MEETING OF THE PARLIAMENT

Wednesday 4 June 2008

Session 3

£5.00

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

CONTENTS

Wednesday 4 June 2008

Debates

Scottish Parliament

Wednesday 4 June 2008

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

Time for Reflection

The Presiding Officer (Alex Fergusson): Good afternoon. The first item of business is time for reflection. Our time for reflection leader today is the Reverend Stephen Taylor of the Kirk of St Nicholas Uniting in Aberdeen.

The Rev Stephen Taylor (Kirk of St Nicholas Uniting, Aberdeen): Around the age of 50, many people begin to relax from the cultural constraints that have been imposed on them and become their own persons in ways that they have conceivably not dared to before. They begin to be defined less by others and more by their own choices. As a result, mid-life is a time that is rich with potential and possibility for personal and spiritual growth.

When that milestone in life's journey approaches, they or—I should confess—we begin to count the years and reflect on what has gone before and what is yet to be. We begin to ask, "How much time is left?" Mid-life offers us the opportunity to position ourselves in deeper meaning. It awakens us to something that is inherent in human nature and to something that is fundamental to our enlightened sensibility that recognises certain distinctions of worth in reality. Society has, by tradition, called the highest of these realities "sacred" or "holy."

There is a part of human experience that evokes awe, reverence and ultimate respect for that which we can never grasp and yet ultimately defines us. As I rapidly approach mid-life, my perception of the sacred these days is concerned less with divine mysteries and theological definitions than with a simple recognition of the interconnectedness of all life and our place within existence. The holy and the sacred bind us to each other, to all other living things, to all of creation and to our home, the Earth. The connection of all living things to each other and to the world that sustains us is holy and sacred. Whatever nourishes that connection increases it, and whatever calls us to an appreciation of it calls us to holiness and invites us to the sacred.

The political realm and the politicians who inhabit it are part of that connection. Politics is about how power is exercised in human relationships; it is about who benefits from the exercise of power and who suffers because of it. This is where the source of life enters into human affairs.

This truth of the matter is possibly that the things that are sacred and holy in this life are neither locked away in the convoluted secrets of the saints nor stored away on mountain-tops. I also doubt that any church has complete control of the sacred or the holy. What holiness there is in this world exists in the ordinary connections between us and in whatever connections we manage to create between the divine and ourselves.

We are all co-creators and preservers of God's beauty in the world in our art, in our science, in our politics, in our communities, in our service to high ideals and, not least, in our devotion to the good and the just.

May God bless you as you do justice, love mercy, walk humbly and serve the people.

Amen.

Business Motion

14:34

The Presiding Officer (Alex Fergusson): The next item of business is consideration of business motion S3M-2050, in the name of Bruce Crawford, on behalf of the Parliamentary Bureau, setting out a revised business programme for today. I call Michael McMahon to move the motion.

Motion moved,

That the Parliament agrees the following revision to the programme of business for Wednesday 4 June 2008—

after	
2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
insert	
followed by	Ministerial Statement: Scottish Ambulance Service—[*Michael McMahon*.]

Motion agreed to.

Scottish Ambulance Service

The Presiding Officer (Alex Fergusson): The next item of business is a statement by Nicola Sturgeon on the Scottish Ambulance Service. The cabinet secretary will, of course, take questions at the end of her 15-minute statement, so there should be no interventions or interruptions during it.

14:35

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): In the debate on 22 May, a number of concerns were raised about the Scottish Ambulance Service. I undertook to investigate each and every one of them. Today, I want to report to Parliament on the actions that I intend to take to address those concerns.

First, I want to emphasise that the Scottish Ambulance Service performs well. The people who work in it do a good job and the people of Scotland should have confidence in it. The actions that I will announce today are intended to address concerns about specific issues in order that the Scottish Ambulance Service can continue to improve its performance and maintain public confidence. I also want to emphasise that my statement today is the start of a process. I intend to return to Parliament after the summer recess to update members on the various strands of work that I will announce today.

I intend to group my comments today under four broad headings that encompass the key concerns that were raised in the debate two weeks ago. They are: the leadership culture within the Scottish Ambulance Service and, in particular, allegations of bullying and harassment; the robustness of the data that underpin the apparent improvement in category A performance; issues relating to staffing, recruitment, overtime and associated concerns around, for example, shift cover and the single manning of ambulances that should be double crewed; and concerns about service redesign and the roll-out of the front-loaded model, in particular.

I will deal first with the leadership culture and allegations of bullying and harassment. I want to stress as strongly as I can that bullying and harassment have no place in Scotland's national health service. They will not be tolerated and any allegations will be treated with the utmost seriousness. The Scottish Government and the Scottish Ambulance Service received complaints about the leadership culture of the Scottish Ambulance Service in the days immediately prior to and following the debate on 22 May. As members would expect, the Scottish Government

has been liaising very closely with the Scottish Ambulance Service on those matters.

However, where such allegations concern employees of an NHS board, it is imperative that they be investigated by the relevant board in its capacity as employer. I therefore welcome the decision of Bill Brackenridge, the board chair, to appoint an independent panel to investigate the allegations that have been made. I confirm that the panel will be headed by Ken Corsar, the chair of Lanarkshire NHS Board. As members are aware, the chief executive and director of operations of the Scottish Ambulance Service have taken voluntary leave of absence while the investigation is carried out. Pauline Moore, the Scottish Ambulance Service's finance director, has assumed the role of acting chief executive. I hope that members will be reassured, as I am, that the Scottish Ambulance Service has acted swiftly and correctly to investigate the allegations. It is right that we now await the outcome of the investigation. In the interests of fairness to all concerned, I do not intend to make any further comment on the matter at this time.

I turn to data. Doubts have been expressed about the reliability of the data that underpin the apparent improvement in category A performance. That is a very serious matter which, if not addressed, would strike at the very heart of patients' confidence. I have therefore instructed a comprehensive review of the performance information that is required for reporting on the category A target. The review will be led by a senior clinician and will include representation from the Scottish partnership forum, the Scottish Government health delivery directorate's improvement and support team, NHS National Services Scotland's information services division, and a director of operations from another NHS board. It will examine how Scottish Ambulance Service information systems are used to generate and report performance information to the Scottish Government and to determine whether the performance levels that were reported recently are accurate. I expect that work to be completed in a thorough and interrogative manner. I have asked for a report to be submitted to me and the Scottish Ambulance Service board by the end of July.

I turn to staffing and related issues. Concerns have been expressed about staffing levels, about the challenges that face the service in recruiting and retaining front-line ambulance crews, and about the practice of single manning of traditional accident and emergency units. Although those challenges are not confined to the Highlands, they are most acute in remote and rural areas. I would like to address the concern that Mary Scanlon raised in the debate on 22 May that a traffic light system for determining the allocation of overtime was in operation in the Highlands. As I have confirmed to Mary Scanlon in writing, although such a system was not in operation at that time, plans to introduce it from 26 May in the north-west of the north division had been developed. As I said in the debate, I consider such a system, which seeks to combine risk assessment with cost control, to be unacceptable, so I have instructed the Scottish Ambulance Service to cease that operational practice. It has confirmed to me that it has done so.

I have also made it clear to the Scottish Ambulance Service that it must take action to eliminate rostered single manning. The Scottish Government's policy is clear: traditional accident and emergency ambulances should be double crewed, with at least one member being a paramedic, unless there are exceptional circumstances. In too many instances, particularly in the Highlands, practice is not living up to that policy. That is not a new situation, but it must be addressed. I have therefore asked the Scottish Ambulance Service to provide me with an action plan demonstrating how it intends to achieve the elimination of single manning. I expect to receive that action plan by the end of this month.

In the meantime, although the service will continue to assess risk and deploy resources accordingly, I have made it clear that every effort should be made to cover all shifts and that budget controls should not determine decisions about whether to cover shifts. I have also asked the Scottish Ambulance Service to provide a status report on the wider challenges that it faces in managing recruitment and retention of staff, and to provide a plan for addressing those challenges. I expect that work to include any issues that arise from the agenda for change, some of which have been raised in Parliament previously.

I will address service redesign and, in particular, the roll-out of what is referred to as the front-loaded model. It might be useful if first I explain in more detail what is meant by "the front-loaded model". Rapid response vehicles have been a feature of the service's response to emergency calls, particularly category A calls, since 2002, when priority-based dispatch was introduced in Scotland. At that time, the resource—in most cases, sole-operating paramedics in cars—was identified as being able to respond more quickly than the traditional accident and emergency unit. When a rapid response vehicle was dispatched to an emergency call, a double-manned accident and emergency unit was dispatched at the same time or as soon as possible thereafter. The accident and emergency unit could then be stood down if, following triage of the patient's condition by the rapid response paramedic, the unit was considered unnecessary.

More recent developments in that model aim to get more paramedics to more patients more quickly, so that early treatment can begin and the patient's need for further support and/or transfer to hospital can be informed by early triage. The dispatch centre determines the most appropriate initial resource, based on the details that are supplied by the caller. In most cases, a double-crewed accident and emergency unit continues to be dispatched. However, for some cases, the fast paramedic response unit will be sent and the paramedic will determine at the scene whether dispatch of an accident and emergency unit is subsequently required.

From January 2008, 54 rapid response vehicles have been operating throughout Scotland under the new model, which has resulted in their being dispatched to deal with a wider range of conditions. Although care begins when the paramedic arrives, patients want, of course, to be assured that if transfer to hospital is required, it will happen quickly. The Scottish Ambulance Service currently has arrangements in place to ensure that that happens and will report back to me by the end of the month on how those arrangements are operating.

The front-loaded model is subject to the Scottish Ambulance Service's risk assessment and clinical governance procedures and has been successfully evaluated in England. During the debate on 22 May, I confirmed that the model was the subject of external evaluation in Lanarkshire. I have confidence in the model and believe that it will improve patients' experience, although I accept that more needs to be done to build public confidence in it. For that reason, I have asked the chief medical officer, Harry Burns, to commission an independent evaluation of the front-loaded model. The terms of reference for the evaluation will be agreed in partnership with the trade unions, and a copy will be placed in the Scottish Parliament information centre.

From comments that were made during the debate on 22 May, it was clear to me that the Scottish Ambulance Service needs to improve its communications with its staff and the public. The service will therefore develop a comprehensive stakeholder engagement plan, designed to give better information to MSPs, Ambulance Service staff and the wider public about service development. I hope that the commitment to an independent evaluation of the front-loaded operational model will help to reassure Parliament and the people of Scotland of our absolute commitment to securing an emergency service that delivers what is best for patients.

I will meet Bill Brackenridge and the board of the Scottish Ambulance Service on 2 July to follow up all the issues that I have outlined in my statement today. I believe that that will allow an appropriate period of time for the key issues to begin to be addressed. The meeting will also provide an opportunity for me to agree with the Ambulance Service the agenda for the formal and public annual review of the service, which will now be rearranged to take place in early autumn. That will, of course, provide an opportunity for public scrutiny and participation, and I hope that members of all parties will take the opportunity to attend the review. I am happy to give an undertaking that my office will circulate the date and venue as soon as they are agreed.

In the meantime, I hope that members will be reassured by the actions that are being taken to ensure that there is sound corporate and clinical governance within the Scottish Ambulance Service. I repeat that I take very seriously the concerns about service redesign, about challenges to the integrity of performance data, about staffing issues, and about allegations relating to the leadership culture. I take the opportunity to thank all members who have raised those issues, either during the debate on 22 May or on other occasions. The actions that I have announced today, less than two weeks after our debate on 22 May, are designed to address those concerns openly and honestly, to make improvements where we consider they are needed, and to build confidence in service changes that will improve patient care.

In closing, I again take the opportunity to place on record my thanks to all the people who work in the Scottish Ambulance Service, and to assure them categorically of my confidence in the job that they do.

The Presiding Officer: The cabinet secretary will now take questions on the issues that were raised in her statement. We have around 30 minutes for such questions, after which we must move to the next item of business, which is very tightly subscribed.

I remind members that all contributions should be made through the chair. That means that members should refer to other members by their preferred name or by their title.

Margaret Curran (Glasgow Baillieston) (Lab): Thank you, Presiding Officer—I will do my very best, I promise. I thank the cabinet secretary for advance copy of the statement.

Cabinet secretary, you will be aware that Labour brought these issues to the Parliament on 22 May because concerns throughout Scotland were so serious that they demanded immediate attention. I begin today by stating categorically that the Labour Party recognises the contribution of ambulance staff in Scotland. The respect that they receive throughout the country is well deserved.

When Labour brought the debate to Parliament, we raised concerns about fewer ambulances being on the streets of Scotland; about clinical safety being compromised in order to meet targets; about basic shifts not being covered because of financial pressures; about ambulances not being cleaned; about staff being pushed to the limit; and about a culture of bullying and harassment that was beginning to emerge.

I welcome the statement—the actions that are outlined in it are exactly what we called for in the debate on 22 May. I will, however, leave to one side that we were told one week ago that they were not necessary, because I want to acknowledge the progress that has been made and the element of independence that has been introduced to the myriad investigations that are under way. Cabinet secretary, I hope that you will keep your word and continue to keep Parliament informed because of members' interest in the issue. I suggest that you meet the party spokespeople before the end of recess because we would like to keep abreast of the detail of the independent inquiries that are under way.

I will ask you a question that I asked the First Minister recently. Are there fewer double-crewed ambulances on the streets of Scotland this year than there were last year and the year before? You also referred in your statement to who determines the dispatch of a double-crewed ambulance. I think you appreciate the scale of the concern throughout Scotland on this issue, and I presume that all aspects and operations of the model will be covered by the Harry Burns investigation.

In the past, I have raised with you my constituency interest in the issue, which is a deeply tragic case involving the death of a young man. The case was highlighted extensively by the *Daily Record*. At the time, I asked for an inquiry into the circumstances of the case but you rejected my request. I ask you to reconsider that, to hear my constituent's representations and to ensure that at the very least there is some independent assessment of the circumstances of the case.

What is the scale in real terms of the efficiencies that are required of the Scottish Ambulance Service by the Scottish National Party Government? What impact is that having on ambulance services in Scotland?

Nicola Sturgeon: I thank Margaret Curran for her questions. I acknowledge that Labour raised those issues two weeks ago. Members of all parties have raised them and I thank all of them for doing so. I hope that Margaret Curran accepts that I have, as I said I would in the statement two weeks ago, acted swiftly to address the concerns. If it is the desire of party spokespeople to meet before the summer recess to discuss progress, I will be more than happy to arrange such a meeting. I am sure that such a meeting would have a useful part to play in ensuring that members and the wider public are kept informed.

I confirm to Margaret Curran that all aspects of the operation of the front-loaded model will be covered by the independent evaluation that will be commissioned by the chief medical officer. I stress again that I have confidence in the model. It has been operating in other parts of the United Kingdom for much longer than it has in Scotland, and with quite impressive results. It is already subject to the clinical governance procedures of the Scottish Ambulance Service, which are in turn reviewed by NHS Quality Improvement Scotland. Although I have confidence in the potential of the model to improve the service for patients, I understand that it is not enough for me or the Scottish Ambulance Service to have confidence in it; the public must have confidence in it, too, which is why I have announced the actions that I outlined in my statement.

Margaret Curran said that there are

"fewer ambulances … on the streets of Scotland."

I draw her attention to the fact that there are more emergency ambulances on the streets of Scotland now than at any time since 2003. That important point should be placed on the record. It is right that the Scottish Ambulance Service continues to ensure that the mix of those vehicles is right. Margaret Curran is correct to say that there are slightly fewer accident and emergency units as part of that fleet, but the reason is that the Scottish Ambulance Service has acted to increase the number of mid-tier ambulances that are more appropriate for activities such as transferring patients between hospitals or to hospitals from general practitioner referrals. That allows the Ambulance Service to make better use of accident and emergency units. Let us be clear: there are more emergency ambulances. However, the Ambulance Service has an obligation to ensure that it has the correct mix of vehicles.

Like every other NHS board and every other part of the public sector in Scotland, the Ambulance Service has been asked to deliver efficiency savings of 2 per cent. That is 1 percentage point less than the figure that Wendy Alexander wanted the public sector to meet. We are absolutely clear that efficiency savings are exactly that. They are not efficiency savings if they reduce service quality, which is why I made it clear in my statement that I do not expect shifts to be not covered for budgetary reasons.

Margaret Curran also mentioned a difficult constituency case. I understand—I am sure that she will correct me if I am wrong—that she has

had the opportunity to listen to the recording of the conversation that took place between the ambulance staff member and the dispatch centre control staff. I am more than happy to meet her constituents, if that would be helpful, and to consider any further representations that are made. However, I emphasise that the decisions that were taken in that case were taken to protect the safety of Ambulance Service staff. I merely speculate when I say that had different decisions been taken and had the staff member come to harm, members would rightly call for an inquiry into that, as well. All I am saying is that difficult judgments need to be made, but I am more than happy to discuss them further.

The Presiding Officer: I remind all remaining members that making contributions through the chair means not calling other members "you".

Mary Scanlon (Highlands and Islands) (Con): I thank the Cabinet Secretary for Health and Wellbeing for a copy of her statement and I place on record the Conservatives' recognition of the excellent work that ambulance crews and staff do. I acknowledge the Government's commitment to the serious issues that were outlined in the statement and which have been raised previously by MSPs of different parties. I am also pleased that single manning is being dealt with and that the Ambulance Service is being listened to as it expresses its concerns for the people whom it serves.

Will the health secretary consider opportunities to train to paramedic level the ambulance technicians whose salaries were cut by £3,000 a year as a result of agenda for change? On the independent evaluation of the front-loaded model, will she now properly consult the staff members who have serious reservations about the model but who have felt unable to express their opinions on service changes for fear of repercussions from senior management?

I thank her courteously for the letter that I received from her last week and the explanation that she gave today on the traffic light system, which I raised last week. I suggest that she should ensure that local ambulance services keep MSPs fully informed of change. That is crucial, particularly given that three meetings that Highland MSPs were to have with the Scottish Ambulance Service in recent months have been cancelled and August or September has been suggested for a replacement date.

Nicola Sturgeon: I thank Mary Scanlon for her acknowledgement of the action that is being taken on single manning. The problem has been with us for many years, but I think we all agree that it must be addressed. I also thank her for her gracious acknowledgement of the letter on the traffic light system and the explanation for it.

She raises an important point about ambulance technicians. The fact is that they are much more skilled today than they were previously. The Ambulance Service is working to upskill them to paramedic level. Another issue that was raised in the debate was the rostering of technicians on rapid response vehicles. I have made it clear to the Ambulance Service that it must work to eliminate that; part of the solution will be for it to train as many technicians as possible to paramedic level.

The point about staff involvement was well made. I hope that I made clear in my statement the importance that I attach to it. The terms of reference for the independent evaluation of the front-loaded model will be drawn up in partnership with the trade unions—I expect them to be integral to that. I expect all parts of the NHS to honour the principles of partnership working, which means involving staff at the earliest stages in service development and policy changes. That is a model of working to which I am committed and I expect all members of NHS management to adhere to it.

I am not aware of the detail of Mary Scanlon's point about cancellation of meetings. However, I will ask the Ambulance Service to ensure, when it draws up the engagement plan about which I talked, that its engagement with elected representatives, as well as with staff and the wider public, is up to scratch, as we all expect it to be.

Ross Finnie (West of Scotland) (LD): My recollection of the conclusion of the debate on 22 May was that it was, in fact, a Liberal Democrat amendment, calling for a statement from the cabinet secretary, that was approved by the Parliament. It would be entirely churlish of me not to thank the cabinet secretary for coming to the chamber so quickly with her statement and for providing copies of it in advance. It would be equally churlish not to recognise that the cabinet secretary has addressed, or is in the course of addressing, or has set in place steps to address, almost all the issues that were raised in the debate last month, which is welcome. I hope that, equally, the cabinet secretary will acknowledge that, although the Scottish Ambulance Service performs well and those who work for it do a good job, the issues that we have been discussing are important. The breadth and range of her statement indicate that a number of them need to be addressed.

I have two questions. First, I accept wholly what the cabinet secretary said about front loading being tested elsewhere. I hope that, in asking for an inquiry, she will not prescribe it narrowly, such that it precludes addressing relationships and staffing. If, as the cabinet secretary has admitted, a number of rostering issues have developed that are not acceptable to her and are not in line with

policy, that could easily undermine the delivery of front loading. I hope that the specification that Harry Burns receives will cover those issues.

Secondly, I refer again to a matter that it is important to raise in the public interest—safety and ambulance journey times. I do not wish to go on and on about it, but I continue to believe that the cabinet secretary is required to give the public assurance on some of the statements that were made in good faith by Professor Walker in his report on Ayr hospital, which implied that extended journeys might not be safe. As I requested during the debate on 22 May, we require some public assurance on the matter.

Nicola Sturgeon: I thank Ross Finnie for those questions. Before this descends into a competition between Labour and the Liberal Democrats as to who is responsible for today's statement, I will try to build some consensus by saying that this is an example of Parliament collectively doing its job properly, and we should perhaps all take some credit.

Ross Finnie rightly says that the issues that the statement raises are important. I hope that I conveyed during last month's debate the fact that I take them seriously. If anybody was left in any doubt about that, I hope that I have demonstrated by coming to the chamber with a statement so soon after that debate and by addressing the issues so comprehensively that I take all those issues seriously. Public confidence in any part of the NHS is paramount; in emergency services, it is particularly important. I will do everything in my power to ensure that public confidence is not compromised in any way.

I turn to the two questions that Ross Finnie asked. First, on the interrelationship between front loading and staffing issues, there is a relationship, and some overlap, between the different work streams that I have announced today. I will consider Ross Finnie's point when we draw up the terms of reference for the independent evaluation to reflect the need for it to assess the safety of the front-loading model and to provide reassurance that it is not being used inappropriately because of other staffing pressures.

Secondly, on Andrew Walker's report, the debate is perhaps for another day, although I appreciate the importance of Ross Finnie's point. I do not think that Andrew Walker was saying that extended ambulance journey times are dangerous and put lives at risk in all circumstances; he was making a point in the particular context of Ayr and Monklands hospitals.

Our discussion of the front-loaded system is not specifically about journey times to hospital; it is about the importance of getting paramedics to patients as quickly as possible and, in many cases, being able to see and treat patients without transfer to hospital. However, I acknowledge Ross Finnie's points and I am more than happy to return to them in future.

The Presiding Officer: We now come to questions from back benchers. More people wish to ask questions than I can possibly fit in, so in order to allow in as many as possible, I make a plea for no speeches, no preambles, one question per member and answers that are as brief as possible.

Christina McKelvie (Central Scotland) (SNP): As the cabinet secretary knows, the pilot scheme for rapid response vehicles that took place in Lanarkshire, which is in my region, is being evaluated externally. Does she agree that certain incidents that the Ambulance Service faces are best dealt with on a see-and-treat basis, and therefore RRVs can play a crucial role in providing an effective ambulance service in Scotland? Can she assure us that the proper regulations will be put in place to ensure that RRVs are used where appropriate and that traditional two-person vehicles are used where appropriate?

Nicola Sturgeon: Christina McKelvie is right to say that the use of rapid response vehicles in Lanarkshire is currently subject to external evaluation, which is an important part of the overall process of building confidence in the system. I hope that all members agree that increasing the use of see and treat, as clinically appropriate, is the right thing to do. We all agree that we must reduce unnecessary admissions and journeys to hospital. See and treat is an important part of that.

Christina McKelvie's points about rapid response vehicles will be covered by the independent evaluation. On the one hand, we all agree that practices such as single manning of ambulances that should be double crewed are wrong and must be dealt with. On the other hand, I believe that the front-loaded model is right, but we must do more to build public confidence in it. That is an important distinction to make.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I join other members in welcoming the speed with which the cabinet secretary has responded to this undoubted glitch in the Ambulance Service, which is an otherwise excellent service. The cabinet secretary has responded by means of four different units: a panel under Ken Corsar, an inquiry by a senior clinician, the internal inquiry on the action plan and the chief medical officer's review. I am concerned about whether the public and staff will be able to respond to those four different inquiries. There is no sign of integration. We wanted a single integrated inquiry. How will she integrate the inquiries? Which inquiry will deal with using the

global positioning system to report attendance within 200m of an incident? It is difficult to determine whether that relates to staff or data sharing. Will the cabinet secretary find a mechanism that will allow staff, who feel quite harassed, to speak freely to the various inquiries without fear of retribution?

Nicola Sturgeon: Of course staff should speak freely. I make it clear to any member of the Scottish Ambulance Service staff that if they have something to say, they should feel free to say it. Many staff members have felt able to raise concerns with Opposition members and with me directly. That is one of the reasons why I made the statement.

I acknowledge Richard Simpson's point about the four different work streams, but I think that it is the right approach, because, as I said to Ross Finnie, although there are interrelationships and overlaps, we are talking about four distinct issues that require to be dealt with separately. All the issues will be taken forward in partnership. It is important to ensure that there is staff and trade union input. I will certainly ensure that the Parliament is kept informed of progress. It is right to say that, when we get further into the process, I will require to consider further how the different strands and conclusions of the inquiries are brought together. I will perhaps be able to update Parliament on that after the summer recess.

On GPS satellite navigation, which Cathy Jamieson raised previously, it is important to clarify that the eight-minute target has not been redefined in any way. We now have a system of automatic recording of ambulances arriving at the scene. We have had automatic recording of ambulances arriving at hospitals for some years. The recording system operates in addition to crews pressing a button manually when they arrive at the scene. The system is intended to record information more accurately and without the inevitable variation in practice that we get with a manual system. The recommended reasonable tolerance for the satellite navigation system is 200m, which, in time terms, equates to roughly 10 seconds. That is the tolerance that is applied to the target. Automatic recording is a more accurate way of recording the information, but if members have further concerns, I am more than happy to consider them. Given that we are talking about the data that are used to record category A performance, I expect the issue to feature in the investigation.

The Presiding Officer: I repeat that there should be one question per member.

Keith Brown (Ochil) (SNP): As the cabinet secretary will be aware, I represent a constituency that includes rural Kinross-shire, whose residents can be quite far from hospitals in time of emergency. Concerns have been expressed to me—as recently as lunch time today, by pupils of Kinross high school—about rumours and media reports of ambulances that are designed for two people running with just one paramedic on board, which, I assume, makes it hard, if not impossible, to deliver treatment on the move.

The Presiding Officer: Question, please, Mr Brown.

Keith Brown: Will the cabinet secretary clarify what has been happening with regard to the issue? Will the action that she is proposing to take reassure my constituents?

Nicola Sturgeon: Keith Brown raises a valid and important point. I covered the issue in my statement, but I will again make it clear that single manning of accident and emergency units that should be double crewed should not be the general rule and should happen only in exceptional circumstances. Usually, there should be double crewing of the units, and one of the crew members should be a paramedic.

The issue is not new, and it is right that we step up action to address it. That is why the Scottish Ambulance Service will, by the end of the month, submit to me its action plan to eliminate rostered single manning.

Helen Eadie (Dunfermline East) (Lab): Does the cabinet secretary have statistics on ambulances that were dispatched but subsequently stood down following a paramedic triage stand-down message to the central base? How do management ensure that the risk assessments have been clearly understood by the primary care staff involved? Are protocols that can be understood clearly by the public in place, so that their expectations can be managed and confidence in our Ambulance Service is not further damaged?

Nicola Sturgeon: Of course protocols are in place to deal with the scenarios to which Helen Eadie refers. The dispatch centre will make decisions about the appropriate type of vehicle to dispatch to a call. Of course, the dispatch centre makes decisions about the categorisation of calls as well, and protocols underpin all of that decision making.

I do not have to hand statistics on the number of double-crewed ambulances that were dispatched and then stood down. If those statistics are gathered centrally—I imagine that they are, but I do not want to give a categorical assurance without checking—I will ensure that they are given to Helen Eadie in writing.

Jackson Carlaw (West of Scotland) (Con): I would like to press the cabinet secretary a little further on the review that is being headed up by

Ken Corsar. No organisation, let alone a major service organisation, can afford to operate for any length of time with its management effectively in limbo. Does she expect the review to be short? What brief has Pauline Moore been given in the interim? Does the cabinet secretary expect the meeting that was to take place on August 12 to take place before or after the various reviews that have been initiated?

Nicola Sturgeon: The date for the annual review, which I have decided to move to early autumn to allow progress to be made, will be set before or around the time when I meet the Scottish Ambulance Service on 2 July to discuss the range of issues that will be covered in the annual review. I will ensure that members are notified of that as quickly as possible.

I emphasise that the investigation that is being headed up by Ken Corsar was established not by me but by the board of the Scottish Ambulance Service—that is an important point of principle. The investigation is into allegations of bullying and harassment, and it concerns employees of the Scottish Ambulance Service, therefore it is right and proper that it is dealt with by the board of the service, in its capacity as employer. It is, therefore, not appropriate for me to comment further on the review, except to say that steps have been taken to ensure operational continuity in the service while the chief executive and operating officer are on temporary leave.

Pauline Moore is the acting chief executive. She has a wealth of experience that will stand her in good stead for the task. Any management support that she needs will be provided by the Scottish Ambulance Service, with help from the Scottish Government health department, where appropriate.

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): On pages 7, 8 and 9 of the written version of her statement, the cabinet secretary frankly acknowledges the staffing problems that I have outlined. Can she assure me that, when she conducts an audit, as it were, of why we are where we are with regard to the unfortunate situation in north-west Sutherland, officials will at least correspond with health professionals in the area, particularly GPs, who will have useful knowledge to impart? As part of her efforts on managing recruitment, will she undertake to consider part-time work, as such employment does nothing to boost recruitment in areas such as north-west Sutherland?

Nicola Sturgeon: I am happy to confirm that the work that I have requested from the Scottish Ambulance Service will cover the issues to which Jamie Stone refers. I am also happy to confirm that, in taking forward that work, all relevant interests will be considered. I am more than happy to hear from any stakeholder or person who can bring experience to bear. I mentioned that, a couple of weeks ago, I visited not Sutherland but Wester Ross, to discuss issues with the people who live there. I am more than happy to continue to engage in that way.

It is important that we accelerate the pace at which we deal with single manning. In the chamber a couple of weeks ago, I told Jamie Stone that I had asked for regular reports about that. I am determined to press ahead to eliminate that practice, which has no place in the Ambulance Service.

Michael Matheson (Falkirk West) (SNP): The cabinet secretary will be aware of concerns about how operational research consultancy—ORCON—targets are being applied, particularly for category A calls, which must be responded to within eight minutes. Does she acknowledge the perverse logic in how that target is applied? If the crew arrives in seven minutes and the casualty dies, that is classed as a success, whereas if the crew arrives in nine minutes and the casualty makes a full recovery, that is classed as a failure. Will she consider further how we can move towards a more outcome-based approach to assessing how the Ambulance Service responds?

Nicola Sturgeon: I understand where Michael Matheson comes from in asking his questions. The eight-minute target was set not by this Government but by the previous Administration, which acted on the basis of international evidence. The target is right, but I am determined to ensure that the performance measures that lead to judgments about whether the target is being met are right, proper and robust. I challenge the notion that it is a failure if an ambulance crew turns up in nine minutes and the patient survives. Of course, that means that the eight-minute target has not been met, but that is only one aspect of performance. Nobody would consider that result to be a failure. We must consider issues in the round but, in the whole picture, the eight-minute target has an important place and is right for category A calls.

James Kelly (Glasgow Rutherglen) (Lab): In the debate two weeks ago, concerns were expressed about the cleanliness of vehicles and the impact on health and safety of pressures on staff. The cabinet secretary's statement did not directly address those issues, so will she undertake to examine them as part of the investigation that she outlined and to report to Parliament in due course?

Nicola Sturgeon: I am happy to do that and to report to Parliament when I make a fuller statement. Members will know the importance that I attach to cleanliness and infection control in the NHS, which applies to ambulances just as it does

to hospitals. The importance of cleaning ambulances cannot be overstated. Ambulances must be cleaned rigorously, and I expect that to happen. Some ambulances are now being cleaned by hospital cleaning staff rather than ambulance crews, to free them to do other tasks, but the standard of cleaning cannot be compromised on. I would take seriously any suggestion that that was happening.

The Presiding Officer: I am afraid that we must move to the next item of business. I apologise to the three members whom I could not call. As I have said, the next debate is extremely tightly subscribed.

Drugs Strategy

The Presiding Officer (Alex Fergusson): The next item of business is a debate on motion S3M-2038, in the name of Fergus Ewing, on the drugs strategy.

15:19

The Minister for Community Safety (Fergus Ewing): It has been six days since the publication of our new national drugs strategy, "The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem". I felt it right to allow time for members to reflect on it and to seek views from the field before we debated it.

Members will express their views today, but I am pleased that there has been widespread support for the central thrust of our strategy, which is the concept of recovery. That support reflects the many positive discussions that I have had with a range of parties—from key experts to practitioners, politicians, and service users and their families—during the development of the strategy. In particular, I am pleased that the health and wellbeing spokesperson for the Convention of Scottish Local Authorities, Councillor Ronnie McColl, welcomed the publication of the strategy, which he said gives a renewed focus to local authorities' work. Last week, Tom Wood, who has retired as chairman of the Scottish Association of Alcohol and Drug Action Teams, said that the strategy

"marks a very positive change in direction, towards recovery",

and the chief medical officer, Harry Burns, thinks that it provides

"a clear set of integrated actions aimed at tackling the drug problem in Scotland."

To recap, recovery means recovery; it means more than simply reducing risk and harm. Services should help a person to move on towards a drug-free life as an active and contributing member of society. Our approach is person centred. It places service users' needs and aspirations at the centre of their care. Recovery is a process, not an event; it is a journey, not an end point. People's milestones on the road to recovery may be as simple as gaining weight, re-establishing relationships with friends and family or building self-esteem and then entering a training or education programme and developing skills.

Brian Adam (Aberdeen North) (SNP): The minister mentioned his widespread discussions with interested parties on recovery and the route back to work. Has he had any discussions with his counterparts south of the border, particularly with bodies such as the Department for Work and

Pensions, on the number of people who can progress to work? If they cannot do so, it will be difficult to move people on.

Fergus Ewing: Earlier in the process, I had constructive discussions with my counterpart down south, Vernon Coker, which were conducted around the confines of the British-Irish Council in Dublin. I also corresponded with him recently, and I met Roger Howard of the UK Drug Policy Commission, which does good work—indeed, it has made proposals on recovery that are similar to ours.

"Journey to Recovery", which was published with the drugs strategy, contains stories of the different ways in which a number of individuals have recovered. Let me be clear: the Government is not in the business of second-guessing clinicians or seeking to disparage particular treatments without which individuals and society would be exposed to unwarranted risks.

Johann Lamont (Glasgow Pollok) (Lab): On a point of clarification, "The Road to Recovery" and the minister say that, above all, recovery is about "movement and dynamism". What does that mean? In addition, if the Government's policy is person centred—it is probably right to be—does the minister envisage circumstances in which individuals could remain on a maintenance programme that involves methadone, for example, without a time limit?

Fergus Ewing: I have had the privilege of travelling around Scotland and visiting a great many service users in every city of Scotland—indeed, I visited service users in Edinburgh this morning. Recovery is hard. It takes a long time to recover and a lot of effort by the person involved and by those who provide help. It can come in many different forms. This morning, for example, I saw skills being developed as part of the transition project in Edinburgh.

Johann Lamont asks whether methadone treatment should or could in some circumstances continue indefinitely. Such matters are matters for clinicians. I have already said that I cannot and will not second-guess what clinicians say. It would be completely wrong for any minister to do so. I am a politician, not a doctor. There is a place for methadone. Some people argue that it is like another drug, and that in some circumstances—perhaps relatively few—people may persist in taking it for some or many years. However, the main point is that it is not for me to second-guess what drugs should be prescribed to whom; rather, my job is to set out a vision and strategy, the guiding and central principle of which is recovery.

We must recognise that substitute prescribing has an important part to play in tackling addiction. That was the conclusion of an expert report that the Scottish Advisory Committee on Drug Misuse published last year, and it is also entirely consistent with the recently reviewed United Kingdom guidelines on clinical management, which are known as the orange guidelines, for obvious reasons. However, simply getting people into treatment can no longer be seen as a successful outcome in itself. That is a key point of the strategy. Treatment services must be integrated with wider employment, training, housing and counselling support services to help people to recover and rebuild their lives.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Will the minister confirm or deny that he is dropping the target of getting an additional 10 per cent of people with drug problems into treatment, which has been the prime target for drug action teams and drugs services over the past eight or nine years?

Fergus Ewing: Working with COSLA, we are pursuing an approach that, as I will explain, is based on the development of outcomes. That is not easy. Of course we want more people to get treatment, but there are dangers in setting targets that may prove to be arbitrary. For example, if the target is simply to deliver an extra 300 people into treatment, there is an in-built incentive for local authorities to chase the numbers, and quantity does not always mean quality. Targets can have unintended consequences.

Similarly, at the transition project this morning, an official from City of Edinburgh Council said that there is a danger that, if the focus of all the activity is on treatment, as Richard Simpson suggests, other worthy parts of recovery, such as training, will be sidelined and will not receive resources, because they will all be going towards meeting a target. Therefore, although I have some sympathy with the approach that is set out in the Labour amendment, I say with respect that I hope that we can instead continue to work across the parties on the outcome agreements with local authorities, to which COSLA has agreed.

The implementation of the strategy is key. We have developed it in partnership and it is essential that we deliver it in partnership, both within and outwith the chamber. I am personally committed to working with ministerial colleagues, external stakeholders and political parties to ensure that the strategy is implemented successfully. I want to do that in the same spirit—and, I hope, with the same vigour—that we have already shown. We owe it to every person in Scotland who has been affected by drug use to work together to support practitioners who will work on the ground to implement the strategy.

Central to the delivery of the strategy is reform of the way in which drug services are planned, commissioned and delivered. To make recovery a

reality, local partners need to ensure that the appropriate range of services is in place locally and regionally. We have, therefore, set up an expert delivery reform group to consider future delivery arrangements. The continuing work of that group will determine how best performance management and accountability arrangements for local delivery of drug services should operate within the context of single outcome agreements and national health service accountability structures. That is broadly similar to what I just said to Dr Simpson. The same group is also seeking to develop an outcome-based framework for assessing and managing performance at a local level to improve outcomes for service users.

Margo MacDonald (Lothians) (Ind): On the outcome agreements I agree with the minister. However, has he received representations from the local authorities concerned that they cannot now recruit the number and, perhaps, quality of people that they require to act as counsellors and support workers?

Fergus Ewing: Margo MacDonald makes a telling point. The problem may often be not insufficient resources but lack of skills, personnel, or skills and personnel at the right place or throughout Scotland. We accept that point.

The Deputy Presiding Officer (Trish Godman): One minute.

Fergus Ewing: Because I have taken interventions, I must fast-forward about eight pages into my speech, to the approach that we are taking in our prisons.

The Scottish Prison Service is piloting a new model of care within Saughton prison, which aims to integrate medical treatment with wraparound therapeutic support to give prisoners the best chance of recovery from drug problems and enable them to rebuild their lives after prison.

We are happy to consider carefully the proposal in the Conservative amendment, which was lodged yesterday. The Government has some technical difficulties in accepting it, because it makes a proposal that we must consider extremely carefully, but I undertake that the Scottish Government will examine it fully, and we have agreed to meet Annabel Goldie to do just that. I hope that that assurance provides some comfort.

The publication of our new drugs strategy provides an opportunity for everyone in the chamber to work together, to put the sterile debates of the past behind us, and to reform drug services so that more people recover, reclaim their lives and make a positive contribution to society. Our new strategy provides a sound framework on which to take that work forward, and I recommend it to the chamber.

I move,

That the Parliament welcomes the publication of the national drugs strategy, *The Road to Recovery*, as a sound framework for tackling drug misuse in Scotland; acknowledges that it is founded on expert advice and has been developed through a wide-ranging and inclusive process; supports the Scottish Government's vision that recovery should be the guiding principle of all services for problem drug users; recognises the breadth of action set out in the strategy to prevent drug use, to make communities safer, to tackle drug use in prisons and to protect children affected by parental substance misuse; recognises the Scottish Government's intention to support action to tackle drug misuse with £94 million from the Justice portfolio alone over the next three years and welcomes the work that Audit Scotland is carrying out into the scale and effectiveness of drugs expenditure, and resolves to support the implementation of the strategy over the coming years.

15:31

Paul Martin (Glasgow Springburn) (Lab): The background to the debate has been about seeking consensus and working together on an issue that troubles many of us and concerns us all as members of the Scottish Parliament. Our constituency case loads identify those constituents who are affected by drug misuse. It could be a constituent who has lost a son or daughter, or a grandparent who is now caring for children who have lost their parents because of drug misuse. Those are real-life examples that face us every day. We owe it to those people to ensure that we stand up for our communities. It is quite right that that requires robust, frank and honest scrutiny of any proposals that the Government makes. That is why we have proposed an addendum to the Government's motion that raises a number of issues that require further scrutiny.

First, our amendment makes it very clear that we want the word "target" to feature in the strategy document; it is used on only two occasions. If we are to spend public money, we must ensure that we get best value for it. That is what the people of Scotland expect from us. We should ensure that we get best value for every pound that is invested in the strategy.

Members should be reminded that the Parliament debated a drugs strategy in January 2000 and delivered an action plan in May 2000. It would therefore be wrong to suggest that the Executive and the Parliament at that time did not reach a cross-party consensus and work together on the challenge that faces us today.

Margo MacDonald: Will the member give way?

Paul Martin: I want to develop my point, but I will give way to Margo MacDonald if there is time available.

We called for resources to tackle the issue but also for more precise information on where the

money would be spent. In May 2000, the Deputy Minister for Justice, Angus MacKay, advised us that £250 million per year would be spent on tackling drug misuse and that half of that would be spent on enforcement; that meant that the Deputy Minister for Justice could have been held to account. If the Scottish Government genuinely wants to engage with us on the issue, the minister must provide more detail on how he will progress what was a pre-election commitment to provide an additional 20 per cent to the drugs budget. Another commitment was to restore ring-fenced funding for drugs education. We are entitled to have a robust and honest debate, and the minister should answer our questions if he wants to make a difference for the people of Scotland.

Margo MacDonald: I believe that progress should be monitored, along with how the public pound is spent. If we are to have a more sophisticated evaluation of the services provided, as the minister described, how does the member propose to identify a new type of target?

Paul Martin: The word "outcome" is very serious, but we should be clear that we want to set targets and we should not fear setting targets. We need to set a clear agenda and all those who have a responsibility to tackle the issue should show leadership and ensure that clear targets are set.

The previous Executive was also responsible for establishing the Scottish Drug Enforcement Agency, which was set up with a clear emphasis on disrupting the supply of drugs in our community. That was our manifesto commitment in 1999. We wanted not only to tackle the major drug dealers but to deal with the local network of small dealers who feather the nests of the crime bosses. The Labour Party demands more information—it is not in the strategy—on how the Scottish Government will deal with local drug dealers. Local drug dealers are the scourge of every community throughout Scotland; they prey on our communities. The Government should learn from the success of the drug dealers don't care campaign, which was backed up by real outcomes: more than 600 drug dealers were arrested as a result of calls to a hotline and more than £1.5 million-worth of drugs and £61,000 in cash were recovered.

I do not see the minister on his feet to intervene. It was clear from the 430 per cent increase in calls to Crimestoppers that local people were empowered. I see nothing in the strategy that takes us any further forward in disrupting the supply of drugs and in addressing how we should encourage local communities to stand up to drug dealers. Drug dealers do not care about our local communities and the Government strategy should say that clearly.

On public information, the strategy refers to the further development of the know the score campaign, which will result in a leaflet being delivered to every household in Scotland. The Labour Party sees no harm in sending a leaflet to every household, but we find it difficult to see how that will excite and enthuse the communities that are affected by drugs. Not through choice, many parents are already aware of the drugs issue. It is what we do about the dealers that matters to those parents.

Real innovation would be about how we promote alternative, healthy lifestyles throughout our communities in Scotland. Has the minister thought about how we can use the Glasgow Commonwealth games as a catalyst for promoting and encouraging healthy lifestyles? Young people all too often see considerable media coverage being given to so-called celebrities such as Amy Winehouse and the supermodel Kate Moss. They do not send a positive message to young people. Why do we not use our sports personalities to promote a positive lifestyle? We believe that that would make a genuine difference.

The Labour Party appreciates that we face many challenges on this issue and on many related issues. We call on the Government to take the serious steps that are required to ensure that it effectively resources efforts and projects to deal with the issue.

Our amendment is clear. We call for additional resources to deal with the issue and for clear targets to be set to ensure that we make a difference. Let us also reflect on previous debates that have taken place on the issue. There was consensus in the debates in January and May 2000, but it is clear that the challenge that faces the Government is to ensure that we act and take the message forward.

I move amendment S3M-2038.2, to insert at end:

"acknowledges the efforts of all those engaged in drug misuse services; recognises that the strategy identifies the need for broader treatment services and wrap-around care for drug users to move beyond stabilisation; believes that the strategy should provide detail on targets on a range of indicators so that progress can be monitored; strongly believes that there should be a clear and identifiable increase in funding in the justice and health budgets, and further strongly believes that there should be a continuing focus on enforcement against all drug dealers and that communities most blighted by drugs will benefit from the proceeds of crime legislation."

15:39

Annabel Goldie (West of Scotland) (Con): It is with pleasure and a sense of hope that I speak in the debate.

In previous debates on drug abuse in Scotland, although I had no doubt about the sincerity of the

speeches, I always felt a sense of frustration and dismay that the debates seemed to be characterised by an attitude of managing the problem rather than trying to bring forward solutions to the problem. Indeed, when I look back at a debate in the Parliament in November 2002, I recall that my party was roundly criticised for suggesting that, although intentions were good, what was happening in practice was clearly not implementing the good intentions.

What was clear then was that there was an absence of any universal national strategy for dealing with drug abuse in Scotland and an over-reliance on harm reduction—something that I think is now not disputed. I remember saying in another debate that harm reduction had become the predominant response to drug abuse. It meant that many methadone patients were parked on methadone—they were in a cul-de-sac. We were not looking with sufficient urgency at a range of options, including rehabilitation, to try to get people off addictive substances; rather, we were concentrating effort on a state-funded continuance of addiction.

One of the early challenges was the lack of information held centrally. At times, it was impossible to get basic facts. Much information was patchy, incomplete or anecdotal. I pay tribute publicly to Professor Neil McKeganey of the University of Glasgow, who with his research both added significantly to the information bank and brought out into the open the fact that more than half of methadone patients wanted to get off drugs altogether. Professor McKeganey's research also exposed the myth that most people on methadone stop using illegally. Every drug addict whom I have encountered has confirmed that, although they were mainly on methadone, initially they continued to use illegally.

We knew that all around us drug misuse was like a contagion, raging through every community in Scotland. Drug-related deaths were increasing, instead of reducing, and our courts and children's hearings were experiencing increasing evidence of drug abuse in the people who appeared before them. Tragically, our children's hearings showed that some parents and carers—and distressingly, some young people—were affected.

Johann Lamont: Will the member take an intervention?

Annabel Goldie: I am sorry, but I cannot give way. I seek the indulgence of the chamber—the debate is very short, and I want to say what I have to say.

The statistics confirmed that, whatever good intentions were present—I do not doubt that they were—the situation was getting worse, not better. Against that backdrop, as I travelled around Scotland, I found it astonishing that many charitable and voluntary rehabilitation facilities had spare capacity. They could help and wanted to help, but they did not seem to be allowed to provide help because they did not fit into the official structure. I am immensely encouraged by the fact that in the new strategy there is a visible change in political thinking, which has taken us from a cul-de-sac on to a road to recovery. That road will be challenging and in places very rocky, but at least we are on it. I commend the Minister for Community Safety for embarking on that journey and hope that everyone in the Parliament will support it.

People should not be precipitate in demanding detail on the new strategy that cannot be provided at this stage. What matters is that we should all sign up to the new direction towards recovery and allow the Audit Scotland inquiry that my party insisted was an essential component of any new strategy to take place. Vast amounts of money are currently spent through multiple channels with the intention of dealing with drug abuse, but we do not know how much is spent, where and to what effect. It is imperative that those questions are answered, with the publication of the Audit Scotland report early next year, before we rush to judgment on how the strategy will be implemented in detail. I listened carefully to what Paul Martin said but, for the reasons that I have just articulated, I consider the Labour amendment to be premature.

I am pleased that the strategy has been informed by input from diverse groups, organisations and individuals who have direct experience of dealing with drug abuse in Scotland and whose contribution has been allowed to influence the way forward. For too long, many of those people were not listened to. I thank the Scottish Government for having the political courage not just to invite their contributions but to be prepared to listen to what they had to say.

Nowhere is the malign extent of drug abuse more obvious than in our prisons. My colleague Bill Aitken will speak about that issue, including the Pennsylvanian model, in greater detail, so I will say just that it is folly for us to think that we cannot learn from others. It is now universally accepted that there is an appalling problem of drug abuse in Scottish prisons, so I urge the Parliament to look elsewhere—in particular, to the experience of Pennsylvania—to see what others have done. I do not ask the Scottish Government to follow that model to the letter—some aspects may not be competent to the Parliament or competent in our law—but I ask it at least to look at the model, given the dramatic success that has been achieved in Pennsylvanian prisons, to see how much of that success we can translate to Scottish prisons.

I am both encouraged and reassured by the minister's response to the amendment in my name. In light of his comments and the undertaking that he has given, I shall not move the amendment. It is better that we should all go forward with a general sense of progress than that we should not go forward at all.

15:44

Margaret Smith (Edinburgh West) (LD): I welcome the opportunity to speak in this important debate. I thank the minister for the inclusive way in which he has taken the matter forward over recent months and I was pleased that the Government recognised the importance of seeking a wide range of views and taking them on board in the drugs strategy that it published.

There is genuine recognition around the chamber of the tragic scale of the drugs problem. I hope that no one will be tempted to suggest that there are any easy answers to the problems of drug misuse. The Liberal Democrats have consistently taken the view that it is an holistic problem that can be addressed only with properly resourced holistic solutions.

In summing up, Ross Finnie, our health spokesperson, will dwell more on the health impacts. As justice spokesperson, I see drugs and alcohol as one of the biggest criminal justice issues facing our country. If we deal with the drugs and alcohol issue effectively, we will see a reduction in crime and improvements in the quality of life in Scotland's communities, including Scotland's jails. Having discussed with the chief inspector of prisons the lengths to which inmates and prison visitors go to take drugs into prison and the impact that that trade has on life inside, I am clear that it is a key area for action. I welcome Annabel Goldie's comments, which describe the reasonable approach that she takes to the matter. We would not have felt able to support the Tory amendment because it is prescriptive and needed more work, but we support the sentiments behind it.

Drug-related deaths are at a record high and the impact of drugs on crime is significant, with 70 per cent of court cases involving drugs in some shape or form. Our amendment makes it clear that the resources need to be in place to fight drug misuse. Those resources are needed across the board. The Audit Scotland report will be useful in identifying not only where money is being spent but where it is being spent effectively and, therefore, where there should be increased funding in future. That should be the basis on which we build.

Liberal Democrats believe that the individual should be at the heart of tackling misuse. The drugs strategy rightly advocates a person-centred approach and focuses on recovery, treatment and on-going support for problem drug users. Some individuals will benefit from being on methadone, some will benefit from an abstinence approach, and some will benefit from crisis or short-stay rehabilitation. Whichever approach is right for the individual, it is right that recovery is the ultimate goal.

Early intervention is vital to reduce the demand for drugs and to educate young people about the dangers of drugs and their impacts. We must ensure that teachers are supported so that they can successfully deliver drugs education. It is also crucial to involve families in that education process, so we welcome the fact that every family will be sent an information leaflet. We need to identify those children at risk from drug misuse in their homes and to target them particularly because they are potentially at greater risk of misusing drugs themselves.

Early intervention also means giving young people the opportunities in life that will lead them away from drug misuse. It would be wrong to say that drugs affect only a particular social group of people, but investing in community regeneration, sporting facilities, education and skills and providing opportunities for training and employment as a route out of poverty will help to reduce drug misuse.

I was pleased to note the Scottish Government's acceptance of the benefits of a roll-out of drug treatment and testing orders to district courts. DTTOs have been shown to have a significant impact on reoffending rates and users' spending on drugs. A case can be made for a national roll-out of drugs courts, so we welcome the Government's commitment to analyse the pilots as a first step. However, it is also vital to ensure that drugs support services are equally available to problem drug users who have not committed any crimes. To act otherwise would be perverse.

I welcome the report's recommendation that the Government should not seek to disparage particular treatments or seek to second-guess clinicians. I welcome the minister's recognition of the role that methadone has to play in the treatment of heroin addicts. The real achievement of getting heroin users to commit to a programme of methadone and a more structured lifestyle should not be diminished by political agendas. Although recovery must be the ultimate goal, harm reduction must not be seen as dirty words or as some sort of failure along the way. I have dealt with constituents who are managing to care for their families, hold down jobs and run their businesses thanks to that very programme.

I wonder whether the minister can answer the question that I asked last week about what

changes there will be as a result of the strategy for those on the methadone programme. Will time limits be set for that form of treatment, or will those sorts of decisions remain with general practitioners? It is vital to support problem drug users to rebuild their lives following treatment by providing access to affordable housing, training and employment, and regular health services, whether after rehabilitation or a period in prison.

Reducing demand is a key element of tackling Scotland's drugs problems, as I outlined, but we should always be working to cut supply. Progress has been made in the confiscation of assets, and I hope that the Government will ensure that the Scottish Crime and Drug Enforcement Agency and the Crown Office have proper resourcing for the forensic accountants and others who are needed to pursue the drug dealers.

We have sympathy with the view that there is a need for strategic targets and indicators so that progress can be monitored, but we must ensure that targets do not have a perverse impact. I believe that, on balance, having something against which we can measure the Government's progress on this important issue and in promoting recovery would be useful for both the public and the Parliament. Will the minister, in winding up the debate, give us further information on how the Government envisages that being dealt with in the single outcome agreements? What input will health boards have on those agreements?

It is also important that we know exactly how much money is being spent. Is the £94 million to which the motion refers an increase of more than 14 per cent, which is what the minister said, rather than the 20 per cent that was promised in the Scottish National Party manifesto? The minister may point to the 3.8 per cent for health boards. Will he confirm that that represents new money? We need clarity.

The Liberal Democrats have worked constructively with the SNP Government on the issue to date and are happy to do so in the future and to support the Government's motion this afternoon.

I move amendment S3M-2038.3, after

"action set out in the strategy"

to insert:

"and calls on the Scottish Government to provide the leadership and resources necessary".

15:51

Kenneth Gibson (Cunninghame North) (SNP): The issue of drugs is one of the most challenging problems facing Scotland.

We all know the terrible blight that drug addiction has on our communities, destroying individual lives, families and neighbourhoods. The new strategy that the Scottish Government has set out is bold and ambitious. Such a radical approach is needed if the issue is to be tackled effectively.

Successive Governments at Scottish and United Kingdom level have wrestled with the problem, with laudable and well-meaning intentions. The reality is that the fight against drugs has not yet been won, so we cannot continue down the same path.

The Scottish Government's shift away from harm reduction towards a greater emphasis on recovery is the right strategy for Scotland, given the failure of previous campaigns. For too long, it has been too easy to park heroin addicts on methadone indefinitely. We all know why it was so easy. It stabilised addicts' lives by removing the need to engage in criminal activity to feed their habit, and it protected them from the danger of sharing needles.

However, we know from evidence-based research conducted by Neil McKeganey, who is professor of drug misuse research at the University of Glasgow, that giving methadone to heroin addicts has a 97 per cent failure rate. Three years after receiving methadone, only 3 per cent of addicts remained totally drug-free. In stark contrast, the same study showed that there was a 29 per cent success rate among addicts who went cold turkey in a rehabilitation centre.

Shockingly, that shows that, in terms of recovery, methadone use is only marginally better than doing nothing at all. For a programme that is so expensive and with the number of addicts receiving methadone quadrupling in a decade to 22,000, including 714 in North Ayrshire, that is simply not good enough—not when we know that rehabilitation centres have 10 times the success rate and that 97 people died as a result of methadone in 2006.

That is not the end of the story. Professor McKeganey's research also spelled out the wider social benefits of people coming off drugs. Those free of addiction are seven times less likely to commit crimes than are addicts and far more likely to be in work or education.

Just to be clear, no one is suggesting that methadone does not have a place in drug treatment. Of course it does and will continue to do so, in accordance with the so-called orange guidelines. However, the ultimate goal must be recovery and for addicts to be drug free. Parking people on methadone does not do that. It simply stabilises the illness but does not cure the patient. In a way, it is like putting an alcoholic on half a bottle of whisky a day. It is time to be more ambitious—the addicts themselves deserve more.

Margo MacDonald: Will the member give way?

Kenneth Gibson: I would love to, but I am afraid that I have little time left.

We owe the move in emphasis away from harm reduction towards recovery to those who are held fast in the grip of addiction, and we owe it to their children. As many as 60,000 children in Scotland are thought to live in a family where there is drug abuse. I applaud the recognition of that in the Government's early years strategy. Part of the work is the improved drugs education programme to be rolled out both inside and outside schools, with £10 million already announced for drugs education.

Parents must also be involved in the education programme if children are to be protected from the scourge of addiction. Earlier this year, I pressed the minister to provide booklets to every Scottish family to help to educate parents, in particular on drug facts, having as a councillor delivered such a booklet to every home in my ward. I am therefore delighted that the minister has taken up the suggestion and that the publication "drugs: what every parent should know" will be distributed to every family in Scotland, with the aim of informing parents as they try to discuss this difficult issue with their children. I realise that Paul Martin was not enthused by that but, as someone who has delivered such leaflets and discussed the situation with parents, I know that they can have considerable importance in educating parents.

The Government's efforts to strengthen the Proceeds of Crime Act 2002, which helps to prevent criminals from benefiting from their ill-gotten gains by confiscating their assets, are a further positive step, with seized assets being used in the front-line fight against those who stalk our streets peddling drugs. That will, of course, be further reinforced by the fact that there will be an additional 1,000 police officers in place by 2011.

I am optimistic that Scotland can win the long, hard fight against drugs, which is one which every MSP can back. I urge all members to support the Government's vision and motion.

15:55

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I begin by referring members to the declaration in my register of interests on the work that I continue to do for the Edinburgh alcohol and drug action team on the single shared assessment.

No member can take issue with the direction of travel that is embodied in the strategy. Obviously, recovery is important, but the clear message that the Parliament must send out is that recovery is not as Kenny Gibson has just described it. What he proposed is entirely the wrong message for the Parliament to send out. The message that the minister is carefully trying to give is that recovery is about a staged and progressive "movement and dynamism" from a situation of chaos that probably includes criminal activity and damage to family, children and relationships towards—yes, perhaps—the ultimate ambition of being drug free. However, the constant opposition to harm reduction and recovery is damaging to the people who deliver drug services, to users and to communities. That cannot be the Government's intention; I am sure that it is not.

In 2001, when I was in Fergus Ewing's position, I looked at the integration of services. The effective interventions unit produced a good statement on the integration of silo services. Service integration is fundamental to the delivery of recovery projects, however they are defined, yet we do not yet have service integration out there.

In 2001, we produced the report "Moving On: Education, training and employment for recovering drug users", which my successor updated in 2003. Today, many addicts are stabilised on methadone and yet do not have the opportunity to get into education or skills training because the services are not there for them. Indeed, when I was out of the Parliament for four years and working as the lead clinician for addictions in West Lothian, the first service that was cut by the otherwise excellent local authority and health board was the moving on service. The clients whom I was seeing at the time and who I was stabilising on methadone could not get on to that vital programme—that route to recovery.

Getting people on to the road to recovery takes resources. In our amendment, Labour is saying that the resources that the minister has indicated thus far are not sufficient to do the job that we all want to see done.

Margo MacDonald: Will the member give way?

Dr Simpson: I am sorry, but my time is too short for that. I regret that the time for the debate had to be cut. I think that all members are finding that difficult. Perhaps we should return, sooner rather than later, to the subject in a further chamber debate.

Other members mentioned training, which is a fundamental aspect of the debate. When I was in office, we set up the Scottish training on drugs and alcohol—STRADA—partnership, which continues to receive support as we move forward.

I do not have time to go into the whole area of criminal justice. I say to the minister in a friendly way that, back in 2001, I wanted the roll-out of drug treatment and testing orders to happen immediately, yet the final roll-out did not happen until 2005. It takes time to deliver. Labour

members recognise that, but ministers need to set outcome targets—however general they are. Such targets need to be put in place, or service providers in the community, particularly the ADATs, will not be held to account in their application of the resources that they have to deliver the strategy that we all want to see.

I have a question for the minister from the Royal College of General Practitioners. The college says that the methadone programme, which is the most evidenced drugs programme, has to continue. It asks him to confirm that, as a result of his statement on "The Road to Recovery", no one will be forced to come off methadone and that reductions will never be made without patients' knowledge. I seek a guarantee from the minister that the responsibility of clinicians in that situation will be retained.

Harm reduction and recovery are not two opposites. As we read in the excellent "Essential Care" report, harm reduction and recovery are part of a continuum. That is the message that should go out from the Parliament today.

15:59

Bill Aitken (Glasgow) (Con): I listened with interest to what Dr Simpson said. The issue is complex, but we must not forget how unmonitored harm reduction led us into a most critical situation. Of course methadone has a place and is one of the available tools to contain a problem, but the largely unmonitored situation was simply not acceptable.

I turn to enforcement. Several years ago—I think that it was in 2001—accompanied by other members, some of whom may be present, I visited Barlinnie prison in Glasgow. There I saw a unit to which prisoners could volunteer to go to remain off drugs. I thought that that was bizarre. The individuals were definitely making a sincere effort, but what a condemnation of the system it is that, to stay clean, prisoners had to volunteer to go into a closed unit. We must examine closely the reasons why drugs seem to be freely available in our prisons. I am not convinced that all possible appropriate efforts to prevent drugs from getting into prisons have as yet been exhausted.

As I said recently in correspondence with the minister, the degree of ingenuity that individuals demonstrate in getting drugs into our institutions would be almost praiseworthy if it were used in more constructive directions. However, people in custody should be given every opportunity to stay off drugs. Accordingly, we need to look around to see where solutions have been forthcoming. As Annabel Goldie said, we should not be inhibited about looking abroad. The Pennsylvania project undoubtedly produced the result that we all seek in Scotland. It reduced the level of drug use in prisons so that only between 1 and 2 per cent of prisoners showed the effects of drugs.

The project was many faceted. Sophisticated investigatory techniques were introduced, using all sorts of technology, all of which are available to us. We use dogs to an extent in Scotland, but their use in the Pennsylvania project was remarkably successful. Part of the project was to make it clear that it was totally and utterly unacceptable for drugs to be introduced to prisons. We have not been nearly hard enough in that respect. When someone visits a prisoner who seeks to fight an addiction, they certainly do them no favours by smuggling drugs into the jail. Those who do so need to face the consequences.

Margo MacDonald: Will the member take an intervention?

Bill Aitken: I apologise for not taking interventions, but the debate is far too tight. Members will acknowledge that I am usually fairly generous in that respect.

The project in Pennsylvania definitely worked. In many respects, Pennsylvania is not totally different from Scotland—it has many of the social difficulties that have been evidenced here over the years, so we should consider that example. I accept that the Government has not had sufficient time since we lodged our amendment to carry out the appropriate research, but I am reassured by the minister's comment that the Government will consider the project, which is worth while.

The other aspect of enforcement that we must address relates to those who peddle in human misery. Paul Martin referred to such people. We must tackle the many-headed hydra by taking out the big heads—the Mr Bigs, who are prepared to make fortunes at the expense of many people. I am attracted by the system in southern Ireland. The Irish Government has a much more rigorous approach to the confiscation of assets than we have. We must consider that seriously. I have examined the issue in detail and believe that we should not be inhibited in adopting that approach in Scotland.

The debate is constructive. We are making progress and we must now see what develops and make things happen.

16:04

Stuart McMillan (West of Scotland) (SNP): I, too, would like to thank the Minister for Community Safety for his statement last week launching the Government's strategy, "The Road to Recovery". I thank him not only as a citizen who is concerned about the increasing drugs problem in Scotland, but as a parent. On behalf of all who have seen

loved ones succumb to the traumatic lifestyle associated with drugs, I also thank the Government for promoting its strategy.

As the minister has pointed out, 421 people in Scotland lost their lives to drugs in 2006. That number is not only worrying but a sad reflection of the society in which we live. Add to that the estimated 52,000 people with drug problems, and the 46,000 children who, not through choice, are affected by parental drug use, and we have a seriously distressing situation.

In 1995, everyone was shocked at the images of 18-year-old Leah Betts in hospital, attached to a life-support machine and fighting for her life, after taking ecstasy. In 2002, her parents—Paul, an ex-police officer, and Janet, a nurse—and her younger brother undertook a tour of schools in Scotland, telling the story of the time following Leah's death. However, there are not enough members of the Betts family to go round every pupil in Scotland to warn them of the dangers of drugs. That is why a comprehensive educational programme is vital to saving lives. It should not be up to the families of drugs victims to educate our young people on the issue.

Sadly, the cost of drugs is measured not only in lives but in the size of the burden on Scotland's finances. An estimated £2.6 billion a year is the cost of Scotland's drug problem. That equates to £238 a week to feed a heroin addiction.

The strategy focuses on assisting drug users in their aim of living a drug-free life. As has been said throughout today's debate, we should not underestimate the immense task that those people face. Therefore, it is imperative that we support the Government's move to provide resources and support to people faced with that situation.

Before the election last year, I visited the haven project in Kilmacolm; and earlier this year, I visited the moving on project in Greenock. The projects are totally different, but their ultimate aim is to ensure that people get off drugs, thus making their lives a lot better, and making the life of the community a bit better as well.

I am delighted that we have the support of the Tories on the issue of rehabilitation; I am also delighted that Margaret Smith has said that the Lib Dems will back the Government's motion.

Some members have already spoken about methadone. Methadone does not lead to recovery for the majority of users; 90 per cent of addicts are still taking methadone after five years. However, methadone still has an important role in helping to stabilise people, as the moving on project in Greenock has shown.

If we look at the figures, we see that only 3 per cent of methadone users are completely clean after three years, compared with 30 per cent of those treated in rehab, so the benefits of focusing on rehabilitation are obvious.

The road to recovery for drug users is difficult and must be taken in small steps. I am pleased that the SNP Government strategy is starting off on that journey for a healthier Scotland—and for a Scotland that is prepared to take a new approach to tackling the drugs menace that our communities face.

16:08

Duncan McNeil (Greenock and Inverclyde) (Lab): Today's debate has been constructive. Who among us would disagree with the scale of the drugs problem in Scotland and the scale of the chaos that it brings to the lives of individual users, their families and people in the community at large? Who would disagree that people who face inequality and exclusion are more likely to abuse alcohol or drugs? Who would disagree with a strategy that has, at its heart, the ambition to move us on from harm reduction and towards recovery? I certainly would not.

Who could possibly disagree with the objective of giving young people the knowledge and support that will ensure that they can make better choices, or disagree with acknowledging that parents and the wider family have an important role in the preventive strategy?

In the chamber last week, we heard the minister saying that the Government does not condone or promote the use of any illegal drug. However, if the consensus that exists this week and that we had last week is to go beyond the chamber, we would like to hear the minister condemn a little more the drug-abusing lifestyle, which cannot be an excuse or justification for criminality, antisocial behaviour or violence in our communities, which are themselves innocent victims of a drug culture and drug dealing.

The strategy looks to recovery. We have high hopes for that, but not much has been said in the debate about the fact that with the strategy comes a recognition that some people choose to take drugs and enjoy them, and that some drug users, perhaps the majority, will remain on methadone for a very long time indeed, if they ever come off it.

We need to acknowledge that under this strategy, smoking drugs is moving on from injecting drugs. Residential rehabilitation has poor rates of return at the moment, and those rates must improve if we are to see any significant improvement in the problem.

If the significant problem of drug addiction continues to be with us, all the negative impacts on society will also continue. Tom Wood, until

recently chair of the Scottish Association of Alcohol and Drug Action Teams, said in evidence to the Parliament's Health and Sport Committee:

"If we are ever to get ahead of the problem … We need to invest in young people and families. We need to invest in the unborn and young children who are in an environment in which there are alcohol or drug-dependent people, instead of pouring lots of money into lost causes."—[*Official Report*, *Health and Sport Committee*, 14 November 2007; c 162.]

I will need to cut my speech because we are pressed for time. On 9 August last year, the Minister for Children and Early Years said in a written answer that the needs of children at risk were being discussed, identified and met. On 6 September 2007, the Cabinet Secretary for Justice advised me that he was discussing children at risk with his Cabinet colleagues. On 27 September, he assured me in the chamber that those discussions had indeed taken place. On 25 November, the Minister for Children and Early Years told me in a letter on behalf of his ministerial colleagues that

"ministers are driving progress on this important and complex agenda."

That was not evident, I am afraid, in the minister's statement to Parliament last week. If we are driving forward this agenda, we need to get more action and maybe just a little less consensus.

The Deputy Presiding Officer (Alasdair Morgan): I call Brian Adam, to be followed by Cathy Jamieson. Sorry, I call Jamie Stone, to be followed by Brian Adam—my apologies.

16:12

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): You had me worried there, Presiding Officer. For that reason, I shall be brief and give you extra time.

I want to bring a remote and rural perspective to the debate. It would be easy to think that in a beautiful, vast and far-flung constituency such as mine, amidst the straths and the hills, the drug menace does not face us—but it does. I wish to make two points, but first I want to pick up on comments that my colleague Margaret Smith made. She said that resources need to be spread "across the board" and that we need "a person-centred approach". She also referred to every family being sent an information leaflet.

The thought that occurs to me, my constituents and those who are knowledgeable about the drug problem in Caithness and Easter Ross is that it is well and good to send every family a leaflet—that is to be commended—but outreach to families across great distances is a hard issue to deal with indeed. Margaret Smith rightly talked about resources being needed across the board; I believe that that board is a geographic board, which the minister, representing the constituency that he does, will acknowledge, and that presents a challenge that must be addressed, because if there is to be a person-centred approach, it must be about outreach. Therefore, I warmly welcome the motion, which my party supports, but with the caveat that the resources must be there to tackle the problem. The minister is nodding so I see that he acknowledges that.

I quote Councillor Graeme Smith from Wick, the vice-convener of the Caithness drug and alcohol forum, who said:

"Centres with experts in cities like Inverness are all very good, indeed they are essential, but to properly respond to rural and smaller town drug abuse we must have a far more robust rural outreach programme. More innovative ways of connecting with the substance mis-users must be found. More resource is required to deal with mis-use issues in rural areas. Substance mis-users are often dysfunctional in some respect and need easy access to help. This is not often found in areas of low population density."

It is not possible to put it more eloquently than that.

I echo the points that have been made about education. Paul Martin was the first member after the minister to mention it—he talked about ring fencing funding for drugs education—and our colleague Mr McMillan mentioned it as well. Of all the pillars of society's approach to drugs, education and communication can have a permanent effect. Policing and treatment are essentially reactive; education can be truly proactive. It remains the case that prevention is better than cure.

Dr Simpson: Will Jamie Stone give way?

Jamie Stone: I am sorry, but I do not have time.

I find it astonishing that parents like me and people in general throughout Scotland remain ignorant of drugs. The failure to recognise arising problems in children or colleagues is there for one to see. Education, not only for children in schools but across the board, will help with that.

I will conclude with those remarks, unless Dr Simpson wants to make an intervention at this stage. I could take one, I guess.

Dr Simpson: Has Jamie Stone talked to the Highland youth council about its response to the education programme that became compulsory under my watch? He might find that interesting. The issue is not only education but how we deliver it and the quality of it.

Jamie Stone: I take note of those remarks.

16:16

Brian Adam (Aberdeen North) (SNP): I will ask the minister what might be a hard question: what reduction have we had in drug-related crime as a

consequence of the significant rise in the number of people on methadone in the past two or three years? The number of people on methadone has gone up from around 16,000 to around 20,000; if the argument that methadone treatment reduces harm to society is correct—I believe that, broadly speaking, it is—we should have seen a significant reduction in drug-related crime as the numbers of people on it have increased. The minister might not be in a position to give a definitive answer on that today, but I would be happy enough if he wrote to me.

Part of the debate and one of the differences between the parties—which I hope are subtle rather than substantive—is how one measures whether the drugs strategy is successful or otherwise. Milestones and targets have a place, but we really want to know what will happen at the end of the journey—what the outcomes are. Some of the other events that we may wish to measure and in which we may have an interest are merely staging posts on the way there.

In my neck of the woods, the number of people waiting to get drugs treatment was ridiculously high. At one time, Aberdeen had 800 or 1,200 people on waiting lists, but I am delighted to say that, in the past quarter or so, the number has dropped from 780 to 640. Something positive has happened there.

Margo MacDonald: Will Brian Adam give way and explain why?

Brian Adam: If I can complete this part of my speech, I will try to let Margo MacDonald in.

The overall journey needs to be integrated. We can get people on treatment and they may remain on it, but how we get them out at the other end presents problems. My colleague, Stuart McMillan, talked about moving on, as did Dr Simpson. I have had some correspondence today about progress to work, which is also about moving people on. It is a Department of Work and Pensions programme, and the Aberdeen joint alcohol and drugs action team has about 100 people on it. However, because more people are now going into treatment, there is a need to get more folk on the programme. That highlights the difficulty with setting targets—the unintended consequences of measurements and how we assess success—to which the minister has referred.

If appropriate provision is not made, we will not reach the recovery stage. To get to the recovery stage, we must also have the treatment stage. We need to have an integrated approach and I would be delighted to hear ministers address how we will deal with programmes such as progress to work in Aberdeen, which is not delivering as much as it could, and how we will engage with our counterparts elsewhere to achieve that.

16:20

Cathy Jamieson (Carrick, Cumnock and Doon Valley) (Lab): As we have heard during the course of the debate so far, there is no argument with the idea of moving towards recovery and aiming for people to have drug-free lives. However, we need to be honest about the challenges. Ultimately, we are dealing with the behaviour of individuals, and individuals need to take some responsibility for change.

As we have also heard today, parents will have worries and concerns. For parents living in the areas that are most blighted by drug misuse, those concerns are amplified. In those areas, parents see the dealers plying their trade on a daily basis. People in those communities find it hard to understand why that continues. They perhaps think that the authorities are turning a blind eye, which is why the drug dealers don't care campaign was so important in sending a message to communities that we are on their side in trying to stop the drug dealing happening, cleaning up the streets and demonstrating that drug dealing does not pay.

Drug misuse does not just hit some areas; it happens across all communities. Irrespective of whether people are well off or on low incomes, having a serious drug-misuser in the family can bring stigma, loss of property and untold damage to family relationships. I have met families who have been so desperate that they have spent their life savings or borrowed money to pay for treatment. Some families have come under so much pressure from the user that they have borrowed cash to feed his or her habit or have put themselves outside the law to get the drugs that the user needs if there is a crisis and if they cannot get quick access to a detox facility.

Community treatment will be suitable for some, but I hope that assessments will take account of the impact on family support. If we want a long-term treatment plan—a road to recovery—we must support the family in a way that makes sense for them. There is no one-size-fits-all solution. Sometimes, the support that families need is not necessarily the same as what the plethora of professionals will want for them. Sometimes, that means using a residential facility, largely to give the family respite and to let them regain the strength to cope, and also to bring the drug user back into the community.

Helplines and leaflets are useful, but I would say as gently as I can that, when the crisis point is reached, the father whose son or daughter is the latest overdose victim lying on the floor in front of him, the mother whose housekeeping money has been stolen and spent on drugs for the third or fourth week in a row, the brother or sister who has been physically and verbally lambasted by the

drug user to get them money for their next fix or the grandparent who has to step in and stop the children getting neglected need practical help from people who understand the problem that they face, who will not judge them at the point of crisis and who will focus their attention on getting the drug-using person into treatment. I worry about the apparent lack of a target for getting people in at the front end. If we do not get people into treatment programmes at the front end, we will certainly not get them out the other end.

I hope that, when he sums up, the minister will identify how the strategy will support those families who are in crisis at that key moment when they need access to treatment. Will every area have a 24-hour helpline, with access to on-call out-of-hours support? What will be done to continue to tackle waiting lists—a point that Brian Adam made—and access to treatment? What specific action will be taken to ensure that residential places are available in all areas, or are at least accessible from all areas, and that there is no continuation of postcode-based provision? To follow on from the point that Annabel Goldie made, will all facilities be considered for use as part of the process?

I hope that the minister can address those points, as well as the points that have been made about kinship care. As Duncan McNeil has said, we expected more in the follow-up from the "Hidden Harm" report. I certainly did not expect grandparents who are involved with children who are on court orders to be excluded from the possibility of getting financial support, as seems to have happened.

16:24

Ian McKee (Lothians) (SNP): The thrust of the motion is that we should depend less on a drug treatment policy that relies on maintenance—on prescribing a substitute such as methadone more or less indefinitely in order to introduce some sort of stability into a person's life—and instead explore ways of curing the drug user of his or her habit and expanding greatly the facilities for drug withdrawal and rehabilitation, so that a person is free of the tyranny of drugs for ever. One cannot deny that that definition of recovery is an attractive philosophy. However, my concern is that there is a slight degree of wishful thinking in it and that we risk ignoring the reality that lies before us.

I have many years' experience of looking after people with a drug problem. That does not guarantee that I can come up with all the right ideas on how to proceed, because there is always the possibility that I have been so close to the problem that I cannot see the wood for the trees. However, I know that people interact with drugs in many ways and for many reasons. Some people use drugs recreationally. Many can cope perfectly well with their chosen lifestyle and enjoy the experience. However, some become addicted. With help and determination, they can become drug free, in the same way that some people with an alcohol problem can be helped, and they can go back into society and live normal lives.

There are others, who are mainly living impoverished lives in less than adequate social and economic circumstances, for whom the future is not so positive. Many can be identified before they are born—they can certainly be identified in the early years of childhood. They form the great bulk of the 200 to 250 drug users whom my practice looked after in the year that I retired. Given that they are emotionally, educationally and financially disadvantaged, they turn to drugs for a variety of complex reasons. Unless we can somehow change their entire circumstances, their total and permanent withdrawal from drugs will be impossible. Any attempt by others to force the pace of withdrawal, however gentle, is almost always doomed to failure. I know that, because I tried it many times in the early days without success. That is why the use of the word "targets" in the Labour amendment causes me concern.

I never met a person who wanted to stay on drugs for ever and I believed their sentiments to be genuine, but when life off drugs is to be the same as it was before drugs, life on drugs sometimes seems the more favourable option. How do we tackle that? A recent television programme that extolled the benefits of residential care in helping people to come off drugs featured an interview with a young man who was one of its successes. He came from a Scottish housing estate, but, on leaving the home, he said that he was emigrating to England, because his only chance of staying off drugs was to leave his former community behind.

We cannot export all our recovered drug users to England. Giving them houses, training and jobs is fine, but what message does that send to people who are not on drugs? Does it send the message that taking drugs is their best chance of a new house and a new job? We will reduce dramatically the number of drug takers only when we correct the factors that lead to drug taking in the first place and treat communities. Until then, it will be a long haul. Maintenance treatment, with not just methadone but other preparations such as suboxone, will still have an important role. Complex problems do not succumb to simple solutions. However, I am pleased that the Government has at least turned its attention to the subject.

16:28

Johann Lamont (Glasgow Pollok) (Lab): I welcome the opportunity to contribute to this serious debate. It is important to build consensus, but it is simply wrong to suggest that that has not been done in the past, because there is huge evidence that it has been done.

The Minister for Community Safety said in his statement to the Parliament last week that there was a concern because of the terrible health inequalities that afflict Scotland. Of course, the bigger challenge is the inequalities that exist within Scotland. We know that many young people experiment with drugs, but the reality is that communities that experience disadvantage and deprivation lose their children to drugs and the accompanying death toll disproportionately. Those communities understand that. Yes, we have to have a person-centred approach, but we also have to have a community-centred approach. We cannot simply say that that is what happens in such communities; we must listen to people in those communities who suffer as a consequence of drugs being taken and we must take account of the impact on the broader community. Regardless of whether people in those communities take drugs themselves, they see the impact on their schools, health centres and the very fabric of their neighbourhoods. The life chances of their children can be determined by our inability to address the consequence of drugs. It is therefore important for the minister to reaffirm that the Scottish index of multiple deprivation will remain a key driver in distributing resources across a range of services in order properly to meet need.

Of course, there are always those who wish to create the impression that the debate around drugs is somehow about opposites—that it is either maintenance or abstinence—but I acknowledge that the minister confirmed that the Government's strategy does not seek to come down on one side or the other in that way. However, I believe that talking about targets drives action by those who are charged with the responsibility for supporting people who have a drug problem. In that regard, will the minister consider setting one target in particular, on the level of methadone use? Does he accept that meeting such a target would indicate the success of the strategy?

There are huge challenges around the issue of hidden harm. It is a scandal that the torch is shone on the lives that some of our children live only by those who are raising issues about antisocial behaviour in their communities. Only then do we learn about some of the experiences that too many of our children have, and that is wrong. We have a strategy for young carers, but we do not say often enough that too many of those young people are caring for adults who have addiction problems and that that is inappropriate. I urge the minister to confirm that he will place the drug strategy in the broader context of the Administration's policies on education, housing, employment, justice and enforcement. I know that there are anxieties locally about projects that support people into work and which work by addressing those problems.

I note the strategy document on drugs. However, if the minister resources families that have experienced a problem with drugs to talk about what needs to be done in our communities to address the broader problems that are faced there, there will be a large return for that effort. Therefore, I want to know what support there is for family support projects. Further, I want to know that schools will not only provide education, but will be places in which the teachers and staff identify children who are in need; schools should be the first place in which it is seen that a child is not being nurtured. The Cabinet Secretary for Education and Lifelong Learning has described the skills strategy as demand led—does it still have a place for those with drug and addiction problems, for whom employment is an important bridge?

I ask the minister to respond to the comments that were made about the power of Crimestoppers to use proceeds-of-crime money in the communities in which it was harvested to give people a voice. I know constituents who whisper on the telephone in case people hear them and think that they are talking to the police. I urge the minister to support Crimestoppers and other initiatives that give a voice to those who are most intimidated by the consequences of drug problems in our communities.

The Deputy Presiding Officer: We move to winding-up speeches. I will have to shave about half a minute off each speaker's time.

16:32

Ross Finnie (West of Scotland) (LD): The Liberal Democrat amendment attempts to inject a sense that the Government has to accept its responsibility for delivery, rather than simply noting what is contained in the excellent strategy document, "The Road to Recovery". The Liberal Democrats are happy, as my colleague Margaret Smith made clear, to support the principal thrust of the strategy, which has the idea of recovery at its heart and recognises the importance of a person-centred approach.

Dr Ian McKee and Johann Lamont emphasised the need to take an holistic approach. This is not simply a matter of criminal justice or community health; we must also take into account the

circumstances in which many of our people get themselves into problems with drugs. The issues touch on deprivation, child poverty, health inequalities, education—as Johann Lamont said—and the environment in which people live and which results in many of them feeling the sense of hopelessness that leads to them resorting to drugs. Those points need to be woven into the fabric of what we are trying to do.

Annabel Goldie pointed out, rightly, that we have to recognise the importance of the Audit Scotland report with regard to the resources that might be available for any action that will be taken. We should not lose sight of that.

We can all sign up to the principles of the report, but there are two broad themes on which the Government must indicate to us that it is taking matters forward and is not simply awaiting the outcome of the Audit Scotland report—that report must not be used as an excuse for inaction.

The "Promoting Recovery" section of the report calls for more community facilities, detoxification, relapse prevention, harm reduction and so on. If all those measures are to be improved and if their provision is to be increased, the Government must assure us that it is working to deliver that, so that when resources become available, further delay does not take place as we enter into further planning and discussion.

If we are talking about changing the approach, that raises questions about prescribing substitute drugs, increasing the alternatives to methadone and supervision of methadone. I accept what the minister—who has, sadly, left us—said: he is not there to second-guess clinicians. However, a massive change will be required in the culture of how people deal with the problem. That may involve elements of resource, but it also creates a clear need for the Government to say that it wants a change in that culture. The Government will have to drive and lead that change in the cultural approach to how we take people from being on methadone or another substance to another form of treatment. It is critical to hear from the Government about that.

Through consulting clinicians, we need to know where we stand on the alternatives to methadone. Given that our culture has been that methadone was almost the only show in town, we need to hear what the alternatives are and how they are to be progressed. The report refers to pharmacological therapies, but non-pharmacological therapies also exist. As communities, we need to know about those treatments, so that we can discuss them in more detail.

Margo MacDonald: Does the member accept that administering methadone via a pharmacist is cheaper than providing a team of support workers for a drug addict who is not taking methadone?

Ross Finnie: I regret to tell Margo MacDonald that, as the time for my speech is short, I do not want to go into that issue.

I am concerned that, if the clinical advice is that we should have more use of supervision of methadone and of alternatives to methadone, the Government must make that clearer now, rather than wait until resources become available. Evidence shows that health care professionals genuinely believe that supervised consumption encourages engagement and treatment compliance. However, the same evidence also suggests that only one in five patients believes that that is the purpose of supervision. If we are to have a change in culture, we must address those issues. If more resources become available, we will require that planning.

As for Labour's amendment, I think that the Government is correct to move towards outcomes, although I would prefer them to be much clearer—my colleague Margaret Smith called for that. I am pleased that the Conservatives did not move their amendment, because the use of the word "adopt" in Annabel Goldie's amendment would have made it difficult for us to support.

The Deputy Presiding Officer: The member must conclude.

Ross Finnie: We are very supportive of the report's main thrust and we are happy to support it in principle.

16:38

Mary Scanlon (Highlands and Islands) (Con): This has been a good debate on one of the most important issues, which affects many people throughout Scotland. Conservatives made the commitment to choice, abstinence, recovery and re-engagement in our manifesto and we are pleased to honour that commitment by supporting the strategy.

As Annabel Goldie said, we are moving to solving the problem and not just managing it. The move to open-mindedness about what works is welcome. We also welcome the choice along the road to recovery, which should be for patients and clinicians and not for politicians.

Labour's amendment is premature. The Conservatives called for Audit Scotland's investigation. As the Health and Sport Committee knows, until we know where the money is going and how effective that spend is, spending more on justice and health matters—as Labour requests—would be unwise. More might need to be spent on education to address the truancy link, for example.

The fact that every £1 that is spent on recovery results in a saving of £9.50 on other services was well costed in our manifesto, but the benefit of a parent, son or daughter returning to their family cannot be measured financially.

There have been mixed messages on drugs—particularly on cannabis—from the Westminster Government. That has not been helpful. Cannabis is the most commonly used illegal drug in Scotland; cocaine is the next most commonly used; and ecstasy is the third most commonly used. I raise the issue because recreational drug use today can become problematic drug use tomorrow. Neither cannabis nor cocaine users are included in the estimated 52,000 problem drug users, but there is no doubt that the detox and rehab facilities and prevention strategies that we are considering will need to take into account the proliferation of what are known as recreational drugs in the future. I am not implying that everyone who uses those drugs will become a problem drug user, but some will. Poly drug use alongside the consumption of alcohol is a serious issue that cannot be ignored in the debate.

Much has been said about children who are affected by drug-addicted parents. There are up to 60,000 such children in Scotland. I hope that the minister will ensure that any cutbacks in local government funding to voluntary groups will not prevent young carers groups from being adequately and appropriately funded. As Jamie Stone knows, there is a particularly excellent group in Golspie; there are also excellent young carers groups in many other villages and towns in Scotland, with child carers for people with a cross-section of diseases and parents with addictions. As Johann Lamont said, the responsibility on those young children should not be underestimated.

I am concerned about the minister's confidence—if that is the right word—in alcohol and drug action teams delivering such an important drugs strategy. As members have mentioned, the stocktake of ADATs concluded that although many had done excellent work, there were serious shortcomings in many of them, and that clarity about their remit and function was needed. The Health and Sport Committee was even told in evidence that their accountability is not clear, and it was alleged that they are not empowered to do the job that they should be doing. I hope that the minister will look closely at the delivery of the strategy through ADATs.

My main concern about "The Road to Recovery" relates to the desperate need for dual diagnosis—the need for detox and rehab services to address people's mental health issues as well as their addictions. That is critical, given that an estimated 42 per cent of drug addicts have mental health problems. Those problems may be the result of their taking drugs, but they could also be the underlying cause of their taking drugs, which may be a form of self-medication. Whatever the cause and effect, it seems that there is no point in treating a person's addiction unless services are also in place to address their mental health problems. That said, the Scottish drug services directory does not offer an option to search for mental health treatment, and the Scottish Government has confirmed that it does not have a list of dual diagnosis facilities and that it has not produced such a list. I ask the minister to consider that matter.

Finally, paragraph 98 on page 27 of "The Road to Recovery" mentions

"a strong association between unemployment and poor mental health."

Even if a person successfully comes through detox and rehab, their mental health problem will be an obstacle to employment.

I ask the minister to ensure that the issues that I have raised are addressed.

16:44

Pauline McNeill (Glasgow Kelvin) (Lab): The drugs problem is so huge that Labour accepts the need to focus on a critique of the new strategy and to discuss how we can all make it work. We will not be consensual for the sake of it, however. We recognise that the drugs problem is one of the biggest challenges that Scotland faces—indeed, it is one of the biggest challenges across the globe. It is up to Governments to provide leadership and strategy that will take us forward by providing the right types of service with the aim of getting people off drugs and into a better life. Proper resources and a way of showing what progress is being made should be provided. We reserve the right to scrutinise the detail of the policy on the ground. Far from rushing to judgment, we are doing our job in opposition. Communities need to know that, as well as resourcing services to tackle drug misuse, we will not tolerate drugs or drug dealing, as Cathy Jamieson and Johann Lamont outlined; that we will jail all drug dealers; and that we will ensure that our powers to enforce the law are up to date.

The message on enforcement is not helped by the approach that the Crown Office and Procurator Fiscal Service is taking, which means that the value of class A drugs involved must be more than £100,000 and the value of class B drugs involved must be more than £250,000 before a case will go to the High Court. The fact that we are dealing with more seizures does not mean that we should downgrade the status of the cases. We desperately need a discussion with the Crown Office about enforcement. I hope that ministers will

agree that it is also a matter for Parliament to ensure that the right messages are given to the public about how we deal with drug dealers and drug seizures.

I have said many times before in similar debates that the Scottish Crime and Drug Enforcement Agency is crucial in dealing with the seizure of drugs and drug dealers. I know that the Government believes that, too. For that reason, I again ask the Government to reconsider the structures for the agency and free it from the Scottish Police Services Authority. The current arrangement is not working and the Government needs to look at it again.

The Labour Party amendment is an attempt to be constructive. For the purposes of moving on, we will concede that the Government is taking a fresh approach with a new strategy and has charitably recognised the previous Government's work, on which it is building. I agree with many members who have talked about the need to take an all-encompassing approach. Failure to make progress is not an option for our communities, which are blighted by the prevalence of drugs and drug dealers who are exploiting them. Our communities need to know that the Government is still committed to the drug dealers don't care campaign, or its own version of it. They want assurances that the proceeds of crime moneys—which the Government is spending and is about to announce—are being invested directly into those communities that are most blighted by drug dealing.

Many members have talked frankly about the methadone programme. A former director of the Scottish Crime and Drug Enforcement Agency, Graeme Pearson, who was a guest at the Labour Party conference, said that the number of people in Scotland who are now on methadone is ridiculous. He has joined what has become a controversial debate, along with many others. In a genuinely constructive way, I ask for a bit of clarity on the issue. As the minister rightly said, the prescription of methadone is a matter for clinicians—no one has said that it should not be. I agree with Stuart McMillan that the methadone programme is an essential part of the drugs strategy. Scotland's pharmacies and local health providers are doing a good job of conducting the programme and stabilising drug users, helping them to live a positive life. I do not see a change of policy direction, but the minister did not say the words out loud and, so that I am sure about it, when the cabinet secretary sums up I would like to hear from him that that is the Government's position.

There is a need to address some of the complacency that might have set in and to move those who are on the methadone programme on to the next stage. That is where the strategy should now focus. We are not demanding that users be forced off the programme or that time limits be imposed; we are asking for the focus to be moved to getting drug users to the final stages of their rehabilitation. As Johann Lamont pointed out—and I agree with the Government's strategy on this—the drugs strategy alone will not be enough. A strategy of regeneration and recognition of inequalities is absolutely fundamental. I could be wrong, but I suspect that there is a little bit of a difference between the Government and the Conservatives in their approaches to the methadone programme. I would like some clarity on that from the cabinet secretary.

Duncan McNeil has spoken many times in the chamber about an issue that he cares about and which many other members have talked about, too: the 40,000 to 60,000 children who are affected by parental drug misuse. Too many of those children become addicts and their life chances are reduced. Children suffer in silence and they are often not known to the services that need to find them. The "Hidden Harm" report was one of the previous Administration's best policy documents. I hope that the Government agrees and can build on its findings.

Labour supports the Liberal Democrat amendment because we are saying similar things. Leadership is required and resourcing is fundamental to the strategy. Because it is such a huge challenge, Labour is not prepared to leave resourcing to chance so that, further down the line, we have to haggle. We want to see the funding and we want to see it now.

I do not understand why the Government is frightened to set targets and have indicators of progress. If it believes in its strategy, it must be prepared to demonstrate that it is making progress. We are not asking for any particular targets, just for some indication that the Government believes in its strategy, otherwise it will give the impression that it does not want to be judged on it.

We welcome the extension of drug treatment and testing orders. I and others—Richard Simpson and Annabel Goldie, for example—have argued many times that DTTOs are an important intervention. However, I ask the minister to consider extending them further, perhaps to Glasgow, where 90 per cent of street prostitutes who have a drug problem do not get access to DTTOs; it would be helpful if they did.

16:51

The Cabinet Secretary for Justice (Kenny MacAskill): As many have said, the debate has

been wide-ranging. Some contributions have been truncated because of the time restrictions and I believe that I speak for everyone when I say that that is a matter for regret. My colleague Fergus Ewing would have made many more points but he was constrained by the lack of time, which might also apply to me.

We welcome the spirit in which all parties have come to the debate and the general welcome for "The Road to Recovery". We also accept that the drugs problem is not only affecting us now, but has done so for almost a generation. We have sought to deal with the issue by consensus, as did previous Administrations, which is as it should be.

As members said, it is not a problem for western democracies alone. Probably every country in the global economy faces difficulties with the international drugs trade and the problems that go with it. We must also recognise that larger and wealthier countries that have more resources for criminal justice, such as the United States of America, have significantly greater problems.

That is why we must take a people-centred approach at the same time as taking account of our communities, as Cathy Jamieson said. We need that flexibility. As several speakers said, as well as ensuring that we rigorously enforce penalties for supplying drugs, we must tackle demand.

Margo MacDonald: Without responsibility for the supply chain into the United Kingdom, or, in our case, into Scotland, how rigorous can we be in our monitoring?

Kenny MacAskill: We need have no worries about full co-operation. Scotland is very well served by the SCDEA, as Pauline McNeill and others mentioned. We work closely with the Serious Organised Crime Agency, which is responsible for monitoring, and we are close to HM Revenue and Customs and the serious and organised crime task force, much of which relates to the drugs trade, but which also seeks to address other areas of crime. The member can rest assured that all those bodies represent us, even those that are based in the UK. Whether it be HMRC, SOCA, the SCDEA or the Scottish police, we are all on the same side. I also assure the member that we are working with Europol because we recognise that we have to work and co-operate not only with our closest neighbour and jurisdiction south of the border, but with countries elsewhere, whether Columbia, Spain, or the Balkans. We are well served by those organisations. Whether the matter is reserved to the UK or is one for the Scottish police, there is common cause across the criminal justice agencies, as there should be in the chamber.

That brings me to prisons. The Tories are right to raise the issue and I look forward to meeting Annabel Goldie tomorrow, and Bill Aitken, if he accompanies her. Something is clearly wrong. It is not something that is being done deliberately, but there are problems. Annabel Goldie correctly said that we must learn from others, and if it is a lesson from the jurisdiction of the liberty bell—the irony of that—we will be happy to accept it. There are differences and difficulties in respect of how the prison system in the United States is structured and the separation that exists there between short-term prisoners—what we might call bail prisoners—and those on remand, and those who are in for long periods of time. There is also a difference in the United States between federal and state penitentiaries, but the ethos that is being put forward by the Conservatives is correct. Something is wrong and we must tackle the problem. We must assist and support the Scottish Prison Service to try to ensure that those who go to prison do not end up with an addiction, and that prisoners who are seeking to break the cycle of crime by addressing the issues that are causing it have that opportunity. I hope to work with the SPS and we will make every effort to ensure that it is represented at tomorrow's meeting so that it can comment on Pennsylvania, in addition to offering its views on how to tackle the problem.

Members have raised issues about the SCDEA, which is obviously close to my heart as the Cabinet Secretary for Justice. Members can rest assured that we have written to the UK authorities to ensure that the powers on recovering the proceeds of crime are strengthened and deepened. We have made it clear as a Government that those who are involved in a lifetime of offending should face a lifetime of recovery of their assets. We have asked those responsible south of the border to broaden the approach and to reduce the threshold because, if we are to target not only the Mr Bigs but the street dealers, which is essential if we are to drive home in our communities the message that people should not aspire to be drug dealers, we must take the assets of the person in the housing scheme as well as those of the person who resides in a lush housing estate off the backs of other people.

We seek to learn from Ireland. Assistant Chief Constable John Malcolm was recently at a conference in Ireland and we will learn lessons, whether it is from the Garda Síochána or the Police Service of Northern Ireland. We should look at their methods of recovering the proceeds of crime. I assure Bill Aitken that I will keep both him and the Parliament advised of how we hope to drive the matter forward.

The points that Richard Simpson raised about methadone are correct. We believe that it is a matter for clinicians and we will not give any

strictures that people have to have a timetable or time limit. Margaret Smith also raised that issue. The matter is very complicated. We are, as a nation, in a mess on methadone. Nobody ever set out to create a situation in which people are parked on methadone—with all the consequences of that for not only them, but their families and their communities—but that situation has arisen. We must try to get people off methadone, but it is not a matter of seeking to reduce the number of those people overnight. We must work individually with them and take the best possible advice, which we will seek to do.

On indicators or targets, we are giving Parliament a clear indication that we believe that indicators are necessary. That is the whole ethos of the new relationships that the Government is forming through the concordat. Tackling drugs must be dealt with consensually not only across the chamber and in other political forums, but with all the agencies that are involved.

Johann Lamont: Will the minister give way?

The Presiding Officer (Alex Fergusson): I am afraid that the cabinet secretary is in his last minute.

Kenny MacAskill: Health services, social work and the police all have a role. We must work with each of those agencies to find out what the best indicators are to ensure, as Margo MacDonald said, that public funds are accounted for and that we make the best use of them. That is why the Minister for Community Safety has asked Audit Scotland to examine the expenditure. We cannot throw money at the issue; we must ensure that the money that we put into tackling the scourge of drugs is used effectively.

We are setting out on this new strategy and we welcome the consensus. It would have taken the wisdom of Solomon to guarantee that the strategy is a surefire solution. Some things that we do might not necessarily work as effectively as we would intend and we will have to learn lessons from that, but we will have more success with other actions. When new matters arise, such as the issue raised by the Tories about tackling the drug problem in prisons, members can rest assured that we will tackle them. We take on board the points made by many members—in particular Cathy Jamieson and Duncan McNeil—that problems exist not only for individual adults but for their children who are affected. We owe it to them to build on the consensus, to tackle the drugs problem and to make this a better country.

Business Motion

16:59

The Presiding Officer (Alex Fergusson): The next item of business is consideration of business motion S3M-2051, in the name of Bruce Crawford, on behalf of the Parliamentary Bureau, setting out a business programme.

Motion moved,

That the Parliament agrees the following programme of business—

Wednesday 11 June 2008	
2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Ministerial Statement: Alternative Business Structure for the Legal Profession
followed by	Scottish Government Debate: Impact of the Small Business Bonus Scheme
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 12 June 2008	
9.15 am	Parliamentary Bureau Motions
followed by	Scottish Labour Party Business
11.40 am	General Question Time
12 noon	First Minister's Question Time
12.30 pm	Scottish Parliamentary Corporate Body Debate: Expenses Scheme
2.15 pm	Themed Question Time Finance and Sustainable Growth
2.55 pm	Parliamentary Bureau Motions
followed by	Stage 3 Proceedings: Public Health etc. (Scotland) Bill
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 18 June 2008	
2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Stage 1 Debate: Creative Scotland Bill
followed by	Financial Resolution: Creative Scotland Bill
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Thursday 19 June 2008

9.15 am	Parliamentary Bureau Motions
followed by	Scottish Government Business
11.40 am	General Question Time
12 noon	First Minister's Question Time
2.15 pm	Themed Question Time Europe, External Affairs and Culture; Education and Lifelong Learning
2.55 pm	Stage 1 Debate: Scottish Register of Tartans Bill
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business.—[*Bruce Crawford*.]

Motion agreed to.

Parliamentary Bureau Motion

17:00

The Presiding Officer (Alex Fergusson): The next item of business is consideration of a Parliamentary Bureau motion. I ask Bruce Crawford to move motion S3M-2052, on approval of a Scottish statutory instrument.

Motion moved,

That the Parliament agrees that the draft Advice and Assistance (Limits, Conditions and Representation) (Scotland) Regulations 2008 be approved.—[*Bruce Crawford*.]

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

Decision Time

17:00

The Presiding Officer (Alex Fergusson): There are four questions to be put as a result of today's business. The first question is, that amendment S3M-2038.2, in the name of Pauline McNeill, which seeks to amend motion S3M-2038, in the name of Fergus Ewing, on the drugs strategy, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR

Alexander, Ms Wendy (Paisley North) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (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)
Cunningham, Roseanna (Perth) (SNP)
Curran, Margaret (Glasgow Baillieston) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Foulkes, George (Lothians) (Lab)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Gordon, Charlie (Glasgow Cathcart) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Henry, Hugh (Paisley South) (Lab)
Hume, Jim (South of Scotland) (LD)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Kelly, James (Glasgow Rutherglen) (Lab)
Kerr, Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Ken (Eastwood) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McArthur, Liam (Orkney) (LD)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McConnell, Jack (Motherwell and Wishaw) (Lab)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
Mulligan, Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Elaine (Dumfries) (Lab)
O'Donnell, Hugh (Central Scotland) (LD)
Oldfather, Irene (Cunninghame South) (Lab)
Park, John (Mid Scotland and Fife) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stewart, David (Highlands and Islands) (Lab)
Stone, Jamie (Caithness, Sutherland and Easter Ross) (LD)
Tolson, Jim (Dunfermline West) (LD)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Whitton, David (Strathkelvin and Bearsden) (Lab)

AGAINST

Adam, Brian (Aberdeen North) (SNP)
Ahmad, Bashir (Glasgow) (SNP)
Aitken, Bill (Glasgow) (Con)
Allan, Alasdair (Western Isles) (SNP)
Brocklebank, Ted (Mid Scotland and Fife) (Con)
Brown, Gavin (Lothians) (Con)
Brown, Keith (Ochil) (SNP)
Brownlee, Derek (South of Scotland) (Con)
Campbell, Aileen (South of Scotland) (SNP)
Carlaw, Jackson (West of Scotland) (Con)
Coffey, Willie (Kilmarnock and Loudoun) (SNP)
Constance, Angela (Livingston) (SNP)
Crawford, Bruce (Stirling) (SNP)
Don, Nigel (North East Scotland) (SNP)
Doris, Bob (Glasgow) (SNP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
FitzPatrick, Joe (Dundee West) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Highlands and Islands) (SNP)
Goldie, Annabel (West of Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Christopher (Mid Scotland and Fife) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hepburn, Jamie (Central Scotland) (SNP)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Adam (South of Scotland) (SNP)
Johnstone, Alex (North East Scotland) (Con)
Kidd, Bill (Glasgow) (SNP)
Lamont, John (Roxburgh and Berwickshire) (Con)
Lochhead, Richard (Moray) (SNP)
MacAskill, Kenny (Edinburgh East and Musselburgh) (SNP)
Marwick, Tricia (Central Fife) (SNP)
Mather, Jim (Argyll and Bute) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West of Scotland) (SNP)
McGrigor, Jamie (Highlands and Islands) (Con)
McKee, Ian (Lothians) (SNP)
McKelvie, Christina (Central Scotland) (SNP)
McLetchie, David (Edinburgh Pentlands) (Con)
McMillan, Stuart (West of Scotland) (SNP)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Morgan, Alasdair (South of Scotland) (SNP)
Neil, Alex (Central Scotland) (SNP)
Paterson, Gil (West of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Russell, Michael (South of Scotland) (SNP)
Salmond, Alex (Gordon) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Smith, Elizabeth (Mid Scotland and Fife) (Con)
Somerville, Shirley-Anne (Lothians) (SNP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow Govan) (SNP)
Swinney, John (North Tayside) (SNP)
Thompson, Dave (Highlands and Islands) (SNP)
Watt, Maureen (North East Scotland) (SNP)
Welsh, Andrew (Angus) (SNP)
White, Sandra (Glasgow) (SNP)
Wilson, Bill (West of Scotland) (SNP)

Wilson, John (Central Scotland) (SNP)

ABSTENTIONS

MacDonald, Margo (Lothians) (Ind)

The Presiding Officer: The result of the division is: For 57, Against 64, Abstentions 1.

Amendment disagreed to.

The Presiding Officer: The next question is, that amendment S3M-2038.3, in the name of Margaret Smith, which seeks to amend motion S3M-2038, in the name of Fergus Ewing, on the drugs strategy, be agreed to.

Amendment agreed to.

The Presiding Officer: The next question is, that motion S3M-2038, in the name of Fergus Ewing, on the drugs strategy, as amended, be agreed to.

Motion, as amended, agreed to.

Resolved,

That the Parliament welcomes the publication of the national drugs strategy, *The Road to Recovery*, as a sound framework for tackling drug misuse in Scotland; acknowledges that it is founded on expert advice and has been developed through a wide-ranging and inclusive process; supports the Scottish Government's vision that recovery should be the guiding principle of all services for problem drug users; recognises the breadth of action set out in the strategy and calls on the Scottish Government to provide the leadership and resources necessary to prevent drug use, to make communities safer, to tackle drug use in prisons and to protect children affected by parental substance misuse; recognises the Scottish Government's intention to support action to tackle drug misuse with £94 million from the Justice portfolio alone over the next three years and welcomes the work that Audit Scotland is carrying out into the scale and effectiveness of drugs expenditure, and resolves to support the implementation of the strategy over the coming years.

The Presiding Officer: The final question is, that motion S3M-2052, in the name of Bruce Crawford, on approval of a Scottish statutory instrument, be agreed to.

Motion agreed to.

That the Parliament agrees that the draft Advice and Assistance (Limits, Conditions and Representation) (Scotland) Regulations 2008 be approved.

National Health Service (60th Anniversary)

The Deputy Presiding Officer (Trish Godman): The final item of business today is a members' business debate on motion S3M-1923, in the name of Bill Butler, on the 60th anniversary of the national health service. The debate will be concluded without any question being put.

Motion debated,

That the Parliament celebrates the 60th anniversary of the National Health Service, launched on 5 July 1948 by Labour Minister for Health, Aneurin Bevan; recognises the continuing relevance of its founding principles of a socialised health service, funded through general taxation, free to all at the point of need; salutes the huge contribution of all NHS staff down the years in providing vital, lifesaving care and treatment which has improved the quality of life for millions of people, leading to dramatic improvements in life expectancy; supports the central role of the state in providing healthcare free at the point of need; encourages communities throughout Scotland to become involved in events to mark this anniversary, including those organised by NHS Greater Glasgow, the *Evening Times* and Radio Clyde, which will tell the story of the first 60 years of the NHS and serve as a powerful reminder of the unacceptable state of healthcare available to the vast majority of the population prior to 1948, and considers that all citizens, trade unions and politicians should remain true to the founding principles of the NHS.

17:03

Bill Butler (Glasgow Anniesland) (Lab): It is my privilege to speak to the motion in my name, which allows the Scottish Parliament to celebrate, albeit a little prematurely, the 60th anniversary of our national health service.

On 5 July 1948, the NHS was launched by Aneurin "Nye" Bevan—south Wales miner, incomparable orator, consummate parliamentarian, intellectual, practical and successful minister, the most influential socialist of his generation, and a charismatic member of the most radical and progressive Labour Government bar none. The creation of a socialised health service was the high point of Bevan's political career and remains the crowning achievement of Labour in government.

However, it should never be forgotten that the birth of the NHS was far from easy. Its successful delivery required all Bevan's flexibility of approach and ability to make concessions that did not dilute the main objective of the legislation—the creation of a health service funded through general taxation and free to all at the point of need.

As Bevan put it in a speech on 25 June 1948,

"The new Health Service has been having a most uneasy gestation and a very turbulent birth, but all prodigies behave like that".

An often-forgotten fact, of which I will remind members, is that the NHS was fiercely opposed by the British Medical Association and by the Tories, who voted against the bill at both second and third readings. Yesterday, in advance of this debate, colleagues received from the modern-day BMA a briefing paper stating its belief in the founding principles of the NHS. That shows that at least that organisation has been converted.

Despite those Jeremiahs and defeatists, as Nye described them, the NHS scheme was an immediate success. By the day itself, three quarters of the population had signed up with the doctors. Two months later, 39.5 million people—93 per cent of the population—were enrolled. A few months later again, the proportion had risen to 97 per cent, at which it has stabilised ever since. More than 20,000 general practitioners—about 90 per cent—participated in the scheme from its inception. The NHS was popular from the beginning and, despite challenges over the decades, it has remained so ever since.

Undoubtedly, one of the central reasons for the NHS's popularity and its place in the public's affection is the dedication and commitment of all those who, down the years, have worked in it—often in challenging circumstances—to deliver vital life-saving care and treatment. On behalf of my fellow MSPs, I welcome a number of those health service workers, past and present, to the public gallery tonight as representatives of this country's excellent, caring NHS workforce. Down the years, NHS workers have created a service that has improved the quality of life for millions of our fellow citizens.

Despite some setbacks and failings, the NHS has been notably successful over the past 60 years. Huge strides have been taken in improving the health of all our constituents. It is worth remembering, as we celebrate the NHS's birthday, that there was precious little worth celebrating for the majority of the population before the advent of the NHS. In Britain in the 1930s and 1940s, life was tough. Every year, thousands died of infectious diseases such as pneumonia, meningitis, tuberculosis, diphtheria and polio. Infant mortality was around one in 20. There was little that the then piecemeal health care system could do to improve matters.

Prior to 1948, the poor often went without medical treatment. They relied either on dubious and sometimes unsafe home remedies or on the charity of doctors who gave their services free to their poorest patients. Access to a doctor was free to lower-paid workers, but national health insurance—as it then was—often did not extend to cover wives and children. Hospitals charged for services. Although the poor were reimbursed, they had to pay before receiving treatment. Health care in Britain was a failed mixture of voluntary hospitals that were permanently on the verge of financial collapse and municipal hospitals that were comprehensively detested. Sixty years ago, health care was, in effect, a luxury that too many people could not afford.

The advent of the NHS changed all that, utterly and for ever. Now, both men and women live on average 10 years longer than they did in 1948. In a typical week, 1.4 million people will receive help in their homes from the NHS. Every day, NHS staff are in contact with 1.5 million patients and their families. Life expectancy is increasing by one year every four years. Children are now more than five times less likely to die in infancy than was the case in 1948. Killer diseases such as TB and influenza have either been defeated or have at least been brought under control. The development of vaccines against polio, measles and other diseases has dramatically improved the nation's health. In the decade before the polio vaccine was introduced, there were 45,000 cases of the disease. Since 1985, there have been fewer than 40. Such indisputable progress has meant that today the NHS is viewed, quite correctly, as our society's most valuable treasure. It is an example of commonsense collective action in practice.

Of course, there is no room for complacency. The NHS faces many difficult challenges, which the Cabinet Secretary for Health and Wellbeing and her Government must meet. For example, the welcome improvement in life expectancy has immeasurably increased demands on the service. Waiting times, the number of NHS dentists, staff pay and conditions, the danger posed by unacceptable outsourcing proposals and the need for greater democratic accountability are among the many issues with which we will all have to wrestle in the immediate future.

As communities across the country are encouraged to become involved in events to mark this diamond anniversary, including those organised by NHS Greater Glasgow and Clyde, the *Evening Times* and Radio Clyde, it should be emphasised that the NHS is not merely an important part of our past and present but central to the creation of a better future for all. In its 1945 manifesto, a copy of which I have with me, Labour stated that

"the best health services should be available free for all. Money must no longer be the passport to the best treatment."

That view is still shared by the overwhelming majority of our constituents across the nation, and they are right to hold it.

Let me leave the last word to Nye Bevan:

"A free Health Service is a triumphant example of the superiority of collective action and public initiative applied to a segment of society where commercial principles are seen at their worst."

That observation remains as true today as when he first made it 60 years ago. Presiding Officer and colleagues, here's to the next 60 years of the people's health service.

17:11

Jamie Hepburn (Central Scotland) (SNP): I begin by thanking Bill Butler for securing tonight's debate and apologise to members for the fact that I may be unable to stay for the entire debate due to a prior commitment.

The national health service is one of our society's best creations. Before its existence, it was all too common for the sick and ill among our poorest citizens to go without treatment, such was the prohibitive cost of seeking medical assistance. As Bill Butler has spelled out, there was a degree of free health care provision, but a system that relied on the philanthropy of individuals and private organisations was never going to serve the people well. That is why it is right to praise the founding fathers of the NHS.

It is correct to confer praise on Nye Bevan as a founding father, but we must also pay tribute to the generation of citizens who ensured the birth of the institution. The individuals who brought us through the bad years of the second world war and ensured the creation of a burgeoning welfare state, including free health care, are true heroes. That generation—the generation of my grandparents—ensured that all subsequent generations would not have to scrimp and save just to access the most basic health care, as they had to do.

I am delighted that Bill Butler has brought forward the issue for debate. I agree with the part of his motion that states that we should remind people

"of the unacceptable state of healthcare available to the vast majority of the population"

prior to the creation of the NHS in 1948. However, just as we celebrate the existence of our system of free medical care, we should take stock of the fact that millions of people around the globe lack the basic protection that we take for granted at home.

The United Nations declaration of human rights states clearly that everyone

"has the right to medical care and … to security in the event of … sickness".

That noble ideal is the same age as our own NHS, with the declaration having been signed in the same year as the NHS was created. However, for so many people around the world, the ideal remains a hopeless aspiration—and not just in the developing world.

As a percentage of gross domestic product, the United States of America spends around twice as much on health care as the UK does. Despite that, some 50 million Americans are without any form of health insurance, leaving them entirely vulnerable in times of illness. Indeed, the Institute of Medicine estimates that some 18,000 Americans die each year as a result of being uninsured. That is a damning indictment of the system of private health insurance used by the wealthiest nation on the planet. As much as tonight's debate is about celebrating 60 years of the NHS, we should always remain vigilant against any suggestion that we should somehow turn back the clock and move towards a model of private insurance.

We should also note that since 1999 health policy has been devolved to the Scottish Parliament, which will result in distinctive Scottish health care policies. In many ways, that reinforces the fact that the NHS in Scotland has always been an individual entity in the United Kingdom context, having been formed by separate legislation from that which created the NHS in England and Wales. We should embrace the fact that distinctive Scottish policies will be brought forward to suit Scottish circumstances and strengthen our Scottish NHS.

In 1951, Aneurin Bevan resigned his post as a Government minister, such was his upset at the introduction of prescription charges. In the 21st century, the Scottish Government of the Scottish National Party is following the positive example of the Welsh Assembly Government in reintroducing free prescriptions. That reintroduction is a vital reinforcement of the founding compact with the people at the creation of the NHS that health care should be free at the point of access.

The NHS in Scotland is changing with the times. Bill Butler has campaigned hard for direct elections to health boards. I am sure that he joins me in welcoming the news that we heard this week that the Scottish Government intends to ensure an elected element of NHS boards. That policy signifies just one way in which our 60-year-old NHS is adapting to ensure its fitness not only for the next 60 years but beyond.

17:16

David Whitton (Strathkelvin and Bearsden) (Lab): I am delighted to be taking part in this members' business debate. I add my congratulations to Bill Butler on getting this celebratory item on to the Parliament's agenda.

Like any member under 60 in the chamber—which includes most of us, I think—I have never known anything other than the NHS for my

medical treatment. Other members may have had occasion to be grateful to NHS staff for the services that they provide, as I have on many occasions, from having my tonsils taken out at age five to more major surgery a few years ago. The common thread in all of that was the professionalism of the NHS staff, their dedication to the job in hand and the way in which they put patients first.

In the public gallery today is someone from my constituency who epitomises all that is good about the NHS. Dr Geoff Allan from Kirkintilloch started work at Glasgow royal infirmary just days before the NHS came into being in June 1948. He spent 43 years serving the people of Glasgow, latterly as chest consultant at Stobhill hospital, retiring some 17 years ago. He is undoubtedly an NHS hero—who also happens to be my next-door neighbour.

Dr Allan can tell tales of the early days of the NHS when the people of Glasgow were getting used to the fact that the GRI was no longer a charity hospital and that Stobhill and Ruchill hospitals were no longer run by the local authority. Over the years, we have shared a glass or two of medicine while discussing the NHS and its various problems. He told me that, in the 1950s, it was NHS staff at Ruchill who devised strategies to cope with the tuberculosis epidemic—strategies that would not have been possible in the 1930s and 1940s. Bill Butler referred to those days. As a direct result of having a national health service, staff at that hospital were able to introduce mass X-ray campaigns, which marked the beginnings of the preventive medicine that we take so much for granted, 60 years on.

Pre-1948, the consultant was king and patients were almost of secondary importance. In today's NHS, all that has changed and the patient is now at the centre. Indeed, 21st century medical care has advanced at such an astonishing rate that the procedures that are carried out today were unheard of just 60 years ago. Next year, following a £100 million investment, a new day care hospital will open at Stobhill. The hospital will have magnetic resonance imaging scanners and computed tomography scanners, giving top-level health care to my constituents and the people of north Glasgow.

I should declare a personal interest in the debate: my daughter is a consultant physiotherapist and her husband is a consultant neurosurgeon. From speaking to them, I know the effort that goes into patient care, not only in Glasgow but elsewhere in the United Kingdom.

There is no doubt that our national health service—a service that provides medical care free at the point of need—is worth celebrating. I am glad to support the motion in Mr Butler's name.

17:19

Mary Scanlon (Highlands and Islands) (Con): I welcome the opportunity to debate the national health service in its 60th year, and I congratulate Bill Butler on the motion that he has lodged for debate. It is always good to be reminded of mistakes that were made 60 years ago—doing so serves to remind us just how far we have come.

A system that strives for equal access to health care is not a dream of socialism. I want to make clear my party's support for the NHS and the equity of treatment that it provides. Conservatives acknowledge and respect fully the institution that is the NHS.

I pay tribute to the excellent work of NHS staff, who have for the past 60 years provided a service to each and every one of us in Scotland. However, the NHS is not just about nurses and doctors—Christine Grahame will not be surprised to hear me mention allied health professionals such as physiotherapists and podiatrists. David Whitton mentioned them, although they are often forgotten when we praise the NHS.

As we celebrate the NHS's 60th anniversary, I want to consider the differences between when the NHS was formed in the late 1940s and today, in 2008, because they are different times and eras. In 1948, penicillin had been on the market for only three years, whereas now it is widely available. As Bill Butler said, the greatest threats to health in the 1940s were the big epidemics such as diphtheria, whooping cough and measles. Now, we face new public health threats that would have been alien to the founders of the NHS six decades ago, such as obesity and widespread drug abuse. People are aware of the dangers but do not always try to avoid them, which is the opposite of the 1940s, when people tried to avoid the epidemics. Because of huge advances in immunology, we do not live with the threat of those diseases.

Much progress has also been made in areas such as organ transplants, in vitro fertilisation, anaesthesia, antibiotics and surgery and the potential in genetics, nanotechnology and robotics is unlimited. The 21st century will undoubtedly be one of the most exciting times in the history of medical science, although there will be questioning and challenging debates, as happened at Westminster a couple of weeks ago.

I referred to how personal choices affect our health. We cannot rely on advances in medical science to save us from our decisions. We can do more for ourselves by staying in shape, taking more exercise, avoiding toxins and eating and drinking in moderation. We need to look after ourselves more proactively and not just reactively when problems occur.

Nowadays, doctors are often seen as special advisers who engage with patients on complex choices about medical care or changes to lifestyle. In the 1940s, a visit to the doctor happened only when a person was extremely ill. As with all aspects of life, the internet now plays its part: a patient can check the doctor's diagnosis and is presented with a bank of knowledge. Patients in the 1940s did not have that tool. Today, patients are much more ready to challenge doctors—rightly or wrongly.

I agree with much in Bill Butler's motion. We should acknowledge that the national health service has achieved much in the past 60 years, and look forward to what it will deliver in the next 60 years. We want a service that is focused on outcomes rather than on process targets because a focus on outcomes would result in an evidence-based health policy that would deliver not only equity, but excellence and value for taxpayers' money.

17:23

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): It is a pleasure to take part in the debate. As other members have done, I thank Bill Butler and congratulate him on lodging the motion and on his thoughtful and well-researched speech. We will all go away with a little more information on the national health service than we had when we entered the chamber this evening. Bill Butler's history of the NHS has said it all.

We should think back to what some of our relatives have said about how the NHS has changed. Only last week, I was in the company of some of my elderly relatives when the NHS's 60th birthday was mentioned. The stories that came up were like some of those that Bill Butler mentioned: stories of women saving up for childbirth; stories of women scared about their children becoming ill because they could not afford the cost of treatment; and stories of people feeling the insult to their dignity of having to go cap in hand for what they regarded as charity. Such stories should make us realise how privileged we have been to grow up in a country in which health care services are free at the point of need. We should all celebrate our health service and be grateful for it. I am sure that times will come when other members of my family will say, "Thank goodness for the NHS." I know that I have said thank you many times for the NHS and for the work that its staff have done. That work has often been life saving for members of my family.

Today, we should focus on the future and on the primary care professionals. As Mary Scanlon said, we all have a responsibility to take care of our own health by ensuring that we keep fit through exercise and through the food that we eat. However, we should pay tribute to the great work that district nurses and GPs do, and we should appreciate the difference that they make to our day-to-day lives. We should also remember the contributions that health centres with one GP made in the past; in those days the surgery might be in the doctor's back room, or in a room and kitchen somewhere. If those people were able to see how hospitals deal with certain conditions today, the health service would be unrecognisable to them. Conditions that might once have led to people spending weeks or months in hospital can now be treated quickly, with people being allowed home the same day.

We have to move with the times and we have to admit that modern health care is good but that it can always get better. We also have to protect the idea that everyone should have access to the national health service. That is why, two weeks ago, I was concerned to hear about the scanner facility that will be offered by a hospital in Edinburgh, where access will be shared between the ordinary punter and the staff of a very large private company. The health service should be open to everyone; there should be no fast-track access and we should all be treated the same.

I hope that, over the next 60 years, we are able to maintain the service and ensure that it remains true to Nye Bevan's vision of 60 years ago. It should remain a health service that is fit for all and free at the point of need.

17:28

Ross Finnie (West of Scotland) (LD): I am delighted to participate in this debate and I congratulate Bill Butler not only for securing the debate but for his quite excellent opening speech.

There is no question but that the credit for the creation of the national health service goes—as Bill Butler made clear—to the post-war Labour Government, and in particular to Nye Bevan, its Minister of Health. As Bill Butler said, it was Nye Bevan who with some difficulty piloted the National Health Service Bill through a somewhat recalcitrant Parliament in 1946. The resultant act led to the establishment of the national health service in 1948. Nothing can detract from that Government's outstanding historical achievement in establishing a truly national health service.

To put the 60th anniversary of the creation of the NHS into its historical perspective, I hope that Labour members in particular will forgive me if I mention a man whom many historians have described as the father of the welfare state—the eminent Liberal politician, economist and social reformer, William Beveridge. Beveridge first gained prominence as a social reformer and as an adviser to Lloyd George in Asquith's Government,

when he was credited with framing the National Insurance Act 1911. It was no surprise when he was appointed chair of the Government committee of inquiry into social insurance and allied services in June 1941. Early minutes from that inquiry reveal that Beveridge intended to place a very ambitious interpretation on the committee's terms of reference. The inquiry's findings were published as "Social Insurance and Allied Services—A Report by Sir William Beveridge" on 1 December 1942. The report set out the basis under which the Government should tackle what the report described as the five "Giant Evils" of

"Want … Disease, Ignorance, Squalor and Idleness."

The report proposed that all people of working age should pay a weekly national insurance contribution and that, in return, benefits would be paid to people who were sick, unemployed, retired or widowed. The system was to provide a minimum standard of living,

"below which no one should be allowed to fall."

The report recommended that medical treatment covering all requirements be provided for all citizens by a national health service organised under a health department, and post-medical rehabilitation was to be provided for all persons who would profit from it.

So it was that Beveridge's template was picked up by the Labour Government, and Nye Bevan moulded it to create the NHS. Let us be clear, however, about one point: when Beveridge, by that time in the House of Lords, was challenged to answer whether he had created the NHS; he said no, and that it had been created by Nye Bevan and the Labour Government.

Since its inception, as other colleagues have said, the NHS has made an enormous contribution to the improvement of our health. It has eradicated diseases, as Bill Butler narrated, and it has driven up health standards and the standards of the NHS and all who work in it. It has encouraged research and development in drugs and equipment, and it has promoted innovation and overseen a massive expansion in the availability of primary and other care services. Furthermore, throughout its existence, as Bill Butler pointedly made clear, the NHS has stuck to its core founding principles. I hope that that will always be the case.

The NHS has always been, and no doubt will continue to be, a demand-led service. If we think about it, it is therefore inherently unsustainable. One of the key challenges in the next 60 years will be to temper demand by placing ever-greater emphasis on preventive medicine. Only in that way can we ensure that those who will continue to need treatment can be provided with the best and most up-to-date treatment that is available within what will always be limited resources.

In supporting the motion, Liberal Democrats add our congratulations to the founders of the NHS and to all who have worked in the NHS over the past 60 years. We certainly look forward to another 60 years of the NHS both preventing ill health and providing health care that is tailored to meet the individual needs of our citizens.

17:32

Patricia Ferguson (Glasgow Maryhill) (Lab): I, too, thank Bill Butler for securing the debate.

In common with most if not all members in the chamber, I regard the national health service as one of the best and most important achievements of the United Kingdom and, indeed, of the Labour movement. Like most members, I have used the service—thankfully, not often. However, I know the difference that it has made to the lives of my friends and family, and to the lives of my constituents. I also had the privilege of working in the NHS for some 15 years.

Despite all that, it was not my intention to speak in the debate. However, a chance conversation with Bill Butler last week changed my mind—in itself, an uncommon experience. I happened to mention that I remembered the 30th anniversary of the NHS, an occasion that was celebrated in Gartnavel hospital, where I was working at the time, and throughout the NHS by a reduction in the cost of food in the NHS canteen to 1948 prices. That reminiscence prompted him to suggest that perhaps I would want to speak in the debate. For those who think that that was just an excuse to dispel the myth that he married a much younger woman, I have to say that it was not. In fact, the reminiscence got me thinking and made me decide that I should speak in the debate—not least because it was Mrs Thatcher's policies on the NHS in the 70s and 80s, and even into the 90s, that encouraged me to become involved in politics.

I think that we should all celebrate this anniversary proudly because, prior to the inception of the NHS, the practice of medicine was conducted very differently, as we have heard. Many GPs had two entrances to their surgeries: one for patients with national health insurance—the panel patients; and one for private patients. Doctors could not call on advanced medical knowledge or effective drugs. Many doctors were, of course, unhappy with that situation and knew that often people who needed to be treated were not and that many who were treated could not afford the subsequent cost. Of course, many doctors regularly waived their fees.

In spite of that, when Bevan introduced his bill in 1946, one former chairman of the BMA said:

"I have examined the Bill and it looks to me uncommonly like the first step, and a big one, to national socialism as practised in Germany. The medical service there was early put under the dictatorship of a 'medical fuhrer'. The Bill will establish the minister for health in that capacity."

Fortunately, as we have heard, the BMA's views have moved on significantly. Bevan eventually won over the medical profession in spite of that vehement opposition and the NHS was established.

Since then, life expectancy has increased by 10 years for men and women, and many of the illnesses that were most prevalent in 1948 have effectively been eradicated. While we laud the new medical technologies, we should remember that much of the NHS's success in the early years was built on the new antibiotics that became available and the opportunity that the service afforded to share good practice, provide economies of scale and institute the mass screenings of which David Whitton spoke.

What will the NHS of 2048 look like? Just as our focus has moved significantly from the hospital to the community, the patient should and, I think, will become the main decision maker, with nursing and medical staff becoming our health advisers. In part, technology will move us in that direction, but so too will the demographics.

We should all be proud of the NHS and, in particular, the staff who make it possible. They work day in and day out, often in jobs that are physically difficult and emotionally draining. In large numbers, they volunteer their services in places such as Malawi, where people are not as fortunate as we are. We should be resolute in our determination that the generations that follow us into this Parliament will also have an NHS to celebrate and be proud of.

17:37

Christine Grahame (South of Scotland) (SNP): In 1948, I was four years old in post-war Scotland. The four of us had just moved out of a house that we shared with my grandparents and into the first of the prefabs. People grew vegetables in their gardens and ate seasonally. Mothers stayed at home and shopped every day. No one had heard of Tesco and no one had a television. Cars were a rarity and, as a child, I went into town to the co-op only twice a year, for school clothes and the divvy. Teacher gave us slates to write on and we shared reading books. I am that old.

That was the world into which the NHS was born, where children—including me—contracted a range of childhood diseases that spread from street to street—and the streets were our playground. Chickenpox, measles, German measles, whooping cough, scarlatina and pleurisy—I have had the lot, but so had my friends. One girl contracted polio and became wheelchair bound. I thought that I would get polio if I played out late, as that was my mother's brutal encouragement to me to come in. However, obese children were a rarity.

When I was about seven years old, my best friend's young mother was carried out ashen faced on a stretcher and died days later from some infection or other. People were old at 40, and life expectancy for men was mid-60s and, for women, a few years older. Smoking had been positively encouraged in the wartime years and was considered a sign of glamour and maturity. Sexual activity before marriage was sinful, certainly for women, and a likely punishment was pregnancy, which would lead to the woman being shunned by the community. The pregnancy would be hidden and aborted, or the child would be adopted.

How the world of the NHS has changed. How starkly the social changes accompanying those 60 intervening years contrast with the world of 1948. Those changes have transformed the pressures on, and expectations of, the NHS. My childhood illnesses are of historical interest and curiosity value, but childhood obesity is on an accelerating trajectory with concomitant threats of type 2 diabetes. Microwaved processed food may be the only meals that some children see. Sexual liberation has led to what might be termed an epidemic in chlamydia and other sexually transmitted diseases, which impacts not only on wellbeing but on fertility.

I am pleased to say that old people are getting older, and they are no longer draped in shawls and wearing slippers as they sit by the coal fire. Well-charted demographic changes are shaping the direction of demand on all NHS services.

Despite all that, despite the dynamic and dramatic progress in medicine, treatments and equipment—now, babies not much heavier than a bag of sugar can not only survive but thrive—and despite all the stresses and strains on its systems and personnel, the NHS, in both the primary care and acute sectors remains now as it was 60 years ago: free at the point of need.

With our own Parliament, we shall continue to diverge in our policies and priorities from those in the other component parts of the UK. Free personal and nursing care, despite its ups and downs, is a credit to this young Parliament. With the eradication of prescription charges, to which Jamie Hepburn referred, we have come round full circle to the early days of the NHS.

Challenges in the evolution of the NHS come with the territory. The Scottish public and politicians will continue to criticise and cherish the NHS, sometimes in equal measure. That

emphasises how significant the NHS is in all our lives, from cradle to grave and all the bits in between.

The Deputy Presiding Officer: In order to accommodate all members who wish to speak, I now invite a motion without notice to extend the debate under rule 8.14.3.

Motion moved,

That, under Rule 8.14.3, the debate be extended until 6.00 pm.—[*Bill Butler*.]

Motion agreed to.

17:41

Marlyn Glen (North East Scotland) (Lab): I commend Bill Butler for lodging the motion, which celebrates what is best about the NHS and which enshrines its original set of principles. The NHS was the flagship policy for waging a new war against the old enemies that have already been mentioned this evening:

"Want … Disease, Ignorance, Squalor and Idleness."

That spirit meant that the NHS would treat everyone the same, regardless of their status or income. That led to a health service that was funded out of general taxation, so that people received medical care irrespective of their ability to pay, thus removing one of the greatest pre-war worries for the people of this country: how they could afford to pay for treatment if they fell sick or were injured.

For at least the past decade, health priorities have moved further towards preventive action rather than merely focusing on ill health. Under a Labour-led Executive, groundbreaking and targeted initiatives were launched to reduce health inequalities, including the promotion of smoking cessation, high-quality nutrition and physical exercise. We look forward to such work continuing.

It is interesting to look to the US for comparison. It was a presidential election year 60 years ago, and the opponents of President Harry S Truman were attempting to demonise his proposals to introduce national health insurance as "socialized medicine". As has already been said, in contrast to universal provision, the US model of health insurance results in more than 46 million people—16 per cent of the US population—including more than 8 million children, not having health insurance.

It is presidential election year again in the US, and the need for a universal health care system is still an issue. Democratic Party candidate-elect Barack Obama told CBS News:

"I am absolutely determined that by the end of the first term of the next president, we should have universal health care in this country."

I pay particular tribute to the workforce of NHS Tayside. Since 2000, the number of treatment episodes involving in-patients, day cases and new and returning out-patients has exceeded 4 million. That is thanks to the commitment, dedication and professionalism of NHS Tayside, which is deeply valued by the communities that it serves.

The motion is absolutely right to ask that

"all citizens, trade unions and politicians should remain true to the founding principles of the NHS."

I sound a cautionary note, however, as concern has been raised in Dundee about efficiency savings, which have been proposed because of the budget settlement. I share those concerns.

The values of the NHS offer a model for creating a better, more caring society. What we do with the NHS is, manifestly, how we will be judged by the electorate.

I commend the motion.

17:44

Margaret Curran (Glasgow Baillieston) (Lab): I thank Bill Butler for bringing the debate, which has allowed the Parliament to be part of the tribute to the NHS, and for his typically robust and interesting speech. I hope that this debate will be the start of many full personal and political tributes to the NHS in the coming months. The significance of the NHS to Labour is shown by the fact that so many Labour members are contributing to this debate. I am sure that everyone in the chamber would acknowledge that Nye Bevan is one of the most inspiring figures for Labour members and that we want to continue to honour him.

Tonight, we must not only celebrate the creation of the NHS but recognise its achievements throughout the past 60 years. Without the NHS, the experience of many of our families would be quite different. We can all pay tribute at some level to the compassion of the NHS, because it has touched all our lives. In fact, we could argue that it has touched the lives of all Scots.

Perhaps the greatest achievement of the NHS is that, against all the odds, and despite all the predictions, we have a service that is at its best when it is needed most and which allows us to benefit from its great expertise. The extra dimension is that it offers care and support when it is needed most. I am sure that we could all talk at great length, from our own experience or that of our constituents, about NHS staff who have gone beyond the call of duty and offered us care and attention when we needed it most.

The argument that has taken centre stage tonight is that the extra dimension of compassion that the NHS offers is born out of the ethics on which it is based: the collective approach that Bill

Butler talked about, the absolute commitment to public service, and the notion that a shared problem can find a shared solution. When we have those ethics, we provide public services at their very best.

That all requires political leadership, which there is no doubt that Nye Bevan provided. However, there is no doubt that the NHS has had to face many challenges over the past 60 years. Given that we are in celebratory mode, I do not want to be at odds with other members or to pick on Jackson Carlaw, who is the only Conservative member present, but I have to say that the NHS has faced considerable challenges around funding and waiting times, for example, which have been overcome through political will and determination.

At this time of tribute, it is vital that the staff take centre stage, because they are the people who have provided the NHS. On that, I echo other members' comments.

Nye Bevan said that we should not let the trumpets of the past drown out the clarion call of the future. If the NHS is to survive, we must be prepared to meet the profound challenges of the future, whether they are technological or demographic. As in the past, with resources, political will and the continued commitment of the staff who serve us so well in Scotland, we can be positive about the future of the NHS.

17:48

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I congratulate Bill Butler on securing the debate and on his robust and interesting speech on the subject of the 60th anniversary of the NHS.

I have served the NHS for something like 40 years as a professional. I pay tribute to my colleagues in the service—not just the doctors, nurses and allied health professionals, who have already been mentioned, but all the others, such as the porters and cleaners, who are part of the NHS family. Thank God they are being brought back into the NHS after the services that they provide were privatised, which meant that they were removed from the family. They play a hugely important role, as do the volunteers in the NHS. After all, volunteers kept our hospitals alive before the NHS was set up. Subsequently, they played a major part in helping the NHS, and they could play a much bigger part, which perhaps we should consider.

I also pay tribute to the managers in the NHS. Although we doctors did not like them very much, because they kept telling us what to do, they played a hugely important role in delivering the visions of successive Governments. In addition, I pay tribute to the many boards on which volunteers, people selected by Government and others have played a role down the years in directing the NHS and ensuring that the public interest and political interest are represented and that things are done properly.

The NHS is a massive undertaking—after all, it is the third largest employer in the world, after the Chinese army and the Indian railway. We should not forget that.

When I studied medicine in Edinburgh in the 1960s, the dean of faculty was Sir John Brotherston, who went on to be our chief medical officer. He described to us in graphic terms what was happening when he studied medicine. The squalor that some members have mentioned, the deaths associated with infectious diseases and the malnutrition that resulted in rickets—those were all factors in the unequal society in which he lived.

As many have said, the NHS has delivered on one fundamental aim—it is essentially free at the point of need. If one asks any family in this country whether they worry about the cost of becoming ill, the answer is no. That is the greatest gift that Nye Bevan and the Labour Party gave Britain when they created the NHS following the Beveridge report.

In America, 40 per cent of personal bankruptcies are due to health bills. That is a society in which I have never wanted to live. Indeed, my colleagues might be amused by a story from when I went to North Carolina to visit my soon-to-be brother-in-law in 1966. Obviously, we discussed health services in the state and, after a week, I was labelled as a Communist—that was people's attitude there towards socialised medicine. As my colleagues know, it would be hard to find someone much further from being a Communist, in British terms, than I am.

One thing is clear: whatever happens, under whatever Government, this country will never go back from a position in which the NHS is fundamental to our care, even though we might have different views on how to go forward and we face many challenges. One thing that Nye Bevan got wrong—he did not get a lot wrong—was that he persuaded Stafford Cripps that the budget was tolerable because, if we introduced a national health service, the costs would go down. That demonstrates his great powers of persuasion because, of course, that was not the case, and the Labour Government subsequently was forced to introduce co-payment in a number of areas of the health service. No socialist wanted it, but it was recognised to be necessary on a pragmatic basis.

We will face huge challenges as we sustain the national health service. However, we are all committed to it. We will drive it forward one way or another and retain the basic principle that people

will be served by a health service that is, essentially, free at the point of need.

17:53

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): I congratulate Bill Butler on securing today's debate. It is timely, as, one month tomorrow, on 5 July, we will celebrate the 60th anniversary of our national health service.

I echo everything that members have said this afternoon, in what has been a good debate. I have even discovered something that I have in common with David Whitton: I also got my tonsils out at the age of 5—I suspect that that was one or two years later than David Whitton, but I will leave members to draw their own conclusions.

As we all know, the NHS is a very special organisation. It is right that we acknowledge that the NHS was created by a Labour Government. I agree with Patricia Ferguson that the NHS is the biggest achievement of the Labour movement. It is also appropriate to recognise, as Ross Finnie did, the contribution of Beveridge. However, although I acknowledge those facts, I am proud that, in the 60th year of the NHS, it is this SNP Government that will restore the NHS to Nye Bevan's founding vision by abolishing prescription charges.

As Margaret Curran said, every one of us has been touched by the national health service. Most people in Scotland—even Christine Grahame—cannot remember life before our NHS.

The NHS is unique in offering free treatment when and where it is needed. Before 1948, whether to seek treatment involved a tough choice—people would choose whether to feed the family or treat the sick child. Children went untreated, often until it was too late. When the NHS started to operate, it had to deal with years of backlog as patients came to have long-standing illnesses treated.

As an aside, it is worth mentioning that before 1948, a fledgling health service operated in the far north of Scotland. The Highlands and Islands medical service offered free treatment for the poorest families and had started to be noticed elsewhere in the world. Even back then, Scotland was leading the way.

As we celebrate the NHS's 60th anniversary, it is sobering to think that—as Jamie Hepburn and others said—in some parts of the world, and even in societies as developed as the USA, families still have to make tough choices about health care. Sometimes the choice is whether to have health insurance or whether to buy treatment, but often people have no choice, because they simply do not have the money to pay for treatment. That is why it is my belief—which I know that everyone in the chamber shares—that, although we should celebrate our NHS, we must never take it for granted.

I add my heartfelt thanks and admiration for the many staff who have made the health service what it is. I thank the early pioneers in the days when people feared TB and other infectious diseases and I thank those who led the development of transplant surgery, ultrasound, keyhole surgery, the Glasgow coma scale and MRI scanning. I thank all the staff throughout the country who offer high-quality care day in, day out to everyone who needs it, when they need it.

Credit must also go to family doctors, community nurses, midwives, dentists, laboratory technicians, porters, caterers, paramedics, ambulance drivers, allied health professionals, managers, all the backroom staff and staff in health boards without whom it could not all come together. They are just a fraction of the many professional and dedicated staff who make the NHS what it is. I am particularly pleased that the chair of NHS Fife's board and representatives of trade unions are in the public gallery to listen carefully to the debate. We thank all of them.

Like Richard Simpson, I think that we should mention a group that is often forgotten when we talk about people's contributions to the NHS—the thousands upon thousands of volunteers who make an enormous contribution. They give their time to help others in hospices, by working on hospital radio, by running tea bars or by donating blood to save others' lives. Carers offer much valuable support to their families, often in the most difficult and trying circumstances. The health service is about communities as much as it is about doctors, nurses or any staff member. That community idea is at the heart of the mutual health service that we want to create.

It is fitting that we can all come together on the NHS's 60th anniversary to celebrate an amazing and unique achievement. We are organising national events to mark the occasion, which include a multifaith act of celebration in St Giles cathedral on 6 July, but we can invite only a small fraction of the thousands of people who would like to share in the celebration. I hope that staff past and present and the wider public will feel able and welcome to participate in local events, a range of which are being organised throughout the country.

We have made enormous progress in the past 60 years and we are all right to be proud of the national health service but, as members have said, it is important to acknowledge that the journey does not stop here. We know that the health service faces challenges in the future, especially as people live longer and as we learn how to treat and manage more conditions, with

more expensive drugs and technologies to help us. We have challenges in moving towards more anticipatory care—in treating people before they need emergency treatment—and in treating people in their communities. Another challenge is creating a mutual health service in which people are not just passive patients, but co-owners who take more control of their health and are more active in deciding how our NHS is run.

We should recognise that with rights come responsibilities. Members have mentioned that the health service can help us live longer and healthier lives only if we adopt healthier lifestyles. New technologies and new medicines mean that we can do more—recent developments such as living donor liver transplantations and life sciences research illustrate that—and people's expectations are rising all the time.

Our challenge is to harness those developments and expectations to ensure that we get the very best that we can from our continued investment in a universal health service that is free at the point of need.

I give a commitment on behalf of the Government that we will work with our partners in the NHS and elsewhere and with members across the chamber to build on the success of the past 60 years, to face up to the challenges of the future, and to ensure that we have an NHS to be proud of for the next 60 years and well beyond that.

Meeting closed at 18:00.

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

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

The deadline for corrections to this edition is:

Wednesday 11 June 2008

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

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

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

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at Document Supply.

Published in Edinburgh by RR Donnelley and available from:

Blackwell's Bookshop

53 South Bridge
Edinburgh EH1 1YS
0131 622 8222

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

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

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

Telephone orders and inquiries
0131 622 8283 or
0131 622 8258

Fax orders
0131 557 8149

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

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

Scottish Parliament

RNID Typetalk calls welcome on
18001 0131 348 5000
Textphone 0845 270 0152

sp.info@scottish.parliament.uk

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by RR Donnelley