MEETING OF THE PARLIAMENT

Wednesday 14 February 2007

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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 is time for reflection. Our time for reflection leader today is Imam Arif of the Central Scotland Islamic Centre in Stirling.

Imam Arif (Central Scotland Islamic Centre, Stirling):

Imam Arif gave a blessing in Arabic and provided the following translation:

In the name of Allah, most merciful, most beneficent, may the peace and blessing of Allah be upon us.

Imam Arif continued in English:

In Islam, prayer is the fundamental aspect of the believer's religious life. The Prophet Muhammad—peace be upon him—once said,

"Prayer is the essence of worship."

Prayer lies at the heart of a man or woman's relationship with God. It is the acknowledgement of God's divinity—ilahiyya—and mastery over creation—rububiyya.

In Islam, prayer assumes four basic forms: the formulaic prayer or Salat; personal prayer or Du'a; meditational prayer or Dhikr; and communion or Munajat. The first type—Salat—combines the latter three with the ritualistic bodily movements of standing, bowing, and prostration, with which many people are familiar. This type of prayer is also the central liturgical act in Islam, although it is not confined to the liturgy and, like the other three types, can be done privately and away from the mosque.

One way in which we can view the four types of prayer is that the first type is our undertaking an act that God demands of us, while the latter three types provide us with an opportunity to ask God for his blessings, grace, favours or gifts. They all provide one with an opportunity to praise, adore, thank and glorify God.

Every act of the formulaic prayer or Salat has deeper spiritual significance. For example, the great theologian, Imam Abu Hamid al-Ghazali—may Allah's mercy be upon him—says:

"When the servant says at the beginning of the Salat, 'God is Infinite', he removes from his heart the thought that anything is greater than God. When he subsequently says, 'I orient myself towards God,' he focuses completely on his Lord, and orients himself away from any worldly distractions."

Invocations, supplications and communion are usually all expressed in personal terms, but the best prayers are those learned from the Prophet Muhammad—peace be upon him—himself. One well-known prophetic invocation is as follows:

"O God! I ask you to bless me to do only good, and to leave all bad. I ask you that you grant me love of the poor, and that you forgive and have mercy on me. O God! I ask you to grant me your love, and the love of those who love you, and the love of those actions that draw me close to your love."

Imam Arif repeated the invocation in Arabic, then continued in English:

That is a brief summary of prayer in Islam. It is my prayer that we can all do our part, in our respective ways, to work for a safer and more just world.

Budget (Scotland) (No 4) Bill: Stage 3

The Presiding Officer (Mr George Reid): The next item of business is a debate on motion S2M-5551, in the name of Mr Tom McCabe, that Parliament agrees that the Budget (Scotland) (No 4) Bill be passed.

14:35

The Minister for Finance and Public Service Reform (Mr Tom McCabe): As members know, the debate marks the final stage of this year's budget process. It also marks the last year in our current spending review. We have achieved much in the current spending review period: we see a Scotland where unemployment is down and where there is increased investment in transport and other infrastructure and we see that more people are choosing to study, live and work in Scotland. Significant steps have also been taken towards improving our nation's health. We can take pride in the fact that we successfully implemented the ban on smoking in enclosed public places. There is also evidence that our efforts to improve literacy and numeracy are beginning to pay off and we have made good progress on implementing Scotland's first sustainable development strategy.

Around our budget process, we have transparency and a consultative mechanism. I think that that is the subject of comment and praise in other places. As we have said on many occasions, the process is one that should be continually evolving—certainly, the Executive is committed to working with Parliament and its committees to ensure that the process evolves positively.

It is appropriate to say a word of thanks, not only to the Finance Committee, but to the other committees that feed into the budget process. I thank them for their work and for the way in which they contributed to the outcomes that we are debating today. I also want to say a word of thanks to the various officials who have taken part in what is quite a long process—one that they recognise as being an important part of our parliamentary calendar. We will continue to work with the committees on developing the budget process and—importantly, as we approach a new spending review—on clarifying the ways in which we engage with them to ensure their maximum input to the process.

The budget allows progress towards our partnership goal of creating a better Scotland for everyone. It helps us to encourage economic growth, deliver high quality public services, reinforce the ways in which we plan to build the stronger, safer communities that all of us seek and create the more confident democratic Scotland that was one of the founding aspirations and principles of the Scottish Parliament.

The budget allows the totality of our spending to rise to just over £31 billion in 2007-08, which is an increase of approximately 3.5 per cent. We are committing record levels of funds to local government—over a third of our total budget goes in that direction—which will allow councils to fund improvements in teachers' pay and conditions, increase teacher numbers and improve pupil-to-teacher ratios. It will also allow us to fund the free personal care that has been so well received in Scotland, and to provide record levels of funding for the police and fire services. All of that moves us towards the goal of providing world-class public services.

Mr John Swinney (North Tayside) (SNP): Can the minister shed any more light on the discussions with local authorities about implementation of free personal care, which he announced in his December statement to Parliament? When are we likely to hear the outcome of those discussions? What progress has been made?

Mr McCabe: I am pleased to confirm that Scottish Executive officials are liaising closely with the Convention of Scottish Local Authorities—discussions are continuing. Officials are identifying the authorities on which they want to focus in terms of sample studies. As we move through the year, I expect to see some outcomes. As members know, that is one of the conditions that we attached to the additional funding that we allocated to local government; indeed, it was one of the things that local government was more than happy to sign up to.

Importantly, this budget allows councils across Scotland to keep council tax increases to a minimum. As members are well aware, the average council tax increase across Scotland last year was the lowest since devolution, but the increases in 2007-08 are set to better that by some considerable way. So far, the average band D increase of 1.9 per cent takes us one step further along the path to the creation of a system of local taxation that is more stable, fairer and more proportionate. Therefore, we believe this to be a budget that is prudent in its approach, but ambitious in its aims—a budget that will improve the quality of life for people throughout Scotland.

I move,

That the Parliament agrees that the Budget (Scotland) (No 4) Bill be passed.

14:40

Mr John Swinney (North Tayside) (SNP): As the minister said, the debate brings the budget

process—the last in this parliamentary session—to a conclusion.

There are a number of areas in which the Scottish National Party very much agrees with the Executive about its priorities and how it has allocated its spending. In this budget, there has been a material change in the financial settlement to local authorities. We have made it clear to the minister for some time that we welcome that improvement in the financial climate. We further welcome the fact that additional resources—beyond what were planned by the minister—have been found and have been allocated to local authorities. The fruits of that productive dialogue with local authorities over a period have seen us reach a position in which we have a lower average council tax increase than we had last year.

Mr McCabe: We warmly welcome those words of appreciation from the Opposition. Will Mr Swinney take this opportunity to dissociate himself completely from any suggestion that additional finance to local government was an election bribe?

Mr Swinney: It is amazing the frequency with which Mr McCabe refers to "an election bribe". Perhaps he has something on his conscience that he wants to share with us. A problem shared with friends is always a burden taken off the shoulders. If it helps Mr McCabe to talk about it more often, we will be happy to acknowledge that it is a bribe. Everybody is happy with it because everybody's council tax is much lower than it might otherwise have been. I am delighted that even under the harsh settlement from the Scottish Executive, Angus Council—with which I have a close relationship—has delivered a freeze on council tax.

There are areas of the budget that the Scottish National Party can welcome—the material change in local government funding is one of them. However, there are some missing elements. We have waited throughout the budget process for the publication of the Howat review. I had thought that perhaps, in a last gasp, the Finance Minister would publish the Howat review today and answer the questions that I am desperate to have answered, but I will just have to wait a few more weeks. The Howat review would have informed the process in which we are involved, because one of its central purposes was to evaluate the effectiveness of Executive spending on certain key areas of policy. Our debate would have been enhanced had we that assessment to hand. I hope that the preparations for the spending review have in no way been held back by the non-publication of that document.

In addition, the efficient government process rumbles on, but it rumbles on in a fashion that all of us believe needs to be made more robust. Audit Scotland has done a good job in evaluating the work of the Scottish Executive, and I welcome the Executive's achievements on efficient government, but all of us believe that the process could go further. It could be more rigorous, it could be more robust and it could be better evaluated. We can look forward to that in the period ahead.

Some questions remain about the budget. The Finance Committee conducted its usual rigorous consideration of the budget. Among the areas on which the committee concentrated were target setting and priority setting, and the ability to monitor expenditure on cross-cutting themes. Without wishing to pre-judge the comments that my colleague Mark Ballard will make in relation to cross-cutting themes in respect of sustainable development, let me say simply that the budget process lacks the ability rigorously to assess whether the Government's central purposes and objectives are being evaluated and achieved effectively. That is one thing that we must all take from the budget process.

What the SNP takes is that the Government must be much more sharply focused in how it spends money. We must have a much clearer sense of the purpose of public expenditure and what we expect to get out of it, and we must have many more unifying themes for achieving public priorities through public expenditure. If we go down that route, we will have a much stronger process that serves the people of Scotland a great deal more effectively.

Christine May (Central Fife) (Lab): Does that mean that the Scottish National Party will become focused on the key priorities for Scotland and stop making promises to spend money on everything that happens to come to the surface every day of the week?

Mr Swinney: Christine May should know that the SNP is always focused on ensuring that it delivers the best for the people of Scotland. We think that Government in Scotland needs to be aligned with a central objective of measurably improving the quality of life for the people of Scotland. Departments of state must be focused and targeted on that objective—an SNP Administration will pursue that.

One remaining question that arises from the budget concerns the vaunted claims about the great union dividend. I notice from the assessment of identifiable public expenditure that, in 1999-2000, for every £100 of expenditure on education south of the border, Scotland spent £126 and, for every £100 that was spent on health south of the border, Scotland spent £119. However, as a result of the union dividend, that advantage has reduced: we now spend £106 for every £100 spent on education south of the border and £110 for every £100 spent on health south of the border. That simply proves that the union dividend is utterly

worthless. I look forward to the people of Scotland exercising their judgment on that on 3 May.

14:46

Derek Brownlee (South of Scotland) (Con): When the people of Scotland express a view on the benefits or otherwise of the union on 3 May, Mr Swinney might take a different view about whether he should have looked forward to it.

In this final budget debate of the parliamentary session, we are debating not only the budget, but the Executive's record. I got the impression that the minister almost spoke more about the Executive's record—which is what people want to examine, not only today but over the weeks and months ahead—than about the budget, but there were some things in what the minister said that should give us pause for thought about the budget process, how we scrutinise it and some of the claims that the Executive makes. I will give some examples.

The minister mentioned that unemployment in Scotland is down, which may well be the case. We could argue about whether that is a result of actions that were taken in the budget, more general economic trends, actions that the Westminster Government has taken or a host of other policies, but it is almost impossible for anyone to claim that unemployment in Scotland is down as a result of the budget that we are considering.

The minister mentioned economic growth. As we have heard, economic growth in Scotland is not performing as well as in the rest of the United Kingdom, but we do not know to what extent the budget contributes to economic growth.

The minister also mentioned that literacy and numeracy rates are improving. We welcome that news if that is the case, but is it all about money? If those rates are improving as a result of the budget, would they improve more if we spent a bit more, or would they worsen if we spent a bit less? I do not think that anyone would argue that they would. We must break the assumption that spending more money automatically leads to better results and that spending less money automatically leads to worse results.

There are some things in the budget with which we agree and others with which we do not agree. However, our fundamental concern about the budget and the Executive's record is that the Executive badly fails to deliver value for money for the taxpayer. As the minister said, spending is heading towards £31 billion, so the question must be whether we have benefited from that extra spending to the extent that we could have benefited. No independent observer would claim that the Executive has delivered as much value for money for the taxpayer as we have a right to expect.

We hear hints that the efficient government programme might in due course deliver more savings, which would be great. If more efficiency savings can be delivered without affecting public services, the Executive will hear no criticism from the Conservatives on that.

However, does the efficiency programme go far enough? Have we thought radically enough about what we can deliver from public spending in Scotland and how we deliver it? We should not kid ourselves: the budget process is not perfect. There is not the necessary degree of scrutiny, particularly around some spending decisions, and different ways of spending money and different outcomes are not sufficiently contested. We kid ourselves if we think that the process is as transparent, open and effective as it can be. We would be happy to support constructive suggestions that the minister might make in that regard.

In Scotland, we must get away from the mindset according to which spending pound after pound will automatically deliver better services. We must put value for money at the heart of the budget process and not leave it as a tag line at the end. The people who vote on 3 May will not be voting on this budget; they will be voting on this Executive's record. I hope that the outcome will be different from the one that Mr Swinney seeks, and I hope that after 3 May we will at last have a Government that takes value for money seriously.

14:51

Mr Andrew Arbuckle (Mid Scotland and Fife) (LD): There is an air of déjà vu about the debate. The question whether the current budget process is the best and the most searching might well be asked. However, that is a question for the next session of Parliament.

I am happy to underline the most recent successes for the Liberal Democrats in their role in the coalition. I am sure that only an obdurate Opposition member, who is unwilling to acknowledge the positive nature of this year's expenditure plans, would chisel at details about spending. An impartial onlooker can see positive changes in higher education, in support for transport, especially public transport, and in the environment—indeed, in almost every aspect of Scottish life.

As the minister said, during the budget year, more teachers will work at the chalkface, which underlines the coalition's commitment to a better-educated Scotland. Many major capital transport projects are under way, despite lengthy delays in getting them on the road—or indeed the rail track.

In my area, work towards reopening the Stirling-Alloa-Kincardine line is moving ahead. Other projects will help the train to take the strain. It was always the coalition's intention to increase commitment to public transport, and people who pore through the detail of the budget documents will find that Scotland now spends two thirds of its transport budget on support for public transport systems. Some of that spend will go towards schemes to remove heavy goods vehicles from our roads and some will subsidise rural bus routes that would not otherwise be economically viable. The introduction last April of the concessionary fares scheme might be regarded by some people as a burden on the public purse, but the take-up and consequential benefits of the scheme are far-reaching and difficult to quantify. Members who talk to people who partake of the scheme will hear positive comments.

The budget also demonstrates further progress towards greening the economy. There will be more investment in renewable energy and more green jobs, all of which will benefit people in Scotland.

Last week, as the minister said, most councils showed their approval of the local government settlement by setting council tax levels below inflation. I am a serving member of a local authority and I think that it is possible to make further progress in the efficient government programme, in linking services with other public bodies and in procurement. This is a challenging time for local authorities, especially in provision of education and social work services. Social work services in particular face major issues if they are to meet the expectations of society and Government. However, many councils are bringing fresh thinking into their services and their approach to achieving financial targets.

As a Liberal Democrat, I would like the financial rigour that councils are experiencing to be carried through to all other parts of government. As a member of the Finance Committee, I will play my part in considering parts of government, to ensure that we secure the due outcome from taxpayers' cash investment.

As I said, most services have received extra financial support in the short lifetime of the Scottish Parliament. We should look forward to securing positive results from that investment. We must ensure that the public sector in Scotland is as alert to efficiency as the private sector is. As far as the Liberal Democrats are concerned, the budget settlement is good for Scotland and for the people of Scotland. I support the motion.

14:55

Mark Ballard (Lothians) (Green): This debate will be difficult, because there is very little to say. The information that is in front of us is fairly meaningless. For example, we will be voting on giving Scottish ministers just over £1 billion for education to spend on schools, on teachers, on the Gaelic language, on Historic Scotland and on sport. Interestingly, we learn that there will be £100 of accruing resources, alongside that figure of £1,094,349,000. The information does not provide much subject for debate.

Who can argue with giving the Scottish ministers that £1 billion? It is our choice: do we give ministers £1 billion, or do we vote against today's motion and thereby shut down Scotland's schools? We have no choice but to vote for the motion. No amendments to the motion have been lodged for us to consider; indeed, only ministers could have lodged amendments. No one can argue with the motion, so we have to ask: What is the debate for?

I agree with people who say that we have to reconsider the budget process. There is no point in this stage 3, and there will be little content in this debate. However, that is not to say that we do not have an opportunity to bring up key issues that arose during discussions in the Finance Committee. The debate could be valuable if we had the sharp focus that John Swinney talked about and if we were actually discussing the Executive's priorities and what the Executive's cross-cutting themes mean for the billions of pounds on which we will vote, but we do not have such information—the Scottish Executive says that it would be too difficult to collect.

Members of the Finance Committee heard some very unilluminating witness statements from ministers. For example, we were told that the cross-cutting themes are less of a priority than the priorities, but ministers have not been able to explain what happens when a cross-cutting theme is in conflict with a priority, or how the two can be reconciled. How have such matters been reconciled in the budget? If we had that kind of information, this debate might be more substantial.

We might be able to consider the budget's implications for sustainable development. We could consider the implications for sustainable development of spending up to £1 billion on a new road bridge across the Forth, but we cannot do that because all we have to debate are the billions of pounds that are laid out in the bill, together with the hundreds of pounds of retained income. We cannot have a debate, but we need a debate. We need a useful discussion of the budget.

It is worth reflecting on what might happen after the coming Scottish Parliament election. What will happen if there is no workable coalition with a workable majority? What will happen if we move into a period of minority Government in Scotland? Will the present budget process be effective in

such circumstances? With a minority Government, it will be necessary to build consensus in Parliament to get stage 1 and stage 3 voted through, so we will need some kind of amendment process. Parties that are not part of the minority Government will have to be able to play a role by making their suggestions about and offering comment on what they would like to be reprioritised. The present system will not be fit for purpose if there is a minority Government: that is the situation that we may face in only a few months.

The budget debate would be very interesting indeed if there were a minority Government and if Tom McCabe were not simply reading out a list of achievements but was instead trying to convince Parliament to support the budget, and if we had some real choices to make—tough choices, but genuine choices. Until we are able to make such choices, debates such as this will be flawed.

The Presiding Officer: We move now to the open debate. Wendy Alexander missed Mr McCabe's speech and most of John Swinney's speech. That is not good. However, she has sent me an explanation and an apology, so I will call her to speak.

14:59

Ms Wendy Alexander (Paisley North) (Lab): Thank you, Presiding Officer. I offer a profuse apology to you and to the minister, and—by way of explanation—I offer a profound thank you to the staff at the information technology helpdesk, who managed to extract some of my speech from my computer after I had failed miserably to do so myself.

I had been under the impression that I was summing up the debate, but I will take the opportunity to speak first in the open debate.

As other members have said, today is the final stage in our consideration of the budget for next year. As others have also noted, the imminence of the election focuses minds on what that budget will deliver for Scotland. It could, on the one hand, be a new or refurbished school every week, shorter hospital waiting times, new health checks, new university and college buildings, new neighbourhood wardens, major infrastructure projects—including projects that are now under construction, such as the M74 extension, trams in Edinburgh and the Glasgow airport rail link—new water investment, new housing and so much more. That is £28 billion of taxpayers' money and £28 billion of services. Either we have a budget that maintains momentum in Scotland, or—this is the important question—we change direction.

I have another important question to ask. Are any of the parties that are currently represented in the chamber seeking to negotiate a new spending system for Scotland next year? During this budget year, we will have a spending review. My question is simple: does any party want a new financing system for Scotland next year?

My attention was drawn to a column in today's edition of *The Scotsman* by George Kerevan, who, as he admits in the column, is an SNP sympathiser. He writes:

"Scottish business does have a proper interest in examining the likely impact"

of

"any radical transfer of fiscal powers to Holyrood".

I concur with him, but I think that not just every business, but every man, woman and child in the country has that interest.

The question is very simple, and the SNP and, to some extent, the Greens, have had years to contemplate it. Do they want a new financing system next year, or do they want to stick with the spending review, which will be published in October? I genuinely do not know the answer.

Derek Brownlee: I am tempted to wish that Wendy Alexander had managed to recover a different speech from her computer. In thinking ahead to a new financial system, does she feel that the present Executive has spent the union dividend as wisely as it should? Is she confident that the Howat report will not reveal any examples of wasted money?

Ms Alexander: The relevant point is that the Howat report is going to be published with the spending review. It is absolutely clear that the Executive is in favour of the spending review forming the basis of how every service in Scotland is financed.

Those of us who diligently read our newspapers will have noted that, on Sunday, Alex Salmond was telling us how cosy his relations were going to be with Gordon Brown. The SNP has to do rather better than that. It must tell the rest of us how the country and the Scottish Parliament are going to be financed and how the services on which Scotland relies are going to be supported. That is not for some cosy private chat in Downing Street; the entire point of devolution was that such decisions came back to Scotland.

Let me ask the question again. Does the SNP want the 2007 spending review, or does it want something else? Surely the people of Scotland have a right to know. It is one thing to go into an election with the odd loose promise here or there, or with a few different spending priorities—that is the very stuff of politics. We are talking about something different, however. There are parties here that will not tell us whether or not they want

to tear up the system and start again. They are not prepared to tell us whether they want a different system, although they aim to start negotiating for one within three weeks.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Will the member take an intervention?

Ms Alexander: Happily.

The Presiding Officer: The member is now in the last minute of her speech, I am afraid.

Ms Alexander: I think that that prevents me from taking an intervention.

We are going to keep on asking the question. On the day after this year's election, will the 2007 spending review stand, or do those other parties want to tear up how the country is financed and start again? We have to wonder at the reasons why they will not tell us whether they intend to argue for the ability to collect taxes in Scotland or how much of the North sea oil they want on 4 May. On 4 May, will they argue for pensions to be devolved to Scotland? How much will they pay in for defence on 4 May?

The Presiding Officer: Could you close, please?

Ms Alexander: Are we instead going to stick with the current system?

The Presiding Officer: Close, please.

Ms Alexander: The reason why the parties to which I refer do not give us even a paragraph on the financing of Scotland is that their sums simply do not add up.

15:04

Mr David Davidson (North East Scotland) (Con): I am not quite sure what that rant was about, but I suspect that it has more to do with the election than this budget debate.

Margo MacDonald (Lothians) (Ind): Oh, well spotted, sir.

Mr Davidson: It was not hard, Mrs MacDonald.

Tom McCabe started off full of self-praise, as usual. We hear the annual spin at these budget bill debates because, as Mark Ballard said, the only person who can amend what goes on is the minister, which means that the debates are slightly false.

The minister claimed that he was prudent yet ambitious, and went on to expand on the subject of transparency. I ask the minister: when is that transparency going to come about? What is the big secret? The Finance Committee would love to have such a transparent process. It could get its teeth into it, see outcome figures for every pound spent and examine the choices made, as Andrew Arbuckle said. That would enable us to judge what we got for the money that was spent and how money should be spent in future. However, the minister has not given us that information in time. The committees of the Parliament have a hard time fitting good consideration of the budget around the other work that they must do.

The minister managed to bring up the fact that he is bribing local government—he offered that observation himself, which was magnanimous of him. Nobody argues about the fact that local government needs money to deliver free personal care, which is a policy that everyone in the Parliament supported. It is only a shame that it took so long to come out, and I am interested in where the minister thinks that it will go.

John Swinney, Derek Brownlee and Andrew Arbuckle mentioned the efficient government initiative, which does not go far enough and is not transparent enough. If we are to evaluate Government focus and performance, we need the outcome figures, not just the outturn figures. We need to know what we got—and will get—for the money.

Derek Brownlee talked about value for money. We can examine whether something represented value for money only if we have up-to-date outturn figures. We cannot do it any other way. However, we do not have those figures.

I thought that Mark Ballard's speech was good, as he talked about the process and mentioned cross cutting. Every minister under the sun mentions cross cutting through the year, but nobody can ever identify what it does, where the money comes from, where the money goes and how much it gets. However, Mark Ballard's idea of budget by committee is not the way in which we want to run Scotland's finances.

I hope that, the next time that we have this debate in the Parliament, we get something to debate.

15:08

Jim Mather (Highlands and Islands) (SNP): This has been an interesting debate. It was interesting that the minister started off by talking about unemployment going down. I suggest that he should drill down into that issue in some detail and consider low incomes, the fact that the annual survey of hourly earnings ignores people who work less than 18 hours a week, the fact that Scotland is still exporting many of its skilled high earners, the fact that many people are in part-time work or have short-term contracts and the fact that the reason why we have exceeded the Lisbon target for women in the workforce is because

many Scottish women are in the workforce because of basic family necessity.

I noted John Swinney's recognition of the improvement in the local government settlement. However, even with that improvement, there is a concern about the stop-go nature of local government finance, with efficiency savings being clawed back and money going out again—all of which happens at short notice and all of it drives the complete antithesis of efficient government. In fact, we are not even seeing that antithesis because we cannot get the Howat review—that grave omission continues; the democratic and accounting deficit is still there.

Derek Brownlee, in spite of his positioning, exposed rather well the weakness of the idea of the union dividend, which is evidenced by our low growth, our population decline, our demographic problems, the fact that we have the lowest life expectancy among Organisation for Economic Co-operation and Development countries, our low average incomes and—as we have seen today—the problems with the well-being of Scotland's children. That is not exactly a terrific record.

Although, as John Swinney said, talk of efficient government rumbles on, we did not hear much about it today. However, we need to know more about it. We need to ask about the extent to which it is pulling together the arms of the public sector into a new era of renewal and resurgence and delivering operational and financial efficiencies. To what extent is efficient government becoming a perpetual obsession, subject to arm's-length audit and accounting verification à la Howat?

We have the most unbelievably damaged system. There is no credible aspiration or unifying worthy cause that unites Scotland, no shared national vision, no shared local community visions that feed into that and no widely held belief that the Government is obsessed with the objective of increasing the personal well-being and security of citizens relative to other people. We are falling behind.

Helen Eadie (Dunfermline East) (Lab): Will Jim Mather tell us what is the SNP's vision for Scotland, particularly with regard to our pensioners? We have a clear vision for them. We believe that it is vital to tell them exactly how their pensions will be funded. We have an interest in that as well. Will Jim Mather tell us how the SNP will fund pensions?

Jim Mather: We will do so by the straightforward methodology of maximising the number of working-age people who are in work in Scotland and paying taxes. That will allow us to drive forward our pensioners' terms and conditions, in line with the Irish, the Norwegians, the Spanish and those in other countries who are pushing ahead and giving their pensioners much more.

The budget process is a sham and is incomplete. It does not manage growth, and the minister has no target for growth. There is no mechanism to maximise Government revenue and no need to manage inflation or interest rates. There is no need to manage a deficit or surplus. It is a perverse approach that risks a genuine spiral of dependency and decline. In particular, we do not have interconnected Government departments that have a single, national aim.

Ms Alexander: The member mentioned inflation and interest rates. Does the SNP have any intention of managing those? I thought that, as of 19 January, it intended to keep the pound and the Bank of England. What is its mechanism for managing inflation and interest rates?

Jim Mather: We will use the same mechanism that Ireland and Australia use successfully. The difference is that, when we take that currency move as an interim step, we will have tax powers to maximise the efficiency of Scotland and mitigate the inflation-driven approach of the past.

The lack of unifying aims and macro-objectives means that we have arbitrary numeric targets, which Wendy Alexander herself has said are set by departments on the basis of what they can meet. We should have an open-ended commitment to improve the number of economically active people in work and to measure growth in that area. That would improve the health of Scotland, the pensions of Scotland, the tax take of Scotland, the motivation of children in Scotland and the take-up of everything. We need those objectives if we are to release real energy in Scotland.

Instead, we have a Government without the revenue feedback loop or the checks and balances that should run throughout the full gamut of our affairs. We have an uncompetitive, unsustainable version of national economic management. Compared with what others have, it is a laughing stock. If this debate was held in any other legislature—we are spending 45 minutes on stage 3 of the bill—it would be a laughing stock.

We must consider the success of other nations. Since 1945, the number of independent countries has increased from 74 to 193—119 more. Why is that? People have seen the effectiveness and benefit of having a unifying national objective and the power and policies that can move them towards that objective. People do not sit around waiting for things to get better. Governments are built on networks of predisposed peers who work together to help the nation—networks of self-critical, excited people in every department of Government who are trying to improve things. It is

as if an Alcoholics Anonymous for Governments is coming out and saying, "This is how we can improve things and move them forward."

The creation of the international financial services centre in Ireland has transformed the country. That is a terrific competitive proposition. Now, Ireland has its national development plan, which is worth €184 billion over five years—or £20 billion a year—to build their country. We should be doing the same.

15:14

The Deputy Minister for Finance, Public Service Reform and Parliamentary Business (George Lyon): I was going to start my speech by saying that the debate had an end-of-term feel to it, but after the previous two speeches I could not possibly pursue that argument.

The Minister for Finance and Public Service Reform pointed out that the budget is only a mechanism for delivering improvements to the people of Scotland in all the areas in which the public sector impacts on them. To name but a few, those improvements include extra teachers in our schools, more nurses and doctors, the building of new schools, greater investment in transport and the concessionary travel scheme and central heating scheme for our elderly people. Those are real measures that are making a huge difference to people in Scotland. Those are the things that we will be judged on when it comes to the election in May.

Mr Swinney: Will the minister give way?

George Lyon: I am conscious that I have to make some progress.

As Mr Swinney noted in his speech, this is the last budget process of the parliamentary session, and I think that it is perhaps time to reflect on the process—one or two members also referred to that. I hope that in the next session the Finance Committee will perhaps examine in some detail how we can improve the process and make it more meaningful. By the time that we reach stage 3, a lot of the points have already been made and, a bit like the film "Groundhog Day", we rehearse some of the same arguments, albeit this time with the added attraction of the forthcoming election.

I am glad that Mr Swinney recognised the change in the financial settlement for local government, which will lead to one of the lowest increases in council tax in Scotland since devolution. He also welcomed our efficient government programme and suggested that we need to go further. I do not think that anyone looking at the likely post-spending-review settlement is in any doubt about the fact that the efficient government programme will need to go further to release important extra revenue for investing in our public services and ensuring that they deliver even greater value in the future.

Mr Brownlee touched on the same theme. The Executive has nothing to be ashamed of in our efficient government programme. It is delivering what we said it would, and it will deliver in the future when we need to free up even more headroom to ensure that our public services deliver for us.

Members will not be surprised that I agree with all the points made by Mr Arbuckle. I could not possibly disagree with his contribution, which I think was well worth noting.

Mr Ballard described the information in the budget documents as "meaningless". If so, I suggest that it is like the Green party manifesto because, as we all know, the Greens are on record as saying that they will not enter a coalition and therefore will not implement anything in their manifesto. In the same way, it is also like the Tories' manifesto.

Of course, Mr Ballard could have brought forward an alternative budget detailing the Greens' plans to nationalise all our public utilities and block the Edinburgh airport rail link. However, he chose not to do that, so I do not think that he can criticise us for presenting our budget and allowing, through the budget process, an open debate on it.

Wendy Alexander was right to have her say and to ask the questions that she asked, but her late arrival perhaps caused her to misjudge slightly the tone and temperature of today's debate. It may have been better if she had been present from the beginning of the debate.

Mr Mather continued in the same tone. In his speech, he railed about unemployment, our falling behind and our having an unsustainable and uncompetitive Scotland. He is the Mr Doom-and-gloom of Scottish politics. I sometimes think that he lives in a parallel universe that is totally detached from the reality that we experience every day. Although he might believe all that he says, even the most critical MSPs would find great difficulty in identifying the parallel universe that Mr Mather describes daily in which the whole of Scotland is, to quote him, a basket case.

The only laughing stock is Mr Mather's position that an independent Scotland would rely on the Bank of England to set its interest rates. He also mentioned five different countries with five different fiscal positions, and he failed again to tell us which one he would adopt in Scotland. Which taxation levels would he advise an independent Scotland to follow for personal taxation and inheritance tax? He really should attempt to answer those questions.

Finally, it is worth stressing again that this budget is important because of the impact that it will have—it will allow us to deliver our plans for 2007-08. Our financial plans are responsible. The enormous sum of money distributed by the Executive belongs to the people of Scotland, and it is our duty to ensure that it is spent efficiently to meet the priorities and needs of the whole population. It is a budget that will deliver excellent public services, support stronger, safer communities and develop a confident, democratic Scotland. I commend it to the Parliament, and I hope that it is supported at 5 o'clock.

Making the National Health Service Local

The Deputy Presiding Officer (Trish Godman): The next item of business is a debate on motion S2M-5572, in the name of Andy Kerr, on making the NHS local.

15:20

The Minister for Health and Community Care (Mr Andy Kerr): The national framework for service change and "Delivering for Health" set out the rationale for a fundamental shift in the balance of care. Simply put, our goal for the health service in Scotland is that it should be

"as local as possible, and as specialised as necessary."

As society changes, we need to move away from the traditional models of reactive and episodic care in the acute sector. We need to pioneer and embrace preventive, integrated and continuous care that is delivered in local communities. By expanding and developing local services, we will make the greatest improvement in the lives of the people of Scotland.

I will highlight the progress that has been made to shift the balance of care in the past few years. Primary and community care premises that are fit for purpose are key to the delivery of high-quality care. We have made significant progress on addressing the years of neglect in the 1980s and 1990s. More than £138 million has been committed to 165 projects since 1999, in addition to the investment that NHS boards have made directly.

Examples of what has been achieved include the Leith community treatment centre, the north-west Kilmarnock partnership centre, the Easterhouse health centre, the Aberdeen dental institute and other dentistry facilities throughout Scotland. The first hospitals of a new generation of community hospitals have opened in Hawick, Easter Ross and mid-Argyll and more are to follow in Clackmannan, St Andrews, Girvan and Midlothian.

The recently published community hospitals strategy underlines the fact that NHS boards should provide a range of day-case surgery, minor injuries and diagnostic services in those revitalised local facilities. NHS Grampian is one board that plans a radical shift in the location of services so that, by 2010, 40 per cent of overall out-patient activity and 25 per cent of in-patient activity that specialist hospitals undertake will be managed in alternative settings that are closer to people's homes.

The creation of a network of community casualty units throughout Scotland will mean more local

access for the vast majority of cases that are currently seen in accident and emergency departments. That will ensure that patients who require more specialist care receive it within the target time in appropriately staffed and resourced emergency centres. That approach adheres to the principle—which the Parliament overwhelmingly supports—that care should be

"as local as possible, and as specialised as necessary."

However, the significant investment in such facilities is only one part of the step change in NHS Scotland. In the past three years, funding for primary medical services has increased by 50 per cent. The way in which we work with and reward our general practitioners focuses on Scottish health priorities and ensures the provision of high-quality care and chronic disease management in the community.

In 2005-06, at least 95 per cent of practices achieved targets for important indicators such as the control of blood sugar, blood pressure and cholesterol levels in patients with diabetes. That approach prevents the worsening of health problems and fundamentally improves the patient's health and quality of life. In addition, it reduces the risk of hospital admission.

Our goals are therefore to shift services from hospitals to the community and to shift the nature of services from reactive and episodic care to preventive and continuous care.

Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP): The minister will be aware of the approach that NHS Highland has taken to the proposed closure of Glencoe hospital. Does he agree that, in general, any such proposal should be attached to a detailed and robust plan that sets out clearly the alternatives that are to be put in place? Does he agree that communities require such a detailed plan, in which the long-term arrangements for care of the elderly in particular are provided for, before it is reasonable to expect an application to close an existing hospital to be considered properly?

Mr Kerr: I share that view. It is incumbent on all health boards throughout Scotland to ensure that, before significant service change takes place, they provide evidence of alternatives in the community that seek to provide a service that is better, more sustainable and closer to home, which is what many patients in Scotland would prefer.

That brings me to the question of how we view patients. The traditional concept of people as passive recipients of health care, as we do what we need to do to them, is the way of the old health service. We want people to recognise that they should be full partners in their health care. That should apply to their carers and families, too.

We have some good examples of that. In collaboration with Asthma UK and NHS Quality Improvement Scotland, we have been involved in a project to improve the health and well-being of people with asthma through providing and promoting the use of personal asthma action plans. The approach is targeted at children and adults and informs health professionals and members of the public of the benefits of using the plans. The project will increase the support for self-care for people with asthma, anticipate their needs and provide them with earlier care to prevent deterioration of health, thereby reducing the number of emergency admissions.

Improving health and reducing health inequalities are central to our strategy in "Delivering for Health". A range of health improvement services and programmes that are designed to change behaviours and to increase life expectancy and quality of life are reaching out to people in their local communities at every stage of their lives. Antenatal services are providing a fully integrated package of care, ensuring the best chance for a healthy pregnancy and a healthy start to life for all children. Nurseries and schools are becoming health-promoting environments. We have appointed 600 active schools co-ordinators and we are providing free fruit and drinking water in primary schools.

We are also taking our children's oral health action plan into communities through supervised tooth-brushing initiatives and the provision of oral health packs in nurseries and primary schools. That action is already having significant results. Recent statistics show that 54 per cent of children in primary 1 now have no signs of tooth decay. The figures are the best since the programme began in 1987 and show that the Executive is well on the way to meeting its target of 60 per cent of children having no signs of dental disease by 2010.

Carolyn Leckie (Central Scotland) (SSP): I appreciate the fact that there have been improvements in dental health, but there are also stark inequalities. That is especially evident in the differences between Cumbernauld and Airdrie—two areas that share the same health board, NHS Lanarkshire. What specific strategies is the minister going to put in place to deal with those inequalities?

Mr Kerr: The child smile initiative for oral health and hygiene has been established in parts of Lanarkshire and is targeted at those communities. I will come to that in a minute.

I was describing a journey through antenatal care, care of the young person and primary school. Hungry for success has revolutionised school meals and is now implemented in all 2,700 schools in Scotland. For secondary schools, the

Schools (Health Promotion and Nutrition) (Scotland) Bill will take the initiative further, with specified nutritional standards for food and drink in all schools and additional standards for physical activity.

In the workplace, the centre for healthy working lives is driving the delivery of the workplace health and well-being agenda. Initiatives such as pathways to health mean that more than 20,000 people are participating in led walks every week, the vast majority of whom are over 60 years of age.

At every stage of human life in Scotland, we are working with individuals and communities to ensure well-being and better outcomes. Those are just a few examples of the many initiatives that exist.

Stewart Stevenson (Banff and Buchan) (SNP): Will the minister take an intervention?

Mr Kerr: I need to make progress, but if I have time I will take an intervention from Mr Stevenson later.

Delivering for health commits us to strengthening primary care services and to providing anticipatory care in the most deprived communities in Scotland. That has led to keep well—a new and ambitious approach that is aimed at engaging people who have not traditionally made full use of our national health service, especially those with the greatest health needs. We have identified the most challenged and deprived areas, and the first keep well services are now operating in community health partnerships in Greater Glasgow, Lothian, Tayside and North Lanarkshire.

Services in those areas are being tailored to meet the needs of the communities. In Airdrie, keep well screening is being offered in the evenings in the local community centre and library to maximise uptake. Many of those who are traditionally the most reluctant to come to the national health service are now being driven into it and are being offered screening and appropriate interventions. I am pleased with the early figures that I have for the initiative. Since October, a total of 2,082 people have attended keep well health checks in Lanarkshire, and there have been a total of 1,193 onward referrals to weight management, exercise, alcohol, smoking cessation and chronic disease management services. That is where the preventive anticipatory health care agenda rests.

Stewart Stevenson: The minister made two brief references to dental care. If someone is told at their dental check that work requires to be done, what is the appropriate maximum wait before that work commences?

Mr Kerr: Depending, of course, on the specialty and other issues involved, I would hope that the waiting time would fit with our overall targets, which have brought waiting times in the health service down to an historic low. Depending on the circumstances, the waiting time should fit with those overall targets for health services.

Real and decisive action is being taken to address significant health inequalities and challenges. We are committed to ensuring that those who are in greatest need continue to receive targeted and appropriate support. I am therefore delighted to be able to announce that a further wave of keep well services, representing an investment of £10 million during the next two years, will become operational later this year.

Services like those that I have described will be developed in Fife, North and East Ayrshire, Aberdeen, south Glasgow, Inverclyde and West Dunbartonshire. Enhanced services will mean that there will be more direct and targeted interventions than ever before. These are world-leading services that are targeted at those who have the highest risk factors. They will aim to offer appointments in the evenings and at weekends to ensure that there are no barriers to access, and to have outreach workers who will contact patients by phone and by other means to get them into our national health service. The services will benefit from new guidelines for the NHS in Scotland on the prevention of coronary heart disease, which for the first time will consider deprivation as a risk factor when determining treatment. Keep well will be nationally evaluated, and what is learned will be disseminated so that practice can be extended to ensure that we tackle ill health in all parts of Scotland.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): Will the minister take an intervention?

Mr Kerr: I am sorry; I cannot because I am in the final few moments of my speech.

We can see a real shift in the balance of care. The health service is changing the way it works and is making a real difference, saving and enriching lives and, of course, keeping families together for longer.

I move,

That the Parliament supports the goal of further shifting the balance of care away from reactive, episodic care in the acute sector towards preventive, integrated and continuous care embedded in local communities; congratulates NHS Scotland on the significant progress in making its service more local, as required by "Delivering for Health"; welcomes for instance the 50% increase in funding for primary medical services over the period from 2002-03 to 2006-07 and unprecedented investment in primary and community care premises; supports the new community hospital strategy with its focus on providing local facilities and services appropriate to modern-day demands; welcomes the establishment of the Scottish Centre for

Telehealth in Grampian and the approaches it will bring to widening access to specialist services, such as seen in the tele-neurology service in Orkney; commends the shift from hospital-based provision to local access for services such as chemotherapy and dialysis and expects community health partnerships to continue to accelerate such a shift; recognises the benefits to communities of more local access for the majority of their unscheduled care needs that will be brought about by the development of community casualty units; welcomes the continuing development of new staff roles and expertise as a means to carry services closer to patients; supports the community pharmacy minor ailments service as an excellent example of improved local access; supports the Scottish Executive's intention to improve Scotland's health, focussing especially on reducing inequalities between those with the best and worst health; acknowledges the contribution to improving health of services in local communities for people of all ages, from improving children's dental health in Glasgow to promoting walking for health by older people; applauds the world-leading anticipatory care "Keep well" services which tackle coronary heart disease in the most deprived communities, and welcomes this package of service change and the continued development of local community health partnerships as a strong and coherent response to the changing pattern of demand that NHS Scotland will face.

15:32

Shona Robison (Dundee East) (SNP): I congratulate the Minister for Health and Community Care on lodging possibly the longest motion in the history of this Parliament. We decided to match it with probably the longest amendment in the history of this Parliament.

In the spirit of co-operation, we agree with much in the motion and support the local service developments that are highlighted in the Executive's motion. The Scottish National Party's amendment highlights them, too. Initiatives such as the keep well service should be given our full backing and I am pleased that Dundee has been one of the first areas to benefit. We support such preventive health care measures to tackle health inequalities, particularly in light of the United Nations Children's Fund report, which was published today and shows that the United Kingdom is bottom of the league of 21 industrialised countries for child well-being. The gap between the life expectancies of rich and poor has widened, which is unacceptable for an energy-rich and wealthy nation such as Scotland in the 21st century.

We support the principle of reaching those whose health is in danger, even though they might not yet be aware of it. Men in the 10 per cent least deprived areas expect to live for 13 years longer than men in the 10 per cent most deprived areas. We have some way to go, and we compare very poorly with Norway, which has been top of the rankings for six years now. That is why a Scottish National Party Government will tackle head-on the prevention of major diseases, ill health and low life expectancy rates through our proposals to extend the provision of primary care services in the most deprived communities. We want to focus our attention on intervention in the early years and to identify and work with children who are in danger of developing ill health in childhood that will lead to a reduced life expectancy in adulthood. Our society faces a major challenge in the increase in childhood obesity and its consequent health problems.

Elaine Smith (Coatbridge and Chryston) (Lab): Does the member agree that breastfeeding is of major importance and that we need to focus on it more and consider the funding it attracts so that we can help and support the staff and the mothers, and that we should recognise the new research that was published today that underpins the breast is best message?

Shona Robison: I certainly concur with that. The breast is best message is an important element of the many initiatives that need to be targeted at communities. I know that the matter is a major issue in Elaine Smith's constituency.

One of our proposals is to double the number of school nurses to deliver school-based health checks and individual health plans. The nurses would work with parents, teachers and local health professionals to prevent bad habits from being established in many of our children who, in adulthood, may be most vulnerable to ill health and premature death.

We have some concerns about the proposed changes to the new community nursing model. The proposals could be counterproductive if they diminish, rather than enhance, the health improvement role of nurses. I have written to the Minister for Health and Community Care about that and we will watch developments closely.

Where we differ from the Executive is that we do not agree that we must have Hobson's choice, as if good preventive health initiatives have to come at the expense of the retention of core acute services that are delivered as locally as possible. We do not subscribe to that assertion. Given that the health budget is now reaching £10 billion, we do not believe that the public need to make that choice.

Mr Kerr: I am confused by the term "Hobson's choice". It suggests that finance was the key driver for the changes, whereas the changes were driven by clinical evidence in the health boards concerned. That is evidenced by the investment that Lanarkshire NHS Board and Ayrshire and Arran NHS Board have made.

Shona Robison: I am pleased to hear that finance is not the issue. In that case, the driver is policy. On this side of the chamber, we believe that both policies are important: people deserve to have core acute services that are delivered as

locally as possible at the same time as they are offered the preventive health measures that are being developed.

Karen Gillon (Clydesdale) (Lab): Is that another spending commitment from the SNP?

Shona Robison: The member asks whether that is a spending commitment, but the minister has just said that finance is not the issue. We are pleased to hear that the changes are being driven not by finance but by policy developments.

Karen Gillon: Will the member give way?

Shona Robison: No; let me develop this point.

Of course, many Labour members agree with us that the Kerr report—the report from Professor David Kerr—backs the retention of core acute services, such as accident and emergency and maternity services. They have made that point in the chamber and elsewhere.

Mr Kerr: Will the member take an intervention?

Shona Robison: No, I need to make progress.

As we have said consistently since our submission to the Kerr review more than two years ago, the SNP considers that A and E and maternity services must be delivered as locally as possible. We see merit in community casualty units not as an alternative to A and E units but as a supplement that can take pressure off overstretched A and E services such as those that we have seen closed over the past few weeks.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): The medical profession has told us that it cannot support the accident and emergency units that Scotland has at the moment. As the minister said, the issue is not money but the fact that the medical profession has said that it cannot support the existing number of A and E units. Is the SNP's position that no accident and emergency centres should close, despite what the medical profession has said?

Shona Robison: We are saying that the proposals to close the A and E units in Monklands hospital and Ayr hospital are fundamentally flawed. For example, the Monklands closure was based on a private finance initiative decision rather than on a clinical decision. If Mr Rumbles speaks to the clinicians in the local area, he will find that they had alternative proposals but that they were never heard because the health board had already made its decision. We need an honest debate rather than a debate that is skewed from the start for other, non-clinical, reasons.

Let me be absolutely clear: as well as promoting the important initiatives that aim to tackle health inequalities, we believe that we need to tackle deprivation, which is the root cause of the majority of ill health and low life expectancy in Scotland. It is time for Scotland to enjoy the same wealth and living standards as other small independent nations such as Ireland, Norway and Finland, which came in the top half of the UNICEF league.

I have pleasure in moving amendment S2M-5572.2, to leave out from "the goal of" to end and insert:

"the delivery of core acute services, such as accident and emergency and maternity services, as locally as possible while also recognising that some specialist services may need to be delivered in larger centres; recognises that "Delivering for Health" provides an opportunity to reverse the trend of further centralisation and keep services local; welcomes the additional investment in primary medical services; supports the new community hospital strategy with its focus on providing local facilities and services appropriate to modern-day demands; welcomes the establishment of the Scottish Centre for Telehealth in Grampian and the approaches it will bring to widening access to specialist services, such as seen in the tele-neurology service in Orkney; commends the shift from hospital-based provision to local access for services such as chemotherapy and dialysis and expects community health partnerships to continue to accelerate such a shift; recognises the benefits of community casualty units which can help to relieve pressure from busy accident and emergency departments; welcomes the continuing development of new staff roles and expertise as a means to carry services closer to patients; supports the community pharmacy minor ailments service as an excellent example of improved local access; supports the increasing focus of NHS Scotland on reducing inequalities between those with the best and worst health; acknowledges the contribution to improving health of services in local communities for people of all ages, from improving children's dental health in Glasgow to promoting walking for health by older people; applauds the world-leading anticipatory care "Keep well" services which tackle coronary heart disease in the most deprived communities, and welcomes the continued development of local community health partnerships as a strong and coherent response to the changing pattern of demand that NHS Scotland will face."

15:39

Mrs Nanette Milne (North East Scotland) (Con): The motion is hardly a masterpiece of brevity, but it highlights a number of innovations in the health service that we all welcome. It is an end-of-term report that celebrates significant achievements so far but chooses to ignore several areas of underachievement.

We all signed up to the broad thrust of Professor Kerr's vision of how the NHS in Scotland could continue to deliver high-quality care in the light of demographic change and the rising demand for health services—by focusing on primary care, with locally accessible services and an emphasis on preventive care and self-management of chronic long-term conditions—and to the concept that an increase in the range of locally available services would be a positive development in the NHS that would lead to fewer hospital admissions and take pressure off the hard-pressed secondary care sector. As Professor Kerr developed his proposals

for the NHS, he consulted widely among professionals and the public. I remember the tangible buzz in the chamber when people felt that at last they were being given ownership of their health service and a say in how it was to develop in the interests of local people.

To achieve the Kerr vision, change is inevitable, but that change must be carefully planned, with the agreement of local clinicians and in consultation with the local population. If service change is to be acceptable and to gain the confidence of the public, new services will need to overlap with existing ones as part of the change process. As the British Medical Association says:

"It is misguided to believe that hospital services can close with just a promise that there will be new services in the community to replace them … NHS Boards must find ways to demonstrate that patients will not lose out because of changes to the way services are delivered."

Unfortunately, service reconfiguration so far has had major setbacks because the public and professionals have not been properly engaged in meaningful consultation and, across the country, people have been faced with decisions to close existing local facilities when they are unconvinced that service provision will continue at an acceptable level.

Mr Kerr: Does the member agree that in both cases to which she refers the clinical governance committees supported the configuration changes that boards were making? Community casualty units will be developed before any changes to accident and emergency services take place.

Mrs Milne: I accept what the minister is saying, but I am sure that he will agree that there is a public perception that people are not being listened to. There have been many instances of hospital facilities being closed, and people are not happy with what is happening.

Karen Gillon: Will the member take an intervention?

Mrs Milne: No, I must make some progress.

There is an increasing sense of dissatisfaction with the way in which boards consult the public, and a feeling that outcomes are generally predetermined and do not take public opinion into consideration. The focus on community provision is welcome, but it is important to retain a sustainable number of local acute beds and services. Often, doctors and residents are not convinced that that is being done.

The recent BMA survey of doctors showed that there is consensus that local services should be tailored to local need and that if real benefits are to be delivered to patient care there must be engagement with clinicians in both primary and secondary care sectors. The efforts of community health partnerships to create joint working between health and social care are progressing well but, so far, according to doctors, they have failed to engage effectively with clinical staff, which is not helping to achieve a smooth transition between hospital and community-based care. There must be collaboration between the primary and secondary care sectors. That will be achieved only if service redesign is clinician led and the focus is on improving patient care.

Other significant barriers to shifting the balance of care to local communities are inadequate infrastructure and insufficient human resource. For all that there has been

"unprecedented investment in primary and community care premises",

in three out of four practices premises are still not suitable for future needs. Many health centres, such as one that I visited recently in Inverurie in Aberdeenshire, cannot absorb any further work simply because they lack the rooms and space to allow them to expand their activities. That problem must be addressed if a transfer of care from hospitals to the community is to be achieved successfully.

Furthermore, primary care teams are already fully stretched, without the added work that a community focus will place on them. The Royal College of General Practitioners tells us that one in three GPs will retire in the next few years, with a projected deficit of 500 in Scotland by 2012. The Royal College of Nursing warns of the need to retain the experience of its aging workforce, and to recruit for expansion, not just replacement. Many new entrants to primary care—of both sexes—do not see it as a full-time occupation and branch out into other medical or non-medical pursuits. At the moment, the system is propped up by locum GPs, many of whom are several years beyond retirement. According to Audit Scotland, nurse staffing levels are insufficient to cope with sickness and absence or to allow for the development of leadership skills.

There are huge positives in Scotland's NHS, thanks to a dedicated workforce that punches well above its weight. The Scottish centre for telehealth in Grampian has pioneered some groundbreaking work in bringing specialist advice to remote and rural areas and has let many patients remain in their local communities when previously they would have had to travel long distances to a hospital. The provision of treatments such as dialysis and chemotherapy in cottage hospitals makes a huge difference to the quality of life for patients. Of course, health promotion is essential if we are to overcome the major risks to our population from obesity, lack of exercise, smoking and all the ills that we know currently beset our society.

We agree with the Executive that health inequalities have to be addressed with some urgency, and we hope that the keep well initiative will have the successful outcomes the minister has predicted, but we do not think that the current top-down, tight political control of the NHS is the best way ahead. We agree with the BMA that, for the health service to be truly effective, it needs to be driven by clinical need rather than by the need to respond to centrally imposed targets.

It is right that, in the light of changing patient needs and an aging population, we should focus on shifting the balance of care, but any changes to the delivery of care must be planned and sustainable, must involve professionals and the public, and must be in response to clinical need rather than to political control. I am confident that, with empowered patients and their GPs at the centre of the NHS, services would develop to meet their needs.

I move amendment S2M-5572.3, to leave out from "congratulates" to end and insert:

"however recognises the importance of retaining a sustainable number of acute sector beds and services and recognises continuing public concern over the extent of proposed centralisation of hospital services; congratulates the NHS where it has established innovative approaches to meeting modern day demands such as the use of tele-medicine in Grampian and Orkney and the shift of chemotherapy and dialysis to the local community; recognises the increase in funding for the NHS however notes that despite this substantial increase there are still many issues to address; supports the Scottish Executive's focus on health promotion and reducing inequalities between those with the best and worst health however believes that patient need would be best met with more purchasing power being placed in the hands of patients and GPs so that their choices determine the development of the service, and also seeks to develop a health service driven by clinical need rather than responding to centrally imposed targets."

15:46

Euan Robson (Roxburgh and Berwickshire) (LD): This is an important debate, particularly if it really does mark a sea change in public policy. My party has long wanted a new emphasis on, to use the words of the Minister for Health and Community Care's motion, a shift in the balance of care away from episodic care in the acute sector to health promotion, preventive and anticipatory care. That is not to suggest for one moment that there should be poorer standards of treatment for those who fall ill, but rather that we should seek to ensure that far fewer people require treatment, because they are living healthy and fulfilling lives.

As the minister said, it is not as if the Scottish Executive has not made progress already in changing the emphasis, notably, but not exclusively, with the ban on smoking in enclosed public places and free eye and dental checks, all of which Liberal Democrats have consistently advocated.

The minister listed a number of other initiatives from keep well services—I commend him on his announcement today of extra resources for that—to child dental care, which are truly making a difference. As we know, most interaction between NHS Scotland and the population it serves is in community health. It was therefore important that the Kerr report should underline that and that "Delivering for Health" should point firmly towards making NHS services more local.

We need to cut waiting times by ensuring local provision and by promoting better health, so that fewer people are waiting. It is important to recognise, as the motion does, that there has been a 50 per cent increase in funding for primary medical services and major investments in primary and community care premises. As has been said—and as all parties acknowledge—significant innovations have been taking place in telemedicine. I am sure that we all wish the Scottish centre for telehealth in Grampian every success and that we will all watch the development of the teleneurology service in Orkney with interest.

There are many other significant developments. For example, in July 2006, the community pharmacy-based minor ailments service was introduced. Patients who are exempt from prescription charges can register with a community pharmacy of their choice and have any minor illnesses or common conditions treated by the community pharmacist on the NHS. That means that patients no longer have to bother their GP for a prescription for a relatively minor condition. My understanding is that 660,000 patients have registered for the service and that community pharmacists are providing roughly 50,000 consultations a month. We should all record our thanks to community pharmacists for the effort they have put into an excellent example of making health care more local.

Margo MacDonald (Lothians) (Ind): I will extend the member's point about the role played by community pharmacists. Given the experience of the coeliac breakfast this morning, does he agree that it might be a good idea to take the concept and extend it to access to the special foods that coeliacs need?

Euan Robson: Yes, I see no reason why community pharmacies should not be involved in that, in co-operation with others who retail such products.

We can do so much more to improve the health and well-being of the nation. Lives can be made better if we develop anticipatory care, improve the speed of diagnosis, deliver services as close to

the patient as possible, and support and work in partnership with colleagues in social work and social care and with voluntary carers.

My party believes that the health and well-being of the nation has NHS Scotland at its centre, but we further believe, as we said last autumn in our pre-manifesto, "Bright Future—A Vision for Scotland", that every aspect of government needs to be focused on the links between public health and the environment we live in.

Access to quality green space, having a warm, dry home to live in, the ability to cycle safely instead of using a car and having clean air to breathe are all important in the promotion of health and well-being. Much work has been undertaken in our schools as part of the hungry for success programme, but we need to promote that concept throughout the public sector.

As we said in "Bright Future", government too often contradicts itself—it is no good preaching healthy eating to people if the state still sells fatty, frozen and processed food. We call for protection for our green spaces, for improvements in building regulations, for the central heating programme to be extended to cover the replacement of obsolete systems and for the needs of carers to be covered. We should do all that to improve the lives of individuals. We should never lose focus on the fact that too many of our fellow citizens are burdened with ill health. It is right that we look abroad for fresh talent, to people who wish to devote their careers and their lives to this country, but we must not forget the hidden talent that exists among our own people who are burdened unnecessarily.

Many members will have been to the coeliac reception that took place earlier today. One of the participants in that event told me that, within a fortnight of being diagnosed and a change in diet, she felt a great deal better. She realised that her earlier life had been like driving a car with the handbrake on. By making our health service more local, preventing ill health and promoting health and well-being, we will allow the hidden talent in the nation to flourish.

Let us take the handbrake off the lives of many of our fellow citizens. Such action is important for the economy. Just less than 9 million scheduled work days are lost every year because of ill health. The "Scottish Economic Report" recently showed that a 5 per cent increase in regular physical exercise could reduce the number of days lost through sickness by 7 per cent and save 157 lives, thereby reducing the cost to the NHS by millions of pounds each year. That single example demonstrates the boost to our economy that improving our nation's health would give.

Over many years, health policy has focused on inputs: more doctors, more nurses, more buildings, more treatments, more this and that. They are all important and it will remain necessary to develop community health facilities and NHS workforce planning as crucial parts of making health care local, but the outputs are what really matter for individuals and they need to be our focus now.

I hope that, in years to come, this afternoon's debate will be viewed as a seminal moment when we all chose to concentrate on identifying areas where ill health is profound, on helping people to change their lives, on anticipating illness before it strikes, on improving diagnosis and on getting treatment to people early, so that they do not have to plunge too far into the acute sector. That is what making the NHS in Scotland more local is all about and I commend the motion to Parliament.

The Deputy Presiding Officer: I thank the back benchers whom I am about to call for agreeing to reduce their speeches to five minutes. It will be a tight five minutes. Some members are looking at me as if they have not agreed to that.

15:52

Roseanna Cunningham (Perth) (SNP): I am looking a little puzzled because we were originally told that we would have less than five minutes, so five minutes seems quite generous.

Most members are only too well aware that the public are concerned about the perceived centralisation of health services. It is an unfortunate fact of life that although the removal of services happens relatively quickly, any promised roll-out of compensatory services seems to take much longer.

I am a veteran of the Perthshire campaign to retain consultant-led maternity services at the Perth royal infirmary, which was at its height when Susan Deacon was the Minister for Health and Community Care. There was no end of public involvement—which, in general, was viewed as an infernal nuisance by the health board officials—but at the end of four years of consultation, the outcome was exactly the one that the health board wanted in the first place, despite the opinions that the people of Perthshire had expressed clearly and frequently. I sat at a meeting at which a health board official publicly stated, using almost these very words, "It doesn't matter if everyone in Perthshire wants to retain consultant-led maternity services—it is not going to happen." That was during the consultation process.

It might be a coincidence that the debate is being held just two weeks after the Parliament voted against Bill Butler's member's bill on direct elections to health boards, but we have some way

to go before we can convince people that they are being listened to and are having their views taken into account.

The Executive motion contains a great deal with which I agree, and the SNP's amendment reflects the extent of the consensus, but our amendment specifically acknowledges the difference between core acute services and the more specialist services. It is when core acute services are to be affected that tension really arises.

Contrary to what is sometimes said, most of the people to whom I speak do not expect a hospital at the end of every street. Nor do they expect that highly specialised areas of medicine should, or even could, be available in every locality. Frankly, it is insulting to ordinary people to suggest that they do not understand the difference between the two kinds of health care. What people expect is that certain core services will be made available as locally as possible. They include in those core services the provision of maternity and accident and emergency services, about which there has been a lot of controversy.

Mr McNeil: As Shona Robison said, and as the member has pointed out, the SNP recognises the benefit of community casualty units. What communities would have a community casualty unit and what communities would have consultant-led accident and emergency units?

Roseanna Cunningham: It is a pity that Duncan McNeil did not intervene on Shona Robison with that question. As he may well imagine, my comments will be more narrowly focused on my constituency. It is important that we take people's views on board. Unfortunately, people do not feel that that has happened so far.

It is also important to make the decision-making process much more transparent. For example, when decisions are made about how many prescribing chemists are appropriate for a community, what criteria are used and what weight, if any, is given to local opinion? If pharmacists are going to play the more central role in the delivery of health services that all of us agree is appropriate, the number of pharmacies that are available in a local area will become more and more important. I can see the beginnings of a problem that needs to be sorted out before it becomes a major irritation. I may take up the matter separately with the Minister for Health and Community Care, because there is a specific issue that needs to be dealt with.

The minister will remember that I raised with him the number of minor illness and illness units in Perthshire and, more specifically, the lack of such a unit in Auchterarder, despite the existence of St Margaret's, the excellent local community hospital. He made a welcome comment when he said that he appreciated the point about

"pressures elsewhere in the system, which I want NHS Tayside to monitor closely. I want NHS boards always to review the provision of services, so that we can allow change to occur as appropriate to community needs."—[*Official Report*, 1 February 2007, c 31740-31741.]

I should point out that the "extensive public involvement exercise" that the minister quoted NHS Tayside as having undertaken did not include any direct consultation with the people of Auchterarder and its catchment area on the potential for an MIIU at St Margaret's. Without such consultation, it is understandable that health board officials do not realise that the seven miles from Auchterarder to Crieff—the location of the nearest MIIU—are along unlit, winding roads that would never be the first driving choice of anyone seeking help. Given that the bus service between Auchterarder and Crieff is of the Tuesdays, Thursdays and Saturdays variety, public transport does not fill the gap. The bus service does not exist on Sundays. Even on the days when there is a bus service, the timetable ends around 5pm. From the other areas that would use an Auchterarder MIIU, there is simply no direct public transport provision to Crieff—none at all. In making those comments, I am aware that I have focused on my area, but the same issues and problems will apply in many areas of Scotland.

I appreciate the difficult challenges in all of this, but they are part and parcel of what must be taken into consideration if the desire to make the NHS local—a desire that we all share—is not to founder in the implementation. Too often, it does.

15:58

Dr Sylvia Jackson (Stirling) (Lab): As the minister outlined, the Executive's health policy, which it set out in "Delivering for Health", and the main recommendations of Professor David Kerr's well-received report, are moving in the same direction—we must continue to improve and deliver health services at the local level.

I want to show how primary health care provision in my constituency has improved, although of course we have more to do. I am presently working hard to improve further health centre provision in my constituency, such as at Doune, where proposed new housing will put more pressure on existing facilities.

I will start with the example of the Balfron health centre. In 2005, NHS Forth Valley carried out a £600,000 upgrade of the centre to meet the needs of the expanding population in the area, which is currently around 2,500. The clinic accommodates a full primary care team, which comprises two general practitioner partners, two assistants, a GP registrar, a practice nurse—the list goes on. The clinic also hosts dermatology outpatient clinics from Forth Valley dermatology services—just the

type of provision that the minister described. Balfron health centre is a new model of care that aims to provide care closer to people's homes, thereby reducing the need to go to hospital.

My second example is at Buchlyvie, where a brand new state-of-the-art primary school and medical centre was officially opened in October 2006. The £1.3 million extension and refurbishment project brings together under one roof the local primary school and medical centre. I gather that it is the first of its kind in Scotland. It is the first joint project between Stirling Council's children's services and NHS Forth Valley, and it provides a valuable combined resource for the whole community. The building boasts a number of shared facilities, including a reception, a visitor waiting area and meeting rooms. It also has purpose-built consulting and treatment rooms and a dispensary, to give local residents a convenient and comfortable environment.

Callander medical centre, which saw its first patients in January, is the first new health facility to be built in the Loch Lomond and the Trossachs national park. The £2.4 million GP practice is taking an holistic approach to health, with person-centred psychology among the additional services being provided. It will also be used by Stirling Council as a much-needed day centre. Some of the new services, including a dermatology clinic, will be used by patients from the whole of the north-west area of NHS Forth Valley. Patients groups such as Callander diabetic patient forum, which is an NHS Forth Valley clinical effectiveness prize-winning initiative, will now be able to hold their meetings in the purpose-built meeting room. Trossachs Pharmacy will also be located in the new medical centre. We like to showcase our new facilities, and I invite the minister to visit some of the health centres in my constituency when he can, to see the work at first hand.

Orchard House is part of the Raploch regeneration project in Stirling. The NHS board is providing a comprehensive primary care facility in the area. The new community health complex at Orchard House will provide space for six GP practices, making redundant some of the current Victorian clinics. Co-locating GPs with other community health services, such as dentistry, on the new health campus will bring significant benefits for patients. The work on the full business case continues.

Another arm of the Executive's work in improving our health is the whole government approach to health improvement in Scotland, involving work in schools, increasing recreational opportunities and, most important, improving the quality of the environment in which we live. The minister mentioned most aspects of that approach, which includes priorities on improving diet, increasing physical activity and reducing alcohol consumption and smoking. I could list the many smoking cessation initiatives that are going on in NHS Forth Valley. There is also the Stirling Health & Well-being Alliance, which provides afternoon drop-in sessions for support groups in areas of social disadvantage. Community health partnerships and public partnership forums are playing their part in moving the local health care agenda forward. I could detail some of the important areas that they have been considering.

The infrastructure relating to improvement at the local level—the buildings and the professional services—is moving ahead well in the Stirling constituency. It is important that, as well as keeping an eye on present and future needs, we celebrate those achievements. I support the motion.

16:03

Carolyn Leckie (Central Scotland) (SSP): I draw members' attention to my amendment, which unfortunately was not selected. It is a fair summary of what I would like to say, if I do not have time to say it all.

It is important to place this debate in the context of wider social and economic policy. The UNICEF report that was published this morning should pull us all up by the bootstraps and prompt us to ask whether policy in this country is effective. The difference between countries that have adopted neo-liberal economic policies and those that have more social, public and progressive taxation policies, such as the Scandinavian countries, is staring us in the face in the report's statistics. All the main parties in the Scottish Parliament need to think about their economic policies when they make proposals, for example on reductions in corporation tax.

Last night, I attended a debate organised by the Policy Institute. Unfortunately, I was the only MSP there. While I disagreed vehemently with some of the right-wing conclusions, particularly by a columnist from *The Sunday Times*, at least the ideological debate about the future of the NHS is happening out there. It does not always happen in here. Sometimes we deal with the detail, when the future and strategic direction of the NHS are what are at stake. It is under fundamental attack. The right wing agrees about that, when it is honest about chipping away at the NHS with further market reforms and privatisation, but it is quite difficult to get those issues debated in the Parliament.

I will move on to specific issues, as I do not have much time. My amendment refers to capacity. We need capacity, capacity, and capacity.

Mr Kerr: Where is the evidence for the alleged privatisation of our health service in Scotland? We have the Stracathro centre and other private initiatives, which account for about £140 million of the £10.2 billion health service budget. The PFI and public-private partnership elements of our investment programme amount to less than 20 per cent of our building programme.

Carolyn Leckie: The Scottish health service might be moving towards privatisation at a snail's pace compared with the English service, but it is still moving in that direction, otherwise why did the Executive introduce legislation to enable that to happen? We are the PFI capital of Europe. The minister knows that Serco recently made a serious attempt to grab primary care services in Harthill, facilitated by legislation that the Executive put through the Parliament.

The NHS does not collate enough statistics for workforce or bed-number planning: it is not planning sufficiently. The new consultant contract has been introduced, but the planning for the number of hours that are available for patient care has not caught up with the contract's implementation. The royal colleges are now saying that, because of the contract and other initiatives, such as modernising medical careers, to meet the demand in the service we will need 1.7 consultants for every consultant who is currently employed. That is a huge increase, and I am worried, because I see no sign of the investment that is required to achieve it.

NHS Lanarkshire made a commitment at the beginning of a consultation not to change bed numbers, even though the demography and demand in the area are changing and there is no scientific—

The Deputy Presiding Officer: Ms Leckie, this is a debate on making the NHS local. I have not yet heard that word, so could you make something local?

Carolyn Leckie: I am talking about the capacity to deliver services locally—and anywhere else. If the NHS does not have the capacity, nobody will have any local or distant services.

The issues that face the NHS are capacity, privatisation and the question of which strategic direction it will take. The NHS has also been reorganised to death. There has been a new reorganisation every two years in some areas—there have been six in 12 years—but some of the managers who implement those reorganisations have been in post for only two years. Members should compare that with the length of service of consultants, medical staff, nursing staff and allied health professionals. There are real questions about whether the changes that are introduced are the right ones. Who is involved in and consulted about the plans? Are the changes measured before the managers up sticks and leave?

I have not been able to go into enough detail. There is a debate—which we should be having—about whether we will sustain, protect and reinforce a universal, comprehensive, high-quality service that is free at the point of need. There is nothing in the minister's policies that assures me that he will do that.

16:08

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I warmly welcome the announcement from the Minister for Health and Community Care on the embedding and extension of keep well integrated, anticipatory care in local communities, which is already benefiting my constituents in Leith, Pilton and Granton.

The keep well initiative is a key new part of the NHS's action to close the gap between the richest and the poorest, which is at the heart of the Executive's health policy. It is one of many exciting developments in integrated local care, many of which are mentioned in the motion, including dramatic improvements in the management of long-term conditions. One example that I read this week is that the optimum control of cholesterol levels in the Lothians has increased from 20 per cent to 75 per cent over the past 10 years. Many other examples could be given, including the exciting development of partnerships with the voluntary sector that the Minister for Health and Community Care emphasised in his speech.

There have also been dramatic developments in the provision of local facilities. I am pleased that the minister mentioned the Leith community treatment centre, which I know he enjoys visiting. The centre has performed invaluable work for my constituents during the past three years. It has not just sorted my back; it has provided community-based teams and a community-based consultant, who offer regular appointments and community-based access to diagnostics. The centre is warmly appreciated by my constituents in Leith.

The emphasis on anticipatory care that underlies the keep well programme was a key recommendation of the David Kerr report, which set out a more general vision in which continuous integrated care in local settings would take over as far as possible from reactive, episodic care in acute settings. One of my most important actions as Minister for Health and Community Care was the appointment—indeed, the hand picking—of the members of the David Kerr group. The clinicians, managers and patient representatives who formed the group were committed to the delivery of the maximum possible amount of care in local settings. The group delivered the blueprint

and “Delivering for Health”, which followed, took the general approach that they had recommended. Members of the Parliament signed up to the David Kerr report.

I have been interested to learn that many people across the border have been taking a great interest in the David Kerr report. Two or three weeks ago, I saw an advertisement in the *Health Service Journal* for a conference in England—where there is much controversy about the reconfiguration of services—at which a session on learning lessons from Scotland was to be led by David Kerr and a senior official from the Health Department. It is unfortunate that Opposition parties in the Parliament have not always learned the lessons in the David Kerr report—that might not be obvious in this debate, but it was obvious in the most recent parliamentary debate on health.

A great deal remains to be done to make the NHS local. The motion mentions the role of community health partnerships. CHPs were a key development in the National Health Service Reform (Scotland) Act 2004, which was passed after the most recent election. They are delivery agents for shifting the balance of care further, as the motion emphasises, and we look forward to their further development in that regard. CHPs will also be agents for more local decision making. I was interested to read that during the past couple of weeks NHS Lothian shifted the management of more front-line services to CHPs. CHPs are at the cutting edge of approaches to decentralise care and deliver it more locally.

I hope that members and people further afield appreciate the strengths and achievements of the Scottish health system. Last week, I spoke to a senior clinician who has just moved up from England, who said, “You have a better system here. It is more integrated.” Integration is the key word for the Scottish health service. We should appreciate the benefits of our system and, more important, we should appreciate the delivery that we have witnessed during the past few years. Tributes should go to the Minister for Health and Community Care, to the Health Department, to NHS boards throughout Scotland and, most important, to NHS staff throughout Scotland for their total focus on delivery, which brings spectacular results.

16:13

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I worked in secondary care for 10 years and in primary care for 25 years and I always thought of primary and secondary care as a team that works to provide very much the same service. As we push more activity into primary care, we should praise the people who, for generations, have been trying to prevent illness as well as dealing with acute services. Preventive work, which is extremely labour intensive, has been going on in primary care. We improved the figures on blood pressure, asthma and diabetes and we encouraged healthy eating and healthy lifestyles in the 1970s, 1980s and 1990s. I support the approach, but it is not new.

If we are to look after the public in the community, we need accommodation and highly trained staff. The community is not a ward; it takes time to visit people in their homes and make decisions. Staff need time that is dedicated to learning and keeping up to date.

Safety is important. We have to think carefully before we close a service and move people to a new one. Transition is an important time, and training is required.

Pharmacies will be playing a more important role in future. I have no objection to that, but proper accommodation will be required. Health boards will have to check that accommodation is up to standard and that people will have privacy. Pharmacists, just like doctors and nurses, should be given time to dedicate to keeping themselves up to speed.

Margo MacDonald mentioned a coeliac breakfast this morning that was attended by Andy Kerr. When I was a young doctor, I knew about coeliac disease; it was always in the back of my mind as an alternative diagnosis. However, at the breakfast I was shocked to learn that—perhaps because of the way the system operates—coeliac disease is not being recognised. People are having to wait a long time to be diagnosed with some chronic conditions. Those making the diagnoses have to have the time to do so.

There is nothing wrong with midwife-led units, but from my years in anaesthetics I know that there can be problems if women do not have the right antenatal care and are not treated well at the various stages of pregnancy. If someone holds on to a patient too long, there can be a precipitate birth, a stillbirth or an intra-uterine death. There can also be third-degree tears. Some time back, part of anaesthetists’ lists was to repair such unpleasant incidents that occurred during delivery. Men do not know anything about that sort of thing but, sadly, women do. Clinical need and patient safety should be at the root of every single decision.

We need the right numbers of people. Nanette Milne talked about nurses, doctors and other experienced people retiring. Back in the 1970s, when the Salmon report was implemented, experienced ward sisters were taken out of the wards. They were given a higher salary, but they were no longer where the action was taking place. We had to be careful before sending a child with

appendicitis back to the ward, because young and inexperienced nurses would be looking after them.

We cannot close beds until we are sure that they will not be needed, and we need to know how many beds we have. We cannot change any service until we know what will be put in its place. Buildings will be required, but it is not buildings that make things happen, it is highly trained people. We have to keep that idea at the forefront of our minds, because how we implement the Kerr report is the most important issue. As I said at the beginning, it is how we implement measures that makes them succeed. It will take time.

16:18

Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP): NHS Highland has recently agreed to submit a proposal to the Minister for Health and Community Care seeking legal permission to close Glencoe hospital, which is a small cottage-type hospital serving south Lochaber. It has provided valuable and excellent services to its community for decades.

I have sought to play a role in advising members of the affected community about changes. I have met community council representatives and arranged for them to meet Garry Coutts and Roger Gibbons, the chairman and chief executive of NHS Highland, on 5 February—last Monday. The community is not saying that the hospital must at all costs stay open for ever, but the community wants any alternative arrangements to be as good as, or better than, the existing arrangements, even if a different model of provision is required from that offered by the old-style cottage hospital.

We are working with the members of the health board management team, who have been willing to meet us, and I hope that they will agree to meet the community council representatives again. Between them, those representatives have more than a century of public service. They know their area. We wait to hear whether the health board management team will meet the representatives again. I suspect that they will.

It is the detail of the alternative plan that is hard to put in place. Arrangements are having to be made with a private home, which needs to be converted to provide nursing care in addition to the residential care that it provides at the moment. I am referring to the Abbeyfield home in Ballachulish, which requires adaptations to be made to the building. The car park is not big enough. Planning permission is required. Nurses who work in Glencoe hospital need training to provide a different type of nursing care. That all takes time. The ambulances that are now housed at the cottage hospital will have to be moved. Premises will have to be found, and planning permission will have to be obtained for that, too.

In addition to those difficulties—all of which can be addressed—there is the question whether the alternative arrangements will be robust in the long term. Looking at the wider picture, the population of Lochaber is set to remain the same—between 18,000 and 19,000—over the next 20 years. However, over the same period, the population of over-75-year-olds is set to double, from about 1,300 to 2,600. Plainly, the need for nursing places will be greater in years to come, yet the provision is to remain at the same level.

We all want care to be provided in the community and at home, of course, but that brings problems with it. The financial responsibility for that rests largely with the local authority, which requires joint work between the local authority and the local health board. Ministers will be well aware of all those matters, and I do not want to make this speech too parochial, but I suspect that the difficulties that apply to the situation at Glencoe will apply in many other parts of Scotland.

My plea to the minister, when he considers the proposal, is that he should be willing to consult the local communities about the details and the minutiae of the change and that, before considering the application, he should ensure that he is absolutely satisfied that the alternative proposals satisfy the legitimate needs and aspirations of the people whom Glencoe hospital serves.

I urge the minister to consider the recommendations of the Health Committee about the difficulty of finding medical personnel, especially consultants, including at the Belford hospital, and even at Raigmore hospital. That is perhaps the greatest problem of all. The colleges must be more flexible in relation to the ways in which we can encourage people from Lochaber to become doctors. They are far more likely to want to go back and follow such examples as David Sedgwick, who is so respected as a rural general surgeon. I know that the minister is sympathetic to those ideas. I hope that, together, we can all work towards implementing them, so that the NHS can be delivered locally in my area and throughout Scotland.

16:22

Helen Eadie (Dunfermline East) (Lab): Roseanna Cunningham and Sylvia Jackson both described the special circumstances in their local authority areas. I was especially interested to learn about the dermatology services that Sylvia Jackson spoke about. That issue is close to my own heart, and I hope that such services can be replicated in other parts of Scotland.

Sylvia Jackson did a splendid job outlining how the NHS in her area is going local. The rest of us can see similar good developments in our areas. I listened to what she said with real interest and admiration. It appears from what is happening in her constituency—like in many other constituencies—that decision makers and professionals are showing real dedication. Sylvia Jackson is right that we must celebrate that commitment and ensure that our health service in Scotland is one of the best in the United Kingdom.

It really was unworthy of Carolyn Leckie to suggest that, because some MSPs with a health interest were not at the same meeting as her last night, we did not have an interest. The fact is that I was attending a health meeting in my local community in Dunfermline. MSPs simply cannot be there at—

Carolyn Leckie: Will the member take an intervention?

Helen Eadie: Not at the moment.

On PPP and the private finance initiative, I point out to Carolyn Leckie that only 17 per cent of the capital spend is spent on PFI and PPP projects—83 per cent of capital spending is for public capital projects. Without PPP and PFI, the hundreds of new health service facilities that we are building simply would not exist. It would have taken decades to develop some of them.

When she spoke about hospital beds, Carolyn Leckie made no mention of the way in which medicine has moved on. She did not mention that we no longer need to keep patients in hospital for as many days or weeks as we used to. The new keyhole surgeries, the way in which we now treat people and the new science are bringing dramatic change to patients, not just by prolonging their lives but by vastly improving their quality of life. Carolyn Leckie was being quite disingenuous.

Malcolm Chisholm reminded us all why we signed up to the Kerr report and to the Health Committee's work, in particular its workforce planning inquiry. He gave us a real understanding of the education, training and institutional issues.

However, I remain puzzled as to the SNP's big picture vis-à-vis accident and emergency services throughout Scotland. What is its policy? Whatever we decide today, we need to know that. It is easy for the SNP to say what it would do in Lanarkshire, but what would it do throughout Scotland? It has singularly failed to answer that question here or anywhere else. How does that fit with the fact that Shona Robison and Roseanna Cunningham signed up to the findings of the workforce planning inquiry? The inquiry recognised why many decisions had to be taken. Because in Scotland we have lacked local consultants and specialists, we have had to reconfigure services.

As Nanette Milne said, it is vital that we include the professionals. There must be a triangle of consultation that involves the professionals, patients and politicians. That is critical.

I have lots to say, but I will not do so, in the interests of brevity. Today, we must send out the message that we praise and celebrate the work of our health professionals, no matter whether they are pen pushers, civil servants such as those at the back of the chamber, or people who are delivering front-line clinical services. We praise and thank them on behalf of the people of Scotland.

16:26

Eleanor Scott (Highlands and Islands) (Green): Because I am going to quote from the British Medical Association's briefing later, I should declare that I remain a member of that organisation.

Nobody is going to argue with the concept of making the NHS more local while retaining more centralised services for specialist areas. However, while the concept is sound, it is noteworthy how many debates there have been in this Parliament on the closure of cottage hospitals, maternity units and so on, not to mention Lanarkshire accident and emergency units. There is still a failure of engagement with the public.

Mr Kerr: We also have debates about the many facilities that have opened in Scotland as a result of the changes. For every hospital that is closed in Scotland, there is an alternative service and alternative provision. Many hospitals that have been closed were simply unsuitable for modern healthcare, particularly in the mental health arena.

Eleanor Scott: Absolutely. I am not saying that I would not have closed any hospital or hospital unit. I have never said that. What I am saying is that there is a failure of engagement with the communities whose health needs the facilities are supposed to meet. The problem is not whether I think that they should close; it is whether the public have engaged with and been taken on the journey that the Executive is going on in relation to the health service.

The motion and amendments all contain examples of approaches that are seen to be working, but we must pay heed to the note of caution that is sounded by the Royal College of Nursing in its briefing, which focuses on key nursing workforce issues that need to be considered to help make the NHS more responsive to local needs. It refers to the need to set an appropriate predictable absence allowance to ensure that staffing levels can cope with staff sickness and absence. It would be helpful if, in his closing remarks, the minister addressed that, the

issue that the RCN mentioned about supporting and retaining older nurses, and the issue about reducing the drop-out rate of student nurses, given that the Executive has indicated to me in a written answer that there is no intention to increase the bursary for student nurses in the near future.

The Royal College of Nursing also talked about the new model for community health nurses. That takes me back, hauntingly, to the nurses with whom I worked 20 years ago, when I was a school doctor. Particularly in rural areas, those nurses combined the role of health visitor, district nurse and school nurse and, sometimes, the role of community midwife as well. The new role of community nurse, which will combine the role of health visitor, school nurse and district nurse, seems to be a step back towards those days. Twenty years ago, the Highlands—where the new scheme is being piloted—moved as quickly as funding would allow to have dedicated nurses with single duties, who were either health visitors or district nurses or school nurses. We knew, from the experience of having nurses with more than one duty, that the health promotion side of their work was always displaced by things that were no more important but were more urgent. Elaine Smith mentioned breast feeding. We need health visitors to support mothers to continue with breast feeding. I fear that the skills of each of those groups of nurses could be lost when all of the roles are subsumed into the new post. I would like an assurance from the minister that the pilot will be fully evaluated before the model becomes universal.

With regard to my exchange with the minister earlier, I quote from the BMA's briefing, which was given to all members:

"It is misguided to believe that hospital services can close with just a promise that there will be new services in the community to replace them. The funding for these new services cannot be released until hospitals lose a portion of what they are currently funded to provide."

Karen Gillon: Will the member give way?

Eleanor Scott: No. I am sorry, but I am in my last minute.

The BMA continues:

"The BMA believes that no significant changes to existing hospitals services should take place before there is agreement of clear plans for alternative services in the community, and full details of the interim arrangements that may be necessary."

I agree with that. The crucial point is not that things should never change, but that people should know what alternative services will be in place.

Making the NHS more local is a welcome development and the benefits are especially obvious in rural areas, where travelling to a specialist unit can be much more difficult. However, the key driver for the work must be improvements, not savings.

16:30

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): The Liberal Democrats have long advocated shifting the balance in the NHS away from reactive care in the acute sector towards preventive, integrated and continuous care in local communities. We fully support what the Scottish Executive is implementing.

The thrust of Professor Kerr's report, "Delivering for Health", which was welcomed by all the political parties, was that we had to change the way in which we delivered care in Scotland. The report said that there should be more effective accident and emergency centres, that local community casualty units should be introduced, and that planned care should take place more locally in community facilities.

I am therefore particularly surprised by the reaction that we heard today from the SNP and the Conservatives to the Executive's proposals for reforming health care in Scotland.

Shona Robison: Will the member take an intervention?

Mike Rumbles: Not at the moment. The member will have to let me speak a little first; then I will be happy to give way.

In his opening speech, the Minister for Health and Community Care explained how the Executive plans to implement the changes that we need to make as a result of the Kerr report. He emphasised how important it is to engage patients in the delivery of local services.

Shona Robison started well. She largely supported the Executive's motion even though her amendment to it is almost as long. However, in response to my intervention, she implied that the SNP would retain all accident and emergency units despite the medical profession's view that we cannot support them all.

Shona Robison: Is the member aware of the recent report by the Royal College of Surgeons of England, which recommends that accident and emergency departments should serve a minimum catchment of 300,000 people? Would the member support the translation of that model to Scotland, given that that is the view of the clinicians? If so, which nine hospital accident and emergency units would he close?

Mike Rumbles: I am disappointed by that response. The member knows that the Scottish Executive does not support that approach and that the Liberal Democrats do not support it. I would

have expected the SNP to have cottoned on to the fact that the geography of Scotland is different from the geography of England. It is about time the SNP grew up.

For the Conservatives, Nanette Milne focused on what she said was a lack of confidence in NHS consultations. However, as we know, the buck stops with the minister. I will say more about that in a moment. I am never convinced by the Conservatives' approach to health debates, which always seems to be that doctor always knows best. "Leave it to the professionals" seems to be the view of the Conservatives, who ignore the patients.

Phil Gallie (South of Scotland) (Con): The member contradicted himself. He said that the SNP must listen to clinicians, but then he said that we Conservatives should not listen to doctors. Who is he kidding?

Mike Rumbles: Phil Gallie must listen. I did not contradict myself. I said that the Conservatives' approach is that the doctor always knows best.

My colleague Euan Robson mentioned the preventive health measures that we implemented in the current session of Parliament, including the ending of smoking in public places, which is a real move forward, and the legislation that allows free eye and dental checks. Those are excellent initiatives. The free eye check, for example, is not just the sight test that we used to have. It is a proper medical check that examines people's eyes comprehensively and looks for problems to solve. It is all about preventive medicine.

Roseanna Cunningham said that the health board in her area could do what it liked about withdrawing consultant-led maternity services. I return to the point that health boards do not have the last word. The minister also has responsibilities and, as we have seen with his intervention on maternity provision in Aboyne in my constituency, he is willing to act to ask the health boards to think again and get it right. My experience is certainly different from what Roseanna Cunningham highlighted, and I would like to take the opportunity to put on record again my thanks to the minister for his intervention in that case. The board has agreed to discuss what the right solution is for maternity services in Aboyne.

In her contribution, Carolyn Leckie used the word "local" once. Other than that, her contribution was entirely irrelevant to this afternoon's debate.

In conclusion, we need to reconfigure our health service and make it more local when it is safe to do so. That is the key, it is what Professor Kerr said was essential and it is exactly what the Scottish Executive is doing. As far as I and other Liberal Democrats are concerned, the Executive deserves our support at decision time.

16:36

Phil Gallie (South of Scotland) (Con): I do not usually get involved in health debates, but I have found today's debate extremely interesting. It has been fairly well balanced and, although we are moving towards elections, the speeches have not been the tub-thumping electioneering that we have been so used to in recent times in the chamber. That is certainly of value.

I am slightly disappointed that Mike Rumbles turned the emphasis on the SNP and played politics with the issue slightly. I do not think that that was necessary, but that was a judgment for him to make.

We have heard from several members who have been professionals in the NHS—Jean Turner, Nanette Milne, Carolyn Leckie and Eleanor Scott. I found their contributions well worth listening to, and I hope that the minister has taken on board their comments, because we should not shut out anyone who wants to speak about health care in Scotland.

I tend to agree with much of the Executive motion. I like the move towards primary health care and prevention of diseases—it is a fair policy. However, I plead with the minister not to turn that agreement back on Opposition members in future, as has happened recently with the Kerr report. We agreed in the main with the Kerr report, but there will always be elements on which we find differences. I do not think that, when we find those differences, it is fair that we should be ridiculed by the minister saying, "Well, you embraced the report and thought it was great, and now you are saying something different." There will always be differences and, although we support much of the Executive motion, we will not embrace it to its fullest extent.

The Deputy Minister for Health and Community Care (Lewis Macdonald): Does Phil Gallie agree with Dr Peter Terry, chairman of the BMA in Scotland, that it is vital not to deconstruct the various parts of the strategy that is laid out in "Delivering for Health" and not to pick and choose elements on which to campaign for or against?

Phil Gallie: The all-embracing idea that Kerr referred to was localised input and taking account of local ideas and wishes. I do not want to take that away from the Kerr report, but it means that not all the report will be accepted by local people. On that basis, we have to be prepared to be a little flexible. Not everything is black and white, so let us provide a degree of flexibility that meets the needs of local people.

One example is the A and E situation in Ayr, which is very much in my mind, as I am a local representative. I am shattered that the A and E department at Ayr hospital is down for closure, but I welcome the fact that the minister has said that it will be retained until we can be assured that all the changes have been made in a reasonable manner. That is fine, but one thing that is missing from the Executive motion—something that no member has addressed—is the Scottish Ambulance Service. It is very much tied into the situation with Ayr and Crosshouse hospitals. Recently, criticisms have been made of difficulties with the Ambulance Service in the Borders.

Carolyn Leckie: Will the member take an intervention?

Phil Gallie: The effect on that service has always been one of my main concerns in relation to the closure of A and E at Ayr. Perhaps the minister will think about that and refer to it in his reply.

Mike Rumbles *rose*—

Phil Gallie: I am sorry; Carolyn Leckie wanted to intervene first.

Carolyn Leckie: I thank Phil Gallie for allowing my intervention, which is about ambulances, and for at least listening to my speech. Does he share my astonishment that the Scottish Ambulance Service and the Scottish Executive cannot provide the statistics on the number of ambulances that are staffed on calls by paramedics rather than technicians? If we do not know that, how on earth can we plan for the service's future and depend on ambulances to replace some accident and emergency units?

Phil Gallie: Okay, I have got the message and I pick up what Carolyn Leckie says. The point that I have made to the minister is that such issues must be examined carefully before any change such as the one that is proposed at Ayr A and E is made. I go along with the points that Carolyn Leckie makes and with her concerns, which I would like the minister to address in the longer term.

The Deputy Presiding Officer: One minute.

Phil Gallie: I would have liked to pick up many issues that have been raised. I noted everybody's speeches carefully. First, I will deal with Jean Turner's speech. She referred to the effect on safety of closing services. She also mentioned the change to pharmacist provision, which I accept is a good move. I considered that some time ago in another place and I favoured it in lobbyist approaches.

Jean Turner referred to accommodation in pharmacies, but I wonder about pharmacies in rural communities, which have difficulties with post offices. I would like to think that we can ensure that rural communities do not miss out on the provision of pharmacists and the services that they provide.

Another important issue that Jean Turner raised was the time element—

The Deputy Presiding Officer: You should finish now, Mr Gallie.

Phil Gallie: I am sorry; I will just close, although I had other points to make. The arguments that Jean Turner made on the time that patients are given when they are treated were important and I ask the minister to note her comments carefully.

16:42

Stewart Stevenson (Banff and Buchan) (SNP): The Minister for Health and Community Care started this useful debate with a reminder of where we are coming from. He used the phrase

"as local as possible, and as specialised as necessary."

I heard nothing in the debate from any political party that disagreed with that central tenet of what we are trying to do and that central summary of the Kerr report.

On that basis, I will start with one or two issues on which we agree with the minister. I commend him personally for leading by example in a variety of ways, some of which I will put on record. First, his involvement in the interest of Mr Rumbles and me in maternity services in Grampian was helpful and constructive. It served well the interests of the constituents whom each of us brought to see him. When they went away, they felt that they had been listened to. I hope that other ministers take a leaf out of his book; occasionally, they do not appear to.

I also commend the minister for his personal contribution by leading by example on fitness. If only I still had joints that allowed me to run the occasional half marathon—or was it a marathon? I do not quite remember. For me, a half marathon would have been a marathon, but perhaps not for him.

I thank the minister for his support on maternity services by intervening to correct what would have been a serious wrong for essential local delivery of services in Mr Rumbles's communities and in mine. Of course, I say to Mr Rumbles that had we listened to the clinicians, Aboyne maternity unit would have been closed. He will have to read carefully his contributions to the debate in the *Official Report*.

Mike Rumbles: Will the member take an intervention?

Stewart Stevenson: Very quickly—come on.

Mike Rumbles: My point was that the Conservative approach is that doctor always knows best. Stewart Stevenson knows well that my criticism of Grampian NHS Board was that it always listens to clinicians.

Stewart Stevenson: I hear what Mike Rumbles says. Understanding may follow, but probably will not.

There is a tension in the system that the debate may not have explored fully, which will continue to challenge health ministers of whatever complexion. That is the tension between the minister, on the one side, the health board, in the middle, and the community, on the other side. That tension is a difficulty for whoever fills the post that the minister holds. The health board is appointed by the minister and is therefore seen by local communities as largely a creature of the minister—whatever the reality, that is the perception. For that reason, health boards must be much more sensitive in approaching communities when they believe that there is a need to redesign the services that are delivered locally.

Helen Eadie: Can Stewart Stevenson tell me how the SNP will set up the trusts that it will have throughout Scotland to finance all the capital initiatives? Will they be elected or unelected? Will they be quangos?

Stewart Stevenson: I suspect that that question goes a little beyond local services. Helen Eadie can read our manifesto on the subject, and members have heard our finance spokesman talk about how the trusts will be engineered. As someone who held large budgets and was involved in banking, I know how the idea works and that it can work. The argument will be whether it should work, and that will be for the electorate to decide.

Euan Robson made an important point when he said that we must move from focusing on the inputs in health provision to focusing on the outputs. People see the money being spent, but that means nothing if they do not see the services being delivered.

Another tension that the debate has not focused on as much as it might have is the tension between the focus on prevention and keeping people healthy longer, which we are now moving to and which we all support, and the continuing need to drive down waiting lists. I suspect that that tension is something that we will continue to debate.

In his intervention, back bencher Duncan McNeil exhibited tensions that were perhaps political rather than health related. I seem to recall seeing a picture of Duncan McNeil on the campaign line, ensuring that his own local services were not downgraded.

Mr McNeil *rose—*

Stewart Stevenson: There ain't going to be time—I am sorry.

Community care units are an important part of future provision; indeed, we should have more of them. They may well even serve a useful purpose by being co-located with accident and emergency units, and we should not close our minds to that possibility.

I will briefly give a practical example of the nature of the challenges, some of which are basic stuff. I went to hospital with a constituent who had been savaged by a dog—not too seriously, but seriously enough to require six stitches. We went to the nurse-led local accident and emergency unit in Banff and received a good service. The wound was cleaned, stitched and bandaged and the woman was inoculated against tetanus. The nurse signed the card to say that that had been done, but there was then a 100-minute wait for a return telephone call from a doctor to allow the antibiotics that were required to be prescribed. We have not quite joined the whole thing up. I know that the minister recognises that and realises that we must do something about it.

In response to some of the issues that Helen Eadie raised, I note that the Health Committee did not come to the firm conclusion that centralisation was the right answer. Conflicting views were expressed by various health professionals, and we should tak tent on that.

In today's debate, members have illuminated many of the challenges that remain, talked about some of the successes and touched on areas in which further progress is essential. However, the bottom line is that the debate in the chamber is a lot less important than the debates that local communities are having about the health services that they require in their local areas. I support my colleague's amendment.

16:49

The Deputy Minister for Health and Community Care (Lewis Macdonald): I acknowledge that we have had a mainly positive and constructive debate during which members have taken the opportunity to highlight how they believe that we could better continue to make the NHS local, and in the main, they have supported the central proposition of the Kerr report and our response in "Delivering for Health" that we should provide services as locally as possible but as specialised as necessary. It is important to emphasise that those aspirations are equally significant.

When Parliament debated the Kerr report and "Delivering for Health", all parties recognised that

we need a new approach to the delivery of health care that recognises and responds to the challenges of an aging population and an increase in the number of people who have long-term conditions. We need an approach that aims to shift the balance of care towards preventive medicine, and to shift the location of services, so that more diagnostic and planned care procedures can be delivered within local communities.

Mr McNeil: I am sure that we all acknowledge that the future of the health service is about moving from simply treating illness towards giving people in the most deprived areas of Scotland healthier, longer and better lives. We welcome the extension of the preventive care programme that was announced today, particularly in my community of Inverclyde. Can the minister assure me that that much-needed money is earmarked for my community and that it will be delivered in my community as opposed to being lost in the greater Glasgow area?

Lewis Macdonald: I certainly can give that assurance to Duncan McNeil and to the other members whose constituencies will be involved in the second wave of the keep well pilot. Indeed, Duncan McNeil will recognise that I also have a bit of a constituency interest in that. Ministers have in place an arrangement whereby the expenditure of those funds is monitored by a group that meets every couple of months. I assure Duncan McNeil that the money that has been provided for the keep well initiative in all health boards will be spent on the keep well initiative in those communities where that expenditure is required.

Phil Gallie: On the subject of Inverclyde, the minister will recall that earlier, when I suggested that Ayr's accident and emergency unit should be retained, he asked me about the fragmentation of the Kerr report's proposals. In fact, the minister fragmented them when he retained the Inverclyde facility. Does he balance that out?

Lewis Macdonald: What Phil Gallie has described was an action of the board, not an action of ministers. The point is that the Kerr report says that there are principles that should be applied across all services, but subject to a process of consultation. As we have heard this afternoon, the process of consultation and consideration by ministers will respond to the points made and do so in the most effective way. The Kerr report is not a prescription that says, "This will always happen in all circumstances." It recognises that there will be variety. It is also important to stress the fact that the BMA and Professor Kerr emphasise that the Kerr report cannot be taken in bits; it must be taken as a whole and as a complete strategy. That is what Parliament supported and we should continue to do that.

Shona Robison: Does the minister have a sense of disappointment that so many of his own back benchers do not seem to have accepted that point, because they advocate the retention of accident and emergency services? If he cannot persuade them, how can he persuade the people of Scotland?

Lewis Macdonald: I am disappointed in that contribution from Shona Robison. It is entirely appropriate that anyone who responds to a consultation should make points as they see fit. The point at issue between her party and the Executive parties is not the detail of individual cases; it is the principle of how we take forward the health service and provide health care throughout Scotland. When we debated "Delivering for Health" in October 2005, Shona Robison agreed with the principle laid out by Professor Kerr of the separation of scheduled and unscheduled care, but we could not have deduced that from her contribution this afternoon, or those of the other members of her party.

On unscheduled care services, Kerr said:

> "We believe that current configurations do not appropriately match supply with demand and that highly-trained consultants should focus more on true emergencies, based in well-staffed and resourced departments. … 'Routine' injuries and ailments will be dealt with"

elsewhere. That is precisely what underlies the proposals that we have endorsed where networks of community casualty units can take the majority of cases that currently go to A and E and deal with them as locally as possible. Under recently approved plans, community casualty units will be established in places where emergency services are not currently provided. That is precisely the direction in which we should move. We will allow emergency specialists to concentrate on dealing with complex cases by focusing their resources on those cases.

To make a distinction in service delivery by claiming that emergency services are somehow not specialist is to fail to understand the medicine of modern emergency care. The life-saving end of modern emergency care is indeed highly specialist—

Shona Robison: Will the minister give way?

Lewis Macdonald: I need to make further progress.

By removing perhaps two thirds of the cases that currently present at A and E and dealing with them as minor injuries and illnesses in community casualty units, we can allow for precisely that level of specialisation that is required in modern emergency medicine. Such a change will not only improve productivity and reduce waiting times in unscheduled care and the treatment of minor

injuries, but support quality treatment for the most urgent and life-threatening cases.

Our clear proposition is that the status quo is not sustainable or desirable. That does not mean that every proposal for change will automatically be supported. Every proposal must be seen to be, and be shown to be, in agreement with the principles of the Kerr report. That is what we expect and will continue to deliver.

In response to Nanette Milne, I point out that the relationship between the provision of acute beds and the provision of health services is changing, and that the basis for such change is also laid out in the Kerr report. The number of beds in surgical specialties has indeed gone down, but that has happened because more and more people are being treated as day cases. The proportion of day-case surgery has risen from 57 per cent 10 years ago to 66 per cent today. We welcome that development, which we think is the right direction of travel, and we want to increase that proportion further. We want more and more people to be able to be treated in out-patient departments and in primary care so that they avoid the need for admission to hospital. We believe that, in so doing, we are improving the quality of care as well as delivering care more locally than was the case in the past.

Several members raised issues about the workforce. It is important to say that we are planning and expanding our workforce of nurses and GPs while taking predicted rates of attrition into account. We are ensuring that we provide mechanisms to allow that attrition to be compensated for in future. Workforce planning is a sophisticated process that is now being done in more detail and with more effectiveness than ever before. For both the medical and nursing professions, such planning will provide real benefits in the years ahead.

Elaine Smith: Will the minister take an intervention?

The Presiding Officer (Mr George Reid): I am sorry, but the minister is in his last minute.

Lewis Macdonald: On community nursing, I can confirm that that will be piloted before it is rolled out further.

Mention was made of breastfeeding as an important policy. We completely support that policy and we will continue to support and develop it. I hope that we will continue to see progress on that.

In response to the issues that were raised about hospitals such as that in Glencoe, I can give an assurance that ministers will continue to expect detailed consideration of proposals before approval of any change is given. That will continue to be part of any decision-making process.

The fundamental argument in the motion is that we should celebrate our successes. There are challenges in achieving the shift towards a more locally delivered health service but, as we have heard from a number of members, there are already successes on which we wish to build. I call on Parliament to support that proposition, and to recognise that change is right and that the direction of travel in which we have set out will deliver the best outcomes for patients. As Euan Robson said, it is about outcomes. We have seen good progress in the recent past and want to see further progress in the period ahead.

Business Motion

17:00

The Presiding Officer (Mr George Reid): The next item of business is consideration of business motion S2M-5577, 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 21 February 2007

2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Executive Debate: Antisocial Behaviour
followed by	Scottish National Party Business
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Thursday 22 February 2007

9.15 am	Parliamentary Bureau Motions
followed by	Scottish Conservative and Unionist Party Business
11.40 am	General Question Time
12 noon	First Minister's Question Time
2.15 pm	Themed Question Time— Environment and Rural Development; Health and Community Care
2.55 pm	Executive Debate: Affordable Housing
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Wednesday 28 February 2007

2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Stage 3 Proceedings: Prostitution (Public Places) (Scotland) Bill
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Thursday 1 March 2007

9.15 am	Parliamentary Bureau Motions
followed by	Executive Business
11.40 am	General Question Time
12 noon	First Minister's Question Time
2.15 pm	Themed Question Time— Justice and Law Officers; Enterprise, Transport and Lifelong Learning
followed by	Parliamentary Bureau Motions
2.55 pm	Stage 3 Proceedings: Aquaculture and Fisheries (Scotland) Bill
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business.—[*Ms Margaret Curran*.]

Motion agreed to.

Parliamentary Bureau Motion

17:01

The Presiding Officer (Mr George Reid): The next item of business is consideration of Parliamentary Bureau motion S2M-5574, on approval of a Scottish statutory instrument.

Motion moved,

That the Parliament agrees that the draft Public Appointments and Public Bodies etc (Scotland) Act 2003 (Amendment of Specified Authorities) Order 2007 be approved.—[*Ms Margaret Curran*.]

The Presiding Officer: The question on the motion will be put at decision time.

Decision Time

17:01

The Presiding Officer (Mr George Reid): There are five questions to be put as a result of today's business.

The first question is, that motion S2M-5551, in the name of Tom McCabe, that the Parliament agrees that the Budget (Scotland) (No4) Bill be passed, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR

Adam, Brian (Aberdeen North) (SNP)
Aitken, Bill (Glasgow) (Con)
Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
Baillie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brown, Robert (Glasgow) (LD)
Brownlee, Derek (South of Scotland) (Con)
Butler, Bill (Glasgow Anniesland) (Lab)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Cunningham, Roseanna (Perth) (SNP)
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)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
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)
Gibson, Rob (Highlands and Islands) (SNP)
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)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Johnstone, Alex (North East Scotland) (Con)
Kerr, Mr Andy (East Kilbride) (Lab)

Livingstone, Marilyn (Kirkcaldy) (Lab)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
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)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Milne, Mrs Nanette (North East Scotland) (Con)
Morgan, Alasdair (South of Scotland) (SNP)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Petrie, Dave (Highlands and Islands) (Con)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinburne, John (Central Scotland) (SSCUP)
Swinney, Mr John (North Tayside) (SNP)
Wallace, Mr Jim (Orkney) (LD)
Watt, Ms Maureen (North East Scotland) (SNP)
White, Ms Sandra (Glasgow) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

AGAINST

Byrne, Ms Rosemary (South of Scotland) (Sol)
Curran, Frances (West of Scotland) (SSP)
Fox, Colin (Lothians) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

ABSTENTIONS

MacDonald, Margo (Lothians) (Ind)

The Presiding Officer: The result of the division is: For 108, Against 5, Abstentions 1.

Motion agreed to.

That the Parliament agrees that the Budget (Scotland) (No.4) Bill be passed.

The Presiding Officer: The second question is, that amendment S2M-5572.2, in the name of Shona Robison, which seeks to amend motion S2M-5572, in the name of Andy Kerr, on making the NHS local, 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)
Ballard, Mark (Lothians) (Green)
Byrne, Ms Rosemary (South of Scotland) (Sol)
Canavan, Dennis (Falkirk West) (Ind)
Cunningham, Roseanna (Perth) (SNP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Gibson, Rob (Highlands and Islands) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (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)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinney, Mr John (North Tayside) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Watt, Ms Maureen (North East Scotland) (SNP)
White, Ms Sandra (Glasgow) (SNP)

AGAINST

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)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Frances (West of Scotland) (SSP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Fox, Colin (Lothians) (SSP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
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)
Kerr, Mr Andy (East Kilbride) (Lab)
Leckie, Carolyn (Central Scotland) (SSP)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lyon, George (Argyll and Bute) (LD)
Macdonald, Lewis (Aberdeen Central) (Lab)
MacDonald, Margo (Lothians) (Ind)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Swinburne, John (Central Scotland) (SSCUP)
Wallace, Mr Jim (Orkney) (LD)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

ABSTENTIONS

Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brownlee, Derek (South of Scotland) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (West of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Petrie, Dave (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)

The Presiding Officer: The result of the division is: For 30, Against 67, Abstentions 15.

Amendment disagreed to.

The Presiding Officer: The third question is, that amendment S2M-5572.3, in the name of Nanette Milne, which seeks to amend motion S2M-5572, in the name of Andy Kerr, on making the NHS local, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR

Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brownlee, Derek (South of Scotland) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (West of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
Lyon, George (Argyll and Bute) (LD)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Petrie, Dave (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)

AGAINST

Adam, Brian (Aberdeen North) (SNP)
Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
Baillie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Byrne, Ms Rosemary (South of Scotland) (Sol)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Cunningham, Roseanna (Perth) (SNP)
Curran, Frances (West of Scotland) (SSP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fox, Colin (Lothians) (SSP)
Gibson, Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Gordon, Mr Charlie (Glasgow Cathcart) (Lab)
Gorrie, Donald (Central Scotland) (LD)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kerr, Mr Andy (East Kilbride) (Lab)
Leckie, Carolyn (Central Scotland) (SSP)
Livingstone, Marilyn (Kirkcaldy) (Lab)
MacAskill, Mr Kenny (Lothians) (SNP)

Macdonald, Lewis (Aberdeen Central) (Lab)
MacDonald, Margo (Lothians) (Ind)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morgan, Alasdair (South of Scotland) (SNP)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinburne, John (Central Scotland) (SSCUP)
Swinney, Mr John (North Tayside) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Wallace, Mr Jim (Orkney) (LD)
Watt, Ms Maureen (North East Scotland) (SNP)
White, Ms Sandra (Glasgow) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

The Presiding Officer: The result of the division is: For 16, Against 98, Abstentions 0.

Amendment disagreed to.

The Presiding Officer: The fourth question is, that motion S2M-5572, in the name of Andy Kerr, on making the NHS local, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR

Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
Baillie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Gordon, Mr Charlie (Glasgow Cathcart) (Lab)
Gorrie, Donald (Central Scotland) (LD)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
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)
Kerr, Mr Andy (East Kilbride) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lyon, George (Argyll and Bute) (LD)
Macdonald, Lewis (Aberdeen Central) (Lab)
MacDonald, Margo (Lothians) (Ind)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Swinburne, John (Central Scotland) (SSCUP)
Wallace, Mr Jim (Orkney) (LD)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

AGAINST

Byrne, Ms Rosemary (South of Scotland) (Sol)

Curran, Frances (West of Scotland) (SSP)
Fox, Colin (Lothians) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

ABSTENTIONS

Adam, Brian (Aberdeen North) (SNP)
Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brownlee, Derek (South of Scotland) (Con)
Cunningham, Roseanna (Perth) (SNP)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Gibson, Rob (Highlands and Islands) (SNP)
Goldie, Miss Annabel (West of Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Johnstone, Alex (North East Scotland) (Con)
MacAskill, Mr Kenny (Lothians) (SNP)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
McFee, Mr Bruce (West of Scotland) (SNP)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Morgan, Alasdair (South of Scotland) (SNP)
Neil, Alex (Central Scotland) (SNP)
Petrie, Dave (Highlands and Islands) (Con)
Robison, Shona (Dundee East) (SNP)
Scott, John (Ayr) (Con)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinney, Mr John (North Tayside) (SNP)
Watt, Ms Maureen (North East Scotland) (SNP)
White, Ms Sandra (Glasgow) (SNP)

The Presiding Officer: The result of the division is: For 73, Against 5, Abstentions 36.

Motion agreed to.

That the Parliament supports the goal of further shifting the balance of care away from reactive, episodic care in the acute sector towards preventive, integrated and continuous care embedded in local communities; congratulates NHS Scotland on the significant progress in making its service more local, as required by "Delivering for Health"; welcomes for instance the 50% increase in funding for primary medical services over the period from 2002-03 to 2006-07 and unprecedented investment in primary and community care premises; supports the new community hospital strategy with its focus on providing local facilities and services appropriate to modern-day demands; welcomes the establishment of the Scottish Centre for Telehealth in Grampian and the approaches it will bring to widening access to specialist services, such as seen in the tele-neurology service in Orkney; commends the shift from hospital-based provision to local access for services such as chemotherapy and dialysis and expects community health partnerships to continue to accelerate such a shift; recognises the benefits to communities of more local access for the majority of their unscheduled care needs that will be brought about by the development of community casualty units; welcomes the continuing development of new staff roles and expertise as a means to carry services closer to patients; supports the community pharmacy minor ailments service as an excellent example of improved local access; supports the Scottish Executive's intention to improve Scotland's health, focussing especially on reducing inequalities between those with the best and worst health; acknowledges the contribution to improving health of services in local communities for people of all ages, from improving children's dental health in Glasgow to promoting walking for health by older people; applauds the world-leading anticipatory care "Keep well" services which tackle coronary heart disease in the most deprived communities, and welcomes this package of service change and the continued development of local community health partnerships as a strong and coherent response to the changing pattern of demand that NHS Scotland will face.

The Presiding Officer: The final question is, that motion S2M-5574, in the name of Margaret Curran, on approval of a Scottish statutory instrument, be agreed to.

Motion agreed to.

That the Parliament agrees that the draft Public Appointments and Public Bodies etc (Scotland) Act 2003 (Amendment of Specified Authorities) Order 2007 be approved.

Coeliac Disease

The Presiding Officer (Mr George Reid): The final item of business is a members' business debate on motion S2M-5385, in the name of Margo MacDonald, on awareness of coeliac disease. The debate will be concluded without any question being put.

Motion debated,

That the Parliament is concerned that the average general practitioner has little or no experience of coeliac disease, an extremely debilitating illness that affects one in 100 of the population, of which seven out of eight are undiagnosed; regrets that the lack of knowledge of this condition prevents many people with coeliac disease from receiving early diagnosis, leading to serious complications such as osteoporosis and bowel cancer if left undetected; welcomes the work done by Coeliac UK in providing literature, advice, a helpline and dietary information to address this need, and believes that the Scottish Executive should promote such measures as it sees fit to ensure that GPs in the Lothians and throughout Scotland receive more appropriate training and support to enable them to recognise and to diagnose the disease more accurately.

17:07

Margo MacDonald (Lothians) (Ind): The percentage of the population that is calculated to have coeliac disease indicates that up to 50,000 Scots, or one in 100, could be sufferers. As only one in eight of that number is calculated to have been diagnosed, at any one time more than 40,000 of our fellow citizens are enduring bloating, diarrhoea and nausea. They might also experience weight loss and depression, for which their general practitioner might prescribe Prozac or something like that. Their quality of life is very much affected by coeliac disease, but they might not know it—more important, their GP might not know it.

Not all GPs would miss the symptoms of the disease, but too many do. That causes the sort of distress that Yvonne Murray described for us this morning at the awareness-raising breakfast that we held in committee room 3. Before I remind members of the dreadful experience that Yvonne's family had to endure before Laura, her daughter, was diagnosed, I thank them for their support this morning.

When Yvonne Murray first contacted us to raise her concern that we were not dealing properly with this very debilitating disease, I knew what she was talking about without too much briefing because one of my granddaughters has coeliac disease. We were lucky, in that our experience was not like Yvonne's. Josephine was diagnosed as a very young child. She has never known anything other than a gluten-free diet and the whole extended family understands the implications.

We were lucky, but Yvonne Murray was not. She has given me a copy of her speech, because I wanted to remind members of Yvonne's experience and to share it with members who were not in committee room 3 this morning. She said:

"When my daughter's symptoms first started back in 2003, it was put down to the fact that she was in nursery picking up everyday infections. The GP did mention at the time that my daughter could be gluten intolerant, but at no point did she offer to do a blood test for coeliac disease. During this time I was in and out of the GP practice every month with symptoms which included diarrhoea, vomiting and abdominal pains—my daughter was constantly sick.

As time went on she then developed mouth ulcers on top of everything else. It was at this point that our lives were turned upside down. Her weight started to drop at an alarming rate and she stopped growing. She would cry constantly because her tummy was sore and would crawl up on to the sofa and was so lethargic that she couldn't play with her friends—she didn't have the energy. She then stopped eating and drinking because the mouth ulcers had become so bad and was finally admitted to hospital, where I had to almost beg a Consultant to give her the coeliac blood test. During this time we tried desperately to get my daughter to eat as we had the threat of a gastric tube being inserted hanging over our heads."

Hearing that had a dramatic effect on the people who were at this morning's event. Those things happened, but they should not have done.

A number of basic needs of coeliac sufferers can be identified, a range of which other members want to speak about. I will deal with just two of them. A suitable standard diagnosis procedure that is known to potential patients and to parents with young children should be commonly practised by general practitioners or specialist nurses. We know that an inexpensive and highly effective blood test is produced by Adastra Medical. I do not wish to promote one company at the expense of others, but it demonstrated its product this morning and I believe that it has a 97 per cent accuracy rate. That product or products like it could be commended to GPs. It is perhaps even more important for GPs to be made aware of the fact that many of the people who present with the symptoms of coeliac disease will not be suffering from some other complaint and will certainly not be imagining their symptoms.

It might be possible to provide smart card access to suitable food products. Once again, my family was lucky—we were in a financial position to buy the gluten-free products that are available in the stores. The excellent booklet that is produced by Coeliac UK makes it possible to identify easily which supermarket products are gluten free.

Christine May (Central Fife) (Lab): Margo MacDonald's first point was about the availability of a simple test. Has she had any discussions with the minister about the possibility of having that test

made available through local pharmacies, in the same way that the diabetes test is available?

Margo MacDonald: The minister came along to this morning's event and he is interested in that area. Perhaps when he sums up he will outline some of the routes that the Executive might pursue. Today's events have helped to ensure that minds are open on the issue, which is the important thing.

In conversation with me earlier this evening, John Home Robertson said that it might be a good idea for people's blood to be tested for a wide range of conditions, including coeliac disease, when they first donate blood. That is a straightforward and sensible idea. I know that it is unusual for John Home Robertson to have such an idea, but I should give him credit for it.

The Presiding Officer: You have one minute left.

Margo MacDonald: As I have only a minute left, I will not go into my smart card idea, but I have discussed it with other people and the minister knows that I have put it on the table. It fits perfectly with the prevention and self-management regime for the national health service that was announced earlier this afternoon.

The situation of the many people who suffer from coeliac disease can be improved. I hope that today's activities and the work that has been put into them by Coeliac UK, Yvonne Murray and members of the campaign groups from all over Scotland—some of whom are in the public gallery—along with the interest that has been shown by ministers, the First Minister and other MSPs and the effort that has been made by Peter Warren from my office, will raise awareness of the disease, improve the NHS service to sufferers and allow them to have the much better quality of life that follows from an early diagnosis, access to gluten-free foods and participation in groups such as those that I have met in the Parliament today, as well as the Long-Term Conditions Alliance Scotland. My motion is reasonable and just and I ask members to support it.

The Presiding Officer: We move to the open debate. I ask members to keep their remarks to four minutes, as that will allow me to fit everyone in.

17:15

Christine Grahame (South of Scotland) (SNP): I congratulate Margo MacDonald not only on bringing the motion before the Parliament, but on this morning's substantive presentation. I also commend Yvonne Murray's very moving speech, from which Margo MacDonald quoted, about her experience with her daughter—an experience that came as a huge shock to me. I say to Margo MacDonald that this is one of the debates that will produce ministerial results. Some of the solutions are not too difficult.

I thank Coeliac UK for the substantive briefing that it gave to members, the key point of which was that, if people think that someone who is a coeliac sufferer simply has a food allergy, they underestimate and understate the situation. Of course, we are talking about an auto-immune disease that has severe short-term and long-term repercussions.

I understand that as many as 50,000 Scots could have the disease, but that only one in eight may be diagnosed. That is because of the difficulties in diagnosing the symptoms, but also because of lack of knowledge in the medical profession. Again, that point was highlighted by the presentations that we heard from Yvonne Murray and Gordon Banks MP, the latter of whom was diagnosed late in life.

I want to focus on the price of gluten-free products. Gordon Banks made the point this morning that, even when someone is buying foods that are not marked as gluten free, they have to take a long time to read through the list of ingredients to ensure that the offending ingredients are not included. It is good that Tesco and Sainsbury's now have gluten-free areas—we have all seen them—but we need to look at the prices. I will compare some foodstuffs: if bread is normally 35p, the gluten-free price is £1.78; if plain white flour is 29p, the gluten-free price is £1.43; and if a packet of penne pasta is 37p, the gluten-free price is £1.48.

As I listened to Yvonne Murray's speech this morning, two things came to mind. First, I was struck by the way in which this able, informed and determined woman managed to secure a resolution for her child, through pursuing the issues, and by how she has moved on to helping others. What if someone is not that kind of person? What if they do not come from that kind of background? Perhaps they come from a deprived area, they are not the brightest of people, or they are not determined or informed. If so, they will not be the kind of person who can unlock this puzzle for their child. I wonder how many such people there are in our communities.

The second thing that came to mind was that, even if someone is diagnosed, how can they afford the price of gluten-free products? The coeliac sufferer or the parent of a coeliac cannot deviate from those products. I leave members with that thought. Perhaps some members should approach the supermarkets, which make great profits, and ask them how they can defend the price differences between products. We should ask the supermarkets to bear in mind the many

people who are required to purchase gluten-free products.

I thank Margo MacDonald for bringing the debate to the chamber and congratulate her again.

17:18

Dr Sylvia Jackson (Stirling) (Lab): First, I thank Margo MacDonald for lodging her very important motion, thereby enabling members to debate it in the chamber tonight.

Many of us received a letter from Gordon Banks, the MP for Ochil and South Perthshire, who is a colleague of mine and who has been pioneering awareness of the issue at Westminster. I hope that members do not mind if I read from his letter—he knows that I will do so. Obviously, as a sufferer of coeliac disease, he puts the points better than I would.

Gordon Banks says:

"I was diagnosed as suffering from Coeliac Disease a number of years ago, but as those who have been diagnosed will understand, this late diagnosis only highlights the fact the condition has been present possibly from birth. The longer the diagnosis takes, the more serious the implications can be in as much as this can lead to the development of Osteoporosis"—

which I gather he has—

"Bowel Cancer and other serious illnesses and conditions."

He goes on:

"When I was elected to Westminster in May 2005, I found the transition to this lifestyle challenging, largely due to the lack of signage indicating gluten content in foodstuffs served in Westminster. This prompted me to form an All Party Parliamentary Group on Coeliac Disease and Dermatitis Herpetiformis. I am happy to say that we are now in our second year and have had successes. Gluten free bread has been introduced to most, if not all, of the restaurants and menus in Westminster."

Perhaps we could do something on that front in the Scottish Parliament.

He continues:

"Most menu products are now clearly marked so that sufferers can clearly identify which foods are appropriate. I have tabled two Early Day Motions relating to the Coeliac condition. Last year I tabled EDM 2127, which was designed to raise awareness of Coeliac Disease. I am happy to say that this attracted 144 signatures on a cross party basis. Additionally, this year it has come to light that certain English Primary Care Trusts appear to be restricting the prescribing of gluten free foods."

I know that Margo MacDonald is well aware of that, because she mentioned it to me earlier.

Gordon Banks goes on to say that he has

"recently tabled EDM 276 highlighting this issue which has been supported by 86 members."

He asks for our support in tonight's debate, on behalf of all constituents who may be affected. We heard about the breakfast this morning—I am sorry that I was unable to be there, as it sounds as if it raised awareness even more.

The display outside the chamber, which Gordon Banks and staff from Coeliac UK have been holding all day, has also been very good for raising awareness among MSPs. Like Margo MacDonald, I welcome the people from Coeliac UK to the visitors gallery—I am sorry that I did not do that earlier.

It is important to think about ways forward. I hope that the minister will be able to take on board the issues that have been raised. A huge number of people—in the region of 50,000 in Scotland—is affected. However, only a small percentage—one in eight—has been diagnosed. There must be an easy way of addressing testing—Christine May mentioned the possibility of diagnosis in pharmacies and so on. I hope that the minister will be able to come forward with some ideas.

17:23

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I thank Margo MacDonald for bringing such an important subject for debate. I also thank everyone from Coeliac UK, especially Yvonne Murray, whose story was absolutely horrific. The health service nowadays seems to take a long time to make diagnoses. I have a good friend of about 50—not a child, so she was able to speak for herself—who had to become seriously ill before she was diagnosed with coeliac disease. It took about three months of phone calls to me asking, "What do you think I should do? I'm in agony." I would say, "You've got to go to the hospital." When she got to the stage of lying on an operating table, about to have an endoscopy, her biopsy had been forgotten about, so she was thankful that she was compos mentis enough to be able to ask, "Aren't you doing my biopsy today?" After waiting about three months, she deserved to have a result. Unfortunately, she had to ask the surgeon, but he then carried out the biopsy and she was diagnosed with the disease.

I knew about coeliac disease—Nanette Milne will agree that it was part of a doctor's training—as we all did because it is in the differential diagnosis of many illnesses. As a paediatric resident, I examined children for coeliac disease, but a doctor needs to suspect that something is wrong before he or she can diagnose it. Doctors need to take the time to think about their diagnoses. What happens nowadays is that people are being processed. If doctors are focusing on targets, they are not focusing on people. They should not just be processing patients.

My other fear about the health service as it approaches change concerns continuity. Staff do

shifts, people change over and patients do not always see the same general practitioner or consultant. Those points must be considered in respect of continuity of care and enabling early diagnosis.

Dr Jackson: Does Dr Turner agree that leaving it to GPs to pick up coeliac disease might not be adequate and that we might need a screening programme to pick it up more routinely?

Dr Turner: I agree absolutely. It should not be left for GPs to diagnose coeliac disease. Nurses and whoever else comes into contact with the patient should also play a part but, eventually, we will come to the pharmacist. Cost will probably be at the back of the problem with diagnosis, but many conditions can be diagnosed by blood test. Coeliac disease is one such condition, as is diabetes. Coronary heart disease could also be tested for by blood test, which has been done.

We need to help our clinicians to have time to diagnose. People should not have to be able-bodied before they can fight for their rights. That applies in respect of many chronic conditions—our treating those conditions better would mean a wonderful saving for the health service and it would give back coeliac sufferers their lives. It would enable them to live proper and full lives without the worry of cancer or osteoporosis. Those conditions are preventable if coeliac disease is diagnosed, but it must be diagnosed early.

17:26

Mrs Nanette Milne (North East Scotland) (Con): I add my congratulations to Margo MacDonald on securing the debate and to Coeliac UK on its tremendous efforts in preparing for this evening. The briefing pack that it gave us is extremely readable and informative. Although I had, as a doctor, some previous knowledge of the condition, I have significantly added to that knowledge today. I must also thank the society and Margo MacDonald for arranging such a delicious gluten-free breakfast. It is a long time since I saw such an array of exotic fruit so early in the day.

I first became really aware of the practicalities of coeliac disease about 20 years ago, when my late sister-in-law was put on a gluten-free diet. At that time, there was little awareness of the condition and gluten-free products had to be carefully searched out. I remember studying labels on tins and packets—sometimes in vain—for an indication that there was gluten in the contents, and puzzling over what I would give her to eat when she came for coffee or a meal. She was sometimes regarded as being a little bit of a food freak because there was scant understanding of her condition.

I do not often welcome European directives, but the ones that came into force in November 2005 that made it obligatory to list all ingredients of packaged food must be good news for people with coeliac disease, because that makes it easier for sufferers to be sure of what they are eating. However, it is a great pity that, as Christine Grahame pointed out, gluten-free foods are expensive.

To think that there are probably 43,000 people in Scotland today who have undiagnosed coeliac disease is quite frightening, considering the long-term health risks of osteoporosis, bowel cancer and infertility to which it can lead. I confess, rusty as my medical knowledge is, that I was not aware of those risks until today, but I sincerely doubt whether a high percentage of medical graduates know about them. There is clearly a need to inform people about that hidden threat to health and to educate GPs about it so that they learn to keep it in mind when treating patients who present with unexplained gastrointestinal symptoms, anaemia, weight loss and the many other symptoms that can be manifestations of this autoimmune system disease.

All of us who were at the breakfast meeting today were touched by Yvonne Murray's moving account of the time it took to achieve her daughter's diagnosis. Gordon Banks MP is typical of the many sufferers who are not diagnosed until middle life. Such well-known people are to be congratulated on going public with their stories and are to be admired for doing that. Personal experience is much more effective in spreading information than leaflets or other advertising materials.

I commend Coeliac UK for its continuing campaigns to raise awareness and encourage early diagnosis of coeliac disease, for its commitment to helping people who have the condition by providing support and information, and for backing research into new treatments and the possibility of a cure.

Coeliac UK's campaigns this year for better hospital food and better training for chefs, and its excellent efforts to raise awareness at Holyrood—it even managed to get the Minister for Health and Community Care to come to the breakfast meeting—demonstrate the worth of the charity and its members. I support the charity's efforts and the terms of Margo MacDonald's motion and I will help in any way that I can during coeliac awareness week from 14 to 20 May.

17:30

Euan Robson (Roxburgh and Berwickshire) (LD): I also congratulate Margo MacDonald on securing the debate and I thank the people who

were involved in this morning's reception and the display that has been set up outside the chamber.

If one in 100 people is affected by coeliac disease, as I am sure is the case, about 1,000 people in my home area, the Scottish Borders, and as many as 500 people in my constituency are affected. More than a dozen people contacted me before the debate to describe their experiences. One person, whom I met in the street the other week, said that after she was diagnosed and her diet was changed, she felt like a new woman.

I pay tribute to Evelyn Jackson, of Coeliac UK's Border counties voluntary support group, who is working hard in my part of the world to raise awareness of coeliac disease. During the debate on making the NHS local, which just took place, I mentioned Evelyn Jackson, who said that after she was diagnosed and changed her diet she felt as though she had been driving a car with the handbrake on for years. It is important that we do everything we can do to ensure that as few people as possible have to go through life with the handbrake jammed on.

Members have made constructive suggestions. I am sure that the minister will agree that information for GPs and other NHS professionals is important. There might well be ways of providing information through the normal channels as well as through the activity of local coeliac groups. I agree that blood tests at community pharmacies are an appropriate way forward. As John Home Robertson said, routine analysis of blood samples seems to be particularly important.

Coeliac disease can lead to other conditions, such as osteoporosis. I am not medically qualified, but I understand that because gluten damages the small intestines of people who suffer from the condition, nutrients are not absorbed as they should be, which leads in some cases to unfortunate consequences, such as osteoporosis—which is a particularly horrible condition. If we ensure that coeliac sufferers are identified early, we can save them from other conditions.

Evelyn Jackson took the initiative of writing to everyone who is involved in Borders banquet 2007, which is a celebration of Borders food. She suggested that they advertise a gluten-free diet and I am pleased to say that Churches hotel and restaurant in Eyemouth took up her suggestion—the hotel deserves a mention for doing that. The more awareness of the need for gluten-free diets that we stimulate, perhaps the further the price of gluten-free products will come down. Greater awareness and more demand for products are not the only way to reduce prices, but they would have a beneficial effect.

17:34

Eleanor Scott (Highlands and Islands) (Green): I, too, would like to thank Margo MacDonald and Coeliac UK for this morning's presentation and for securing this debate. I will start on a serious note and finish on a perhaps lighter note.

I was able to attend this morning's presentation. We heard harrowing stories, among which was the story of Yvonne Murray's daughter, which Margo spoke about earlier. We also heard the story of another child who was almost at the point of death before being diagnosed. The child almost died from a condition that is eminently treatable—that is really frightening. The stories that we heard were so harrowing that I found myself thinking about children whom I knew years ago when I was a community paediatrician and I wondered how many cases I might have missed.

We have heard that one in 100 people in our population might have coeliac disease. It is a very common condition, but it is readily diagnosable and readily treatable. To me, coeliac disease is an eminently good candidate for a population screening programme. The *Official Report* might like to record that I have a plaster on one of my fingers; I was tested this morning and am happy to say that the result was negative. The test was almost painless and was very quick and effective. As we have heard, it is not particularly expensive. I therefore wonder whether consideration could be given to population screening for the disease. As I said, the disease is very treatable. However, the effects of the untreated condition are devastating.

Again as we have heard, once it has been diagnosed the disease is treated with a gluten-free diet. So is that all right? Well, not quite. It is not quite as simple as that—although such a diet can transform people's lives. We have heard about the costs of gluten-free products and we have heard about prescription products, but people who suffer from coeliac disease are not automatically exempt from prescription charges. If they are exempt for other reasons, they will not have to pay the charges, but otherwise they will. We have heard that some health authorities down south are restricting what is available on prescription. I seek reassurance from the minister that that will not happen here.

We have heard about labelling issues for ordinary food. When something is labelled as being gluten free, that is fine—although some labelling can be difficult to follow. However, sometimes we know that food should be gluten free but we might not be sure about it.

Eating out must be a minefield for people who suffer from coeliac disease. I was thinking about that because today is Valentine's day—a day

when a lot of people eat out. We all know that today is Valentine's day—apart from Rob Gibson MSP. Choosing from a menu can be difficult. Avoiding pasta and having a dish based on potatoes or rice should be all right, and meat and vegetables should be all right because they are naturally gluten free, but the dishes might not be gluten free because wheat flour is often used as a thickener for sauces. Can we be sure that we know what we are getting in restaurants?

I said that I wanted to finish on a lighter note. I have made up a Valentine's rhyme for Coeliac UK. It goes:

Violets are blue,
Roses are red.
Watch out for the gluten,
It's not just in the bread.

17:37

Mr David Davidson (North East Scotland) (Con): Gordon Banks MP and I came to an understanding one day when I turned up with him at Tayside police: he was puzzled because I had a different plate of food from everybody else's, and I ended up sharing it with him. I am the one in a hundred in this Parliament. The disease was diagnosed only five years ago.

I congratulate Margo MacDonald on securing the debate. Some of the things that have been said are very apt. My condition was picked up simply by an annual medical at the diabetes clinic. Four weeks later, I received a phone call saying, "Oh, by the way, we think you might have coeliac disease." They wanted me to go back so that I could go through the usual rigmarole to find out.

As I had a tube stuck down my throat, I heard the surgeon saying to the nurse, "Look at that—classic pavement syndrome." The inside of my gut apparently looked like a pavement.

Eleanor Scott: Too much information.

Mr Davidson: As others have said, the problem means that there is no absorption of anything. I had thought that I was doing rather well on my diet, but I found out the hard way that I was not. Because of one of my symptoms, my condition had earlier been misdiagnosed.

Eleanor Scott spoke about the minefield of eating out. Another example could be eating on flights. We might have booked a meal in advance for a flight across the world, and on the flight the cabin crew might say to you, "There you are—there's your plate of salad. We know you're a vegetarian." As a former beef farmer, I can assure members that that is not a pleasant experience.

In my early days in pharmacy, we had coeliac patients and tried to get them food on the NHS. One Christmas, a GP came to me and said, "You manage to get fresh bread for people." There was a special bakery that did deliveries of fresh bread. The GP continued, "I've got this gentleman and I want to give him a treat for Christmas." I had to go through all the pages of everything under the sun until I eventually found a tin of Christmas pudding that the gentleman could eat. The GP gave me a prescription for it, which was allowed, and I gift-wrapped the pudding and sent it round to the gentleman. He had not had a pudding for years. He had been told that no such thing was available for him. Little things like that pudding can make a difference.

The reactions to the problem can be very severe among young children. We have had such things explained to us at huge length in relation to diabetes and so on. I believe that, if we are going to do any testing, we should be doing more food allergy testing. That is an increasing problem, whether it is to do with milk or gluten.

The community pharmacist I know would be happy, under the new contract, to take on board such testing, but there is obviously a cost. Combined testing could be done for diabetes and coeliac disease. I hope that the producers of tests might be working in that direction. I give members a little warning that there will be a display by Diabetes UK next week in the garden lobby, and it will be carrying out various blind tests and so on. Perhaps we should ask Coeliac UK to link up with Diabetes UK for some programmes. In Aberdeen, Coeliac UK runs special cookery events to give people more of an understanding of the condition.

The most important thing of all is labelling, notably in restaurants—including in the Parliament's garden restaurant. The staff know that I have a problem with food; I ask what I can eat and they will tell me which things I cannot have. I often find that staff in the Parliament will walk in behind me so that they can find out, without saying anything, what food does not have flour in it. The most awful day was when I ate in the Parliament and discovered that, amazingly, wheat flour had been added to the mashed potatoes, the thought being that that would fill people up. That is nonsense—and there is no labelling in the Parliament. We really have to address that.

The Presiding Officer: After Maureen Watt's speech, we have time for two brief contributions by Alex Fergusson and John Home Robertson.

17:41

Ms Maureen Watt (North East Scotland) (SNP): I, too, thank Margo MacDonald for bringing the issue of coeliac disease to the attention of the Parliament today. I apologise for not being able to

attend the breakfast briefing this morning—I had a late engagement in my constituency last night.

Like many members attending the debate, I had heard of coeliac disease and know some sufferers, but the extra information that we have learned today has been invaluable. I would be pleased to be involved in highlighting this auto-immune disease. The fact that one in a hundred people have coeliac disease is alarming; the fact that four out of five people do not know that they have it is very worrying indeed.

On average, coeliacs will suffer the symptoms for 13 years before diagnosis. Coupled with the fact that they will have visited their doctors twice a year with the symptoms, that must be extremely distressing for those involved. It is that lack of awareness of the disease that the minister and Health Department officials must address with GPs, nurses and others. The number of days lost through misdiagnosis or non-diagnosis must be costing the country millions of pounds. The drop in the number of days lost by people who have been diagnosed, from 21 days per annum pre-diagnosis to three days per annum post-diagnosis, is startling, and it shows, as Euan Robson said, how much better their lives must be after they have been diagnosed.

I congratulate Coeliac UK on its work and on its raising awareness here today and among the public in general. I hope that, with that raised awareness, the price difference between gluten-free products and the products that we usually buy is decreased. Few sufferers can get the right products on prescription unless they are getting free prescriptions for some other reason.

The fact that diagnosis of coeliac disease can prevent other conditions, such as cancer, osteoporosis and infertility, must make it beneficial to the health service and save it costs in the long run. It is important that awareness of coeliac disease and the measures that need to be taken become common knowledge. Just like schoolchildren and their parents are made aware of the problems of fellow pupils with nut allergies, people must be made aware of the products that those with coeliac disease can and cannot eat. As others have mentioned, we should not forget the gravies and other sauces that go with food.

Like other members, I hope that the test for coeliac disease becomes more widely available. It seems a good idea to be able to take it in pharmacies, which could offer a long-term saving for the health service. I look forward to hearing the minister's views and to taking the test with a kit myself.

17:45

Alex Fergusson (Galloway and Upper Nithsdale) (Con): I am enormously grateful to Margo MacDonald for securing the debate. I am also grateful to her for organising this morning's breakfast briefing—although, perhaps, for a slightly different reason from those of other members. Gordon Banks MP, who made a good contribution to the briefing, was modest about his role in putting together the all-party parliamentary group on coeliac disease in the House of Commons, but he was slightly less modest about his feats as England's former goalkeeper. I could not resist the opportunity of ensuring that the Scottish Parliament witnessed the first meeting of those two footballing greats, Gordon Banks and Alex Fergusson.

As many members have said, Yvonne Murray's contribution this morning was incredibly emotive and extremely effective. I commend her whole-heartedly for the work that she is now doing on behalf of Coeliac UK.

I hear exactly what Sylvia Jackson said about a screening programme but it seems to me that huge strides could be made easily in that field simply by raising GPs' awareness of the condition and of the simple test that is needed to identify it. That came home to me personally recently, as my wife has been undergoing tests for one of the many unexplained conditions that seem to abound nowadays. When I asked our good, young and on-the-ball GP whether he had tested for coeliac disease, he looked puzzled and said that he had not thought of doing that. That must be an incredibly simple thing to correct. The Executive should ensure that all GPs test for coeliac disease when the right symptoms are placed in front of them. The rewards to the NHS would surely be enormous and the benefit to thousands of sufferers would be absolutely incalculable.

17:46

John Home Robertson (East Lothian) (Lab): Since the debate has been largely inspired by Yvonne Murray, and since I am one of the constituency members for her home town of Musselburgh, I feel enthusiastic about making a contribution to the debate.

I confess that, until the debate came on to the Parliament's agenda, I had never heard of coeliac disease. I am, therefore, grateful to Yvonne Murray, Gordon Banks, Coeliac UK and Margo MacDonald for bringing it to our attention.

Listening to the basic points that have been discussed this evening, I find it terrifying to think that there are tens of thousands of Scots who suffer from a diffuse range of symptoms but who are unaware of what is wrong with them. The debate has revealed that we need the condition to be diagnosed and that, once we have done that, we need to help people to live with the condition.

Is it good enough to wait until people have had a range of complicated conditions and gone through the gamut of options with their GPs before they are tested for coeliac disease? If it is as common a condition as is suggested, we should think about screening for it. If blood is being tested for one purpose or if people are donating blood, why not screen that blood for coeliac disease? I hope that the minister will address that point and say whether it is practical.

Thereafter, there is the question of improving the supply system for gluten-free foods. I agree that we should talk to retailers and processors about that. However, the crucial step is to improve the diagnosis and detection rate of the condition so that it can be diagnosed as early as possible in people's lives. If that can be done, we should be doing whatever we can to ensure that it is done. I hope that the minister will be able to help.

17:48

The Deputy Minister for Health and Community Care (Lewis Macdonald): I congratulate Margo Macdonald on securing the debate and thank members for their contributions, which have effectively put across their personal experience, in the case of David Davidson, and the experience of other people who suffer from coeliac disease.

On Andy Kerr's behalf, I acknowledge the information that was presented by Coeliac UK in its breakfast briefing and the display that was available to MSPs throughout the day. Earlier today I had the opportunity to speak briefly with Yvonne Murray and others, who ensured that I was provided with some of the wide range of information that they had available. I know that a number of my colleagues, including some of those who, due to prior engagements, were unable to stay for the debate, were pleased to receive that information and will make good use of it.

This evening's debate is an opportunity to highlight the issues and raise awareness of the needs of those in Scotland who live with coeliac disease. I understand that people from throughout Scotland are in the public gallery to witness the debate and I hope that they agree that it reflected the concerns that they brought to the Parliament.

In responding to the debate, I will put our approach to coeliac disease in the context of our wider approach to the management of long-term conditions, of which coeliac disease is one. The essence of our approach is to provide services that are fully responsive to people's needs, that are delivered locally wherever possible, and that are properly integrated across health and social care. Anticipating diseases, trying to prevent them from starting and identifying them early enough to prevent complications are essential aspects of the long-term conditions model and are relevant to coeliac disease.

We recognise the knowledge of people who live with a condition, even if they do not know what it is. That is central to our approach and we are keen to encourage health professionals to acknowledge and take seriously patients' expertise in how to live with long-term conditions.

We have changed the delivery of health care in recent months and years, and community health partnerships are now key organisations in the management of long-term conditions. CHPs are intended to bring together the NHS and its local planning partners to be the point of contact for those who have long-term conditions and those who represent them. Recently, we issued each CHP with a long-term conditions toolkit that will allow them to assess the quality of the services that they provide for people with long-term conditions, including coeliac disease.

Christine Grahame: The debate has been consensual, but I am a little disappointed that the minister has not addressed early intervention. He talked about managing the condition when it has been diagnosed, but the issue that has been highlighted is the initial diagnosis. I do not know whether the minister was going to move on to that, but I am trying to accelerate him.

Lewis Macdonald: It is certainly my ambition to cover all the key areas. However, I need to put our approach to coeliac disease in the context of our wider approach to long-term conditions, because that is perhaps the key to the other issues that were identified in the debate.

Margo MacDonald: The minister knows that I entirely support the Long-Term Conditions Alliance Scotland and mentioned it to Coeliac UK. However, if Coeliac UK is willing to come out to play, will he come out to play and meet its representatives, perhaps when the election is over and done with? A meeting should consider two things: first, early diagnosis and screening; and secondly, the evaluation of foods. That is essential, because if people cannot afford the foods, it is not much use having a good display of them on the supermarket shelf. Those are the two key issues.

Lewis Macdonald: I acknowledge those points, which reflect the points that Margo MacDonald made in her opening speech. Ministers will be happy to meet the organisation at the appropriate point. Margo MacDonald's point about the engagement of Coeliac UK with the Long-Term Conditions Alliance Scotland is critical to progress.

Community health partnerships are responsible for delivering locally against a range of criteria in relation to long-term conditions. Coeliac UK can

influence policy and delivery at the national level through the Long-Term Conditions Alliance Scotland and through a meeting with us, but there is also an opportunity for the support groups that it represents throughout Scotland to influence community health partnerships and ensure that coeliac disease is given the priority that it deserves in the work that is done locally.

Clearly, a point that has been made during the debate is about the importance of getting a firm diagnosis as early as possible and ensuring that the right interventions are made. As we have heard, those diagnoses and interventions are critical for both adults and children, and it is simply not acceptable that the NHS may not have been able to identify the symptoms and get to their root cause in every case. It is unacceptable for the individuals involved—we have heard about the consequences for them—and for the NHS. We want the service to use its resources effectively Part of that involves effective early diagnosis, intervention and treatment.

The Primary Care Society for Gastroenterology last year revised and issued guidelines on the recognition, diagnosis and management of coeliac disease. They are designed to assist the NHS to achieve an earlier diagnosis and they include the latest information on the clinical features, diagnosis and management of the disease. GPs should make full use of those guidelines in every case. Raising awareness of the condition in the general population, as we have done tonight, is vital, but raising awareness among GPs is important as well, and I acknowledge the role of Coeliac UK in doing that.

The prescription of gluten-free products has been mentioned, and such products are indeed available on prescription for people with coeliac disease. That can be helpful to many people. Food labelling is vital to people with any food allergy or intolerance or similar disease, and important work is being done by the Food Standards Agency across the United Kingdom with a wide range of interested parties to ensure that food labelling is accurate and effective.

John Home Robertson and others mentioned screening. The Long-term Medical Conditions Alliance Scotland is the key to that process, and we have a national screening committee that considers such proposals. That would be a helpful way to take forward the issues that have been raised this evening.

From the point of view of ministers and the NHS, we welcome the debate and support the objectives of Margo MacDonald and others in trying to raise awareness and ensure that people can be diagnosed as early as possible and have the best possible quality of life. I look forward to continuing to work with colleagues from across the chamber in order to achieve those aims.

The Presiding Officer: That concludes the debate on awareness of coeliac disease.

I have two brief footnotes. First, having listened to the debate, I shall as Presiding Officer ask staff to report to the Scottish Parliamentary Corporate Body on the availability and labelling of gluten-free products in our canteen and restaurants. Secondly, I say to members of Coeliac UK that the *Official Report* of the debate will be available on the Parliament's website at 8 o'clock tomorrow morning.

Meeting closed at 17:58.

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