patients in the NHS Fife area are waiting longer than two months for treatment and believes that the Scottish Executive should meet NHS Fife to discuss ways to cut waiting times for Fife cancer patients.

17:04

Iain Smith (North East Fife) (LD): First, I thank the members who signed my motion; those who have stayed to participate in the debate; the minister; and the Parliamentary Bureau for allowing me to raise this important issue in the Scottish Parliament this evening.

I should make it clear at the outset that in promoting this debate I am not implying that the Scottish Executive—or indeed NHS Fife—is failing to improve our national health service in general and the treatment of cancer in particular. Instead, I seek to highlight concerns that NHS Fife's rate of improvement appears to be lagging behind that of the rest of Scotland and that such a situation must be putting my constituents' lives at risk.

No one can deny that the earlier cancer is detected, the earlier treatment can start and the greater the chances of survival. As a result, the Liberal Democrat and Labour partnership Government has set tough targets to ensure that no one has to wait more than two months from an urgent referral by a general practitioner to the start of treatment.

In recent years, there has been substantial investment in our health services. Year-on-year cash increases in health board budgets have been well ahead of inflation. Over the past five years, the funding in Fife will have increased by almost 50 per cent to more than £450 million this year.

Throughout Scotland, there has been substantial investment in new and replacement diagnostic equipment. Moreover, specific investment has been made to implement the measures in the "Cancer in Scotland: Action for Change" document, which was published in 2001. That programme currently provides NHS Fife with an additional £640,000 per year to support extra consultants, nurses and other staff to improve cancer services and, since 2001, it has made available more than £400,000 for equipment, training and needs assessments.

In 1998, the death rate in Fife for cancer was nearly 160 per 100,000. In 2003, that figure had fallen to 140, which was in line with the target of a 75 per cent reduction in cancer death rates by 2010. However, I am concerned that recently published figures suggest that Fife is now failing to meet those targets. The latest published figures for national cancer waiting times for April 2005 to June 2005 show that, in nearly 40 per cent of all referrals across the six key target cancer groups, NHS Fife is failing to meet the crucial target of commencing treatment within 62 days of urgent GP referral. More worrying, those second quarter figures show that, instead of getting closer to complying with the two-month target by the end of 2005, NHS Fife was in a worse situation than in the first quarter in 2005, in which it had achieved 64 per cent compliance.

Direct comparisons with 2004 are not possible across the full range of the cancers that are now measured. However, I want to highlight particular concerns about breast cancer, which is the largest of the six key groups and the second-largest cancer killer of women. It is clear that, in this respect, the service in Fife has seriously declined. For example, in the second quarter of 2004, 93 per cent of women in Fife received treatment within two months and, by the final quarter, that figure had reached 100 per cent. By March 2005, the figure had fallen to 59 per cent—although by June 2005 it had improved to 77 per cent.

However, a parliamentary answer given on 13 December 2005 by the Minister for Health and Community Care, Andy Kerr, paints a worrying picture of the increase in waiting times for breast cancer treatment at Queen Margaret hospital in Dunfermline between the first and second quarters of 2005. The median wait in the first quarter was 42 days, with 90 per cent of patients seen within 57 days. By the end of the second quarter, the median wait had risen to 55 days and it took 75 days for 90 per cent of patients to be seen. The longest wait rose from 61 days to 114.

The picture is similar for many of my constituents in North East Fife who receive their treatment at Ninewells hospital in Dundee, where the median wait is 41 days, the longest is 104 days and it takes 72 days for 90 per cent of patients to be seen. In comparison, the Scottish median is 38 days. Indeed, by any comparison, my constituents and other patients in Fife are getting a raw deal.

There are similarly worrying figures for the biggest cancer killer—lung cancer. Within the two-month period, only 54 per cent of patients were treated, compared with a Scottish average of 70 per cent.

It is crystal clear from these statistics that NHS Fife is failing to meet the targets for treating cancer and is failing to match the best in Scotland. NHS Fife needs to get better at detecting and treating cancer. I make no apology for suggesting that, given that early detection and treatment are vital, lives in Fife are being put at risk by NHS Fife's failure to meet the targets.

As a result, I seek certain assurances from the minister. First, are he and the Scottish Executive taking this issue seriously? In his closing remarks, will he outline the action that he has already taken and intends to take to ensure that NHS Fife ups its game and starts to deliver on its responsibilities to improve cancer treatment and cut waiting times? In particular, will he investigate why waiting times for breast and lung cancer treatment have significantly deteriorated? Moreover, will he establish why waiting times at Queen Margaret hospital increased so significantly in the second quarter of 2005 and what action NHS Fife has taken to address that situation?

Will the minister also establish why Ninewells hospital in Dundee has longer than average waiting times for the treatment of breast cancer? Given that NHS Tayside has a significantly better record in meeting the two-month target than Fife, can I have a specific assurance from him that patients from North East Fife are not being disadvantaged in favour of patients from Tayside?

There is considerable frustration in Fife at the length of time that it is taking to implement the "Right for Fife" redesign proposals. In many ways that document, which was approved by the Scottish Executive in 2002, was ahead of its time in going down the route that is now recommended by the Kerr report. However, implementation of the proposals is interminably slow, so I would welcome any action that the minister can take to help NHS Fife to progress more quickly in implementing the proposals in "Right for Fife".

I also ask that he do what he can to ensure that the proposed new hospital and health centre for St Andrews and the east neuk can commence on site more quickly than is planned. That is vital to ensure that local diagnostics and treatment are available to my constituents and it will help to ensure that in future Fife can meet its targets for cancer treatment.

17:10

Tricia Marwick (Mid Scotland and Fife) (SNP): I am grateful to Iain Smith for securing this members' business debate. It is true that cancer patients in Fife wait longer for treatment than patients in almost every other part of Scotland. The figures released by the Scottish Executive show that, despite Executive promises that all cancer patients will receive treatment within two months of being diagnosed, only 61 per cent of cancer patients in Fife are treated within two months. That is the third worst treatment rate of any health board in the country. The figures indicate that only the Western Isles NHS Board and the extinct Argyll and Clyde NHS Board areas have worse treatment rates. Fife is also well behind the national average rate of 74 per cent.

Although there may be individual problems within Fife, it is clear that comparing like with like—health board with health board—Fife NHS Board is failing the patients of Fife. Patients with colorectal cancer are particularly badly served, as a mere 20 per cent receive treatment within two months of diagnosis. Only 55 per cent of lung cancer patients in Fife are treated within the Executive's target period of two months.

As Iain Smith rightly says, at Queen Margaret hospital the median wait is 57 days compared to a median wait of 31 days throughout Scotland. The increase in waiting times in the second quarter of 2005 is extremely worrying because the issue of cancer treatment is one that members of the Scottish Parliament have raised with Fife NHS Board. We sought and were given assurances that the health board was well aware of the issue and was taking steps to address it.

The people of Fife are losing out in the Executive's postcode lottery—it is difficult to define it in any other way—for cancer treatment. Early diagnosis and treatment of cancer are crucial to maximise the chances of survival, yet patients in every other part of Scotland receive treatment quicker than patients in Fife. The Labour and Liberal party Executive has manifestly failed to fulfil the promise that it made in 2001 that all cancer patients would receive treatment within two months of diagnosis. Cancer patients in Fife are paying the price for that failure to deliver. For only one in five colorectal cancer patients to receive treatment within two months for a potentially fatal illness is nothing short of a scandal. Cancer patients in Fife cannot wait any longer. There can be no more excuses. The Executive has a moral duty to ensure that all cancer patients in Fife receive treatment as quickly as patients in other parts of Scotland.

Like Iain Smith, I will be interested to hear the minister's response. Given that the figures that we are discussing are the Executive's figures, I would like to know what representations it has made to Fife NHS Board about its appalling cancer treatment rate to date, what action it has asked Fife NHS Board to take and, if Fife NHS Board has failed to react to Executive pressure, what the minister intends to do about that.

Having cancer is distressing; it is particularly distressing that people in Fife who have cancer

have to wait so long for treatment. For a moment, I will hark back to the previous debate and tell the story of a young woman and a young man who lived together. He was diagnosed with cancer. Although they were not married and he was not working, because she was working and bringing an income into the house, they had to pay for all their prescriptions. As if it is not bad enough that someone has a potentially fatal illness, the Executive condemns them to the serious financial difficulty of trying to pay for their prescriptions.

I repeat that Fife NHS Board's record on cancer treatment is simply not acceptable to me or the people of Fife. I want to know from the minister what he has done about that record and what he intends to do about it in the future.

17:15

Christine May (Central Fife) (Lab): I, too, congratulate Iain Smith on securing a debate on such an important topic. He chose to highlight waiting times and targets specifically for cancer, but I wish to record my view that one of the best things that the Executive has done is to set target times for waiting and for treatment for a range of conditions. Little is more worrying or debilitating than to have, or suspect that one might have, a condition that requires a hospital appointment. Whether it be a relatively trivial matter or something more serious, the anxiety someone suffers while lying awake in the hours between two and five in the morning during the waiting period is enormous. No matter how much they try to avoid it, different scenarios play out in their mind, each worse than the last.

The setting of targets by the Executive was welcomed by all who use the national health service and by those who advocate on their behalf. However, targets must be challenging to be of any use. They should be, and are, difficult to achieve. Once they are achieved, they should be strengthened and extended wherever possible. It is unacceptable that those who can afford to pay get almost instant access and treatment while the rest must wait. My aim would be to have that same level of access and treatment for everybody.

Significant funding has been put in place to help NHS Fife and other boards to achieve their targets. Under the right for Fife investment programme, there has been substantial investment this year alone in new facilities in the Queen Margaret and Victoria hospitals. A new radiology suite, a one-stop colorectal unit and a new acute medical admissions unit are being provided. I agree that the right for Fife programme has taken far too long to implement; nevertheless, I think that we are now on track and that we are getting that investment.

I turn now specifically to cancer waiting times in Fife. It is true, as Iain Smith and Tricia Marwick said, that the waiting time figures have fallen significantly below what has been achieved in previous years, which is very worrying. Cancer patients in Fife have the same right to treatment as other cancer patients in Scotland, but they are not being given it. However, the magnetic resonance imaging facility at the Victoria hospital in Kirkcaldy is being expanded, following pressure from the community and my colleague Marilyn Livingstone. The Executive acted quickly to make available waiting times funding and specific staffing money.

If we consider how people and health boards seek to meet targets, we must factor in matters such as staff changes, retiral and other human factors. Of course, that makes the targets even more challenging. However, bearing in mind my earlier comments about stress, while the factors to which I referred must be taken into account, they are not acceptable excuses for missing the targets by the rate that they have been missed in Fife. The dip in performance, particularly for the treatment of breast, colorectal and lung cancer, is worrying to us as representatives of our constituents and, most of all, to those who are not getting the level of service and treatment that they should be getting. The figures for meeting breast cancer targets in 2004 were 100 per cent in some quarters. However, the figure in Fife for the lung cancer target dropped to an unacceptable 55 per cent, as Tricia Marwick and Iain Smith said, so it is right that we raise these concerns.

I hope that I would be wrong to suggest that either NHS Fife or the Executive were complacent or inactive in relation to their recognition of the issue and of the need to deal with it. I trust that we will hear from the minister that, rather than waiting until this evening to raise the issue with his officials and spur them into action, he has talked to NHS Fife and has agreed courses of remedial action and sought explanations. I hope that he is able to tell us that the explanations have been furnished and that an action plan has been agreed to bring matters in Fife back on track.

I also recognise that, in relation to certain cancers, there might be only a small statistical sample in Fife. If there are only two or three cases of a cancer, a delay in treatment of only one individual can mean a dip in performance of 50 per cent. However, each of those cases is a person much more than a statistic. We must be concerned with the effect on the individual. Everyone in Scotland has the right to expect a level of quality service and treatment from their national health service, wherever they live. Anything less should not be acceptable. That would be my ambition for NHS Scotland. I hope that the minister will confirm that that is also his

ambition and that he will explain what is happening in Fife in order to get matters back on track.

17:21

Mr Ted Brocklebank (Mid Scotland and Fife) (Con): I welcome this debate and thank Iain Smith for lodging the motion, which welcomes the progress that has been made in the reduction in waiting times for the treatment of cancer patients in Scotland. Of course, I echo that. However, Scottish waiting times for cancer treatment still lag far behind those in England and NHS boards now need to drive forward their efforts to deliver faster cancer care for patients.

I remind the chamber that, in 2001, the Executive set the goal that

"no patient should wait longer than 2 months from urgent referral to treatment for all cancer cases by the end of 2005."

Why is it then, that according to the latest figures for Scotland, only an average of 74 per cent of cancer cases reached that treatment target? How is it that 80 per cent of cancer cases were dealt with on time south of the border? Given the fact that £150 million has been invested in cancer services since 2001 throughout Scotland, it is surely disgraceful that people are still waiting and perhaps needlessly dying, especially in Fife, which has always prided itself on its high standards of health provision.

As we have heard, the picture in Fife is no longer just concerning, it is unacceptable, especially in the light of the extra funding that NHS Fife has received. As we have heard, only 20 per cent of colorectal cancer patients in the kingdom are treated two months after diagnosis, compared with a national figure of 56 per cent. Melanoma cancer sufferers fare no better, with 75 per cent of sufferers in Fife waiting more than two months, against the Scottish average of 86 per cent. As we have heard, the situation is similar in relation to breast cancer, with 76 per cent of sufferers in Fife being treated two months after diagnosis in comparison with the national average of nearly 86 per cent. Most alarmingly, in relation to those suffering from lung cancer, which is the biggest killer in Scotland, nationally 70 per cent are treated two months after diagnosis, but only 55 per cent in Fife.

Those figures are all the more disturbing in view of the fact that, earlier this month, as Christine May said, it was revealed that the MRI scanner at the Victoria hospital in Kirkcaldy sat idle for three quarters of the time when it could have been used for the early detection of tumours.

I have been trying to contact NHS Fife since yesterday afternoon to put some of those points to it so that I might fairly represent its case. I regret that my calls have not been returned.

As a Fifer who lost both parents to cancer, I am appalled that my family, friends and constituents might be disadvantaged should they require urgent treatment for cancer. Clearly, early diagnosis and treatment is absolutely crucial in maximising the chances of survival, yet patients in virtually every other part of Scotland receive treatment more quickly.

However, simply setting an arbitrary target of treatment within two months also leads to other concerns. Unlike Christine May, we believe—as do most of the physicians to whom I have spoken—that it should be up to the local health professionals to set their own targets, which should be realisable. Patients should be treated according to clinical need, not to meet arbitrary Government targets. What use are those targets if they are not achieved?

The Deputy Minister for Health and Community Care (Lewis Macdonald): Unless I misheard him, Mr Brocklebank was complaining about the failure to meet Government targets but now he is saying that they should not exist. Could Mr Brocklebank clarify his position?

Mr Brocklebank: The Executive set the targets, but none of them has been achieved in Fife. In addition, we are not even sure that the Executive is setting the right targets; it should be up to local health professionals to decide the clinical necessity of cases.

NHS Fife argues that the kingdom is on target to achieve a 20 per cent reduction in cancer-related deaths by 2010. However, what we require is evidence that the management of health resources in relation to cancer is being tackled now—not promises for four years hence. Iain Smith specifically criticises NHS Fife, but he is part of an Executive that has contributed to the problem by refusing to embrace all the health care options that are available, such as the independent sector. That means that the best possible use has not been made of the available resources. Staff shortages and a lack of well-designed services are key problems, and bureaucracy is strangling the NHS. It is little wonder that we have a depressed NHS workforce, with people leaving the health profession at worrying rates.

Tricia Marwick *rose—*

Mr Brocklebank: I am just concluding.

I commend Iain Smith's motion and urge the minister to meet NHS Fife as a matter of urgency to see what can be done to alleviate the present serious situation. I look forward to hearing the reassurances that the minister can offer to those

whose lives have been blighted by the scourge of cancer in the kingdom of Fife.

17:26

The Deputy Minister for Health and Community Care (Lewis Macdonald): I congratulate Iain Smith on securing the debate, which is on an issue of pressing importance for many. As Christine May said, cancer patients can face a period of anguish and anxiety before treatment has begun. It is therefore right that the Government sets targets to limit that period as far as it can. We have set challenging targets, including a target of two months from urgent referral by a general practitioner to first treatment. As has been pointed out, in the quarter to June last year, four out of 10 cancer patients in Fife were not treated within that target period. The challenge for NHS Fife is to ensure that it can meet its targets in the future. Fife NHS Board can and, no doubt, will speak for itself, but it may be helpful to members if I indicate the current position.

Progress has been made. Over the next few months, we expect to see continuing improvements in Fife and throughout Scotland. In Fife, as elsewhere, the Scottish Executive and its officials will continue to work closely with Fife NHS Board to support it in meeting its targets. That is a continuous and a continuing process. Members will be interested to know that, in response to the figures that have been debated this evening, my officials contacted the chief executive of NHS Fife on 6 January to discuss our concerns about the board's performance. My officials sought assurances that action was under way to rectify problems and they agreed to discuss problems with senior clinicians and managers. That was done by conference call on 16 January and it will be done again, in person, on 7 February. In all their engagements in supporting NHS Fife to meet the targets that we have set it, officials act for and on behalf of Scottish—Labour and Liberal Democrat—ministers in the coalition.

These are not party-political matters, so I am slightly disappointed by some of the tone and comment of a party-political nature in a members' debate on an area of common concern.

I want to lay out the position as I understand it from our discussions with NHS Fife. Christine May referred to the fact that, not so long ago, breast cancer waiting times were 100 per cent on target in Fife. That figure slipped significantly to less than 60 per cent in the second quarter of last year. The cause of that disappointing result is largely a gap in surgical capacity following a retirement and the time taken to recruit a replacement. An increase in the number of referrals has put extra pressure on mammography time. Additional staff and extended working hours are now in place and a new referrals system is being introduced to speed up the issuing of appointments.

Elsewhere, there is a five-week waiting time for endoscopy, which is impacting on the two-month target for first treatment of colorectal cancer patients. NHS Fife therefore is considering the provision of additional endoscopy sessions for the short term and, in the long term, will review its management of surgical and medical capacity to see whether the two can be brought together to maximise the available capacity. On lung cancer, arrangements will be approved to shorten patient pathways and work is under way to make that happen.

The targets that have been set are challenging for boards, doctors, nurses, support staff and everyone in the multidisciplinary teams who work together to deliver the best possible care for patients with cancer. It is important to recognise that each of the different tumour types needs different investigations and treatments and that every patient needs the assessment and treatment that are best suited to them. We are always concerned when problems arise but, in this case, we are pleased that NHS Fife has taken rapid action to restore services to their previous high level.

Iain Smith: The figures with which we are dealing are for the period up to June 2005, but they were not published until December 2005, which is a five-month gap. As part of the action that is being taken, will we consider ensuring that statistics become available earlier so that problems are identified and action is taken more quickly?

Lewis Macdonald: I accept that there can be a lag in the production of the statistics. I will come to Iain Smith's point in a moment, but it is important that members should not overstate the extent to which the waiting time figures here are behind those in England. People can be misled by the lag in publication of the statistics. For April to June 2005, Scotland was 74 per cent on target, compared with 77 per cent for England, not the 88 per cent that was mentioned, which was for the third quarter. The optimum targets that we have set are for the end of 2005, but the figures for that period are not yet available. I understand Iain Smith's point. We are of course keen to be as well informed as possible, but it is appropriate that boards take time to get the matter right and to ensure that they provide accurate figures. We will track and work with NHS Fife in its process of improving the figures. We look forward to receiving further information from the board in that regard.

We have made significant investments in Fife and throughout Scotland. It is worth recording that many patients are treated within the two-month

target, consistent with their clinical and personal needs. As has been noted, in dealing with breast, colorectal and lung cancer, Fife was better than Scotland as a whole. I am confident that, with the measures that NHS Fife is taking, it can be again. For the period to June last year, there was a 74 per cent success rate throughout Scotland in relation to waiting time targets. We expect NHS Fife and other boards to drive continuous improvement.

In response to Iain Smith's query about patients from North East Fife who are treated by NHS Tayside, I reassure him that there is no disadvantage for patients from Fife. However, as part of the process of examining how to address the situation in Fife, on 7 February my officials will meet NHS Tayside as well as NHS Fife, recognising the significance of that wider resource. We also recognise the role that the national waiting times centre in Clydebank and the Golden Jubilee national hospital can play in supporting boards throughout the country.

All of us are touched by cancer at some time in our lives, if not personally then through our family and friends. We all agree that it is unacceptable for patients to wait any longer than is absolutely necessary for diagnosis and treatment of cancer. We look forward to sustainable reductions in waiting times in Fife and throughout Scotland. I give all members who have sought it the assurance that we will keep on the case and continue to work with NHS Fife to ensure that the situation that arose in the second quarter of last year is rectified as quickly and efficiently as possible.

Meeting closed at 17:34.

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