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Official Report

HEALTH AND SPORT COMMITTEE

Wednesday 23 June 2010

Session 3

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Wednesday 23 June 2010

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HEALTH AND SPORT COMMITTEE
22nd Meeting 2010, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Nanette Milne (North East Scotland) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Wednesday 23 June 2010

[The Convener *opened the meeting at 10:00*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning. I welcome everyone to the 22nd meeting in 2010 of the Health and Sport Committee and remind people to switch off mobile phones and other electronic equipment. No apologies have been received.

Agenda item 1 is a decision on whether to take in private item 7, which involves consideration of candidates for the post of budget adviser. Do members agree to take that item in private?

Members *indicated agreement.*

Subordinate Legislation

National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010 (Draft)

10:00

The Convener: Item 2 is subordinate legislation. The committee will take evidence on the draft National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010, a copy of which members have with their papers, as well as a cover note from the clerk that summarises the purpose of the regulations.

I welcome to the meeting Nicola Sturgeon MSP, Cabinet Secretary for Health and Wellbeing, who is accompanied by John Brunton, manager, cross-border health care in Europe team; John Davidson, team leader, cross-border health care in Europe; and Edythe Murie, who is from the Scottish Government legal directorate. A motion that the committee recommends that the regulations be approved has been lodged by the cabinet secretary and will be debated following the evidence session. Once the debate has begun, the cabinet secretary's officials will not be able to participate.

I invite the cabinet secretary to give the committee a brief outline of the regulations.

Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing): I will be as brief as possible, but I apologise in advance for the fact that my opening statement is marginally longer than usual, because it deals with a complicated situation.

Until quite recently—a decade or so ago—there was little discussion of patient mobility at a European level. The United Kingdom and other member states with similar health systems argued that European Union treaty law applied only to insurance-based health systems but, back in 2006, the European Court of Justice delivered its judgment in the Watts case, which concerned an NHS patient who required hip replacement who travelled to France to have the operation. She then sought to recover the costs of the operation from her primary care trust in England.

The court found that under the freedom to provide services provisions of article 49 of the European treaty, which is now article 56 of the Treaty on the Functioning of the European Union, patients have the right to obtain health care services, including private care, in another European economic area country if those services are the same as, or equivalent to, services that would have been provided by the patient's home

health care system. In certain circumstances, that is subject to prior authorisation. The patient pays for the treatment up front and has a right to claim reimbursement up to the amount that the same, or equivalent, treatment would have cost, had the patient obtained that treatment from their home health care system. They can claim the actual amount that the treatment cost if it is lower than it would have been in their home country.

A cross-border health care directive is being taken forward in Europe that will codify the European case law, but that process is taking longer than expected and it will be some time before the directive is finalised and implemented. In the interim, we think that it is important to put in place regulations that reflect the court's decision in the Watts case and which give NHS boards a clear basis on which to make decisions about the circumstances in which patients can be reimbursed for treatment abroad, including when prior authorisation is needed. England and Wales have recently introduced interim regulations and we understand that Northern Ireland will do so shortly.

It is important to stress that the introduction of regulations will not remove all scope for challenge. We will still need to allow for cases to be appealed and reviewed, and patients will retain the right to challenge boards' decisions in the courts. However, the regulations will provide a legal basis for the NHS to introduce prior authorisation in certain circumstances and to limit the amount of reimbursement to what the treatment would have cost the NHS in Scotland. In addition, the regulations will benefit patients in that through the prior authorisation arrangements they will be able to get a clearer picture of what costs they can expect to be reimbursed for and what services are available at home, and to access any knowledge that NHS Scotland has of health care systems elsewhere that they wish to use.

I stress that because waiting times in Scotland are at an all-time low, it is reasonable to conclude that very few patients will wish to travel overseas for treatment that, for the most part, is readily and quickly available at home, but we cannot escape the fact that, under European law, Scots have the right to do that. Therefore, we must ensure that we have in place legislation that allows them to exercise that right and which puts in place the framework for boards' decision making.

The other point to make is that the case law also applies in the opposite direction, to patients from other parts of Europe who might want to exercise their rights to access care here in Scotland. However, the important point is that there is no specific requirement for health care providers to accept any patient, so we are not required to accept patients for planned health care if the judgment is that that would be to the detriment of our own patients with similar health needs. We have no evidence to suggest that there has been a large influx of foreign patients travelling to Scotland to receive treatment but, of course, as members would expect, we ask health boards to keep a close eye on that.

The regulations are being introduced to provide a stable foundation for reimbursement and prior authorisation decisions that NHS boards make; they reflect the existing case law of the European Court of Justice, so it is important to stress that they do not impose new obligations on boards but simply reflect existing law in the form of the Watts judgment and provide a framework in which decisions that boards might need to make from time to time can be made in a way that complies with EU law. As I said, the regulations are intended to be interim measures until the cross-border health care directive comes into force and codifies the law, bringing certainty to the rules surrounding patient mobility.

I am happy at this stage, convener, to answer any questions that members have.

The Convener: Thank you very much; that was very helpful.

Rhoda Grant (Highlands and Islands) (Lab): Obviously, people have to ask for prior authorisation; on what basis can a health board refuse it?

Nicola Sturgeon: The regulations apply to all "eligible services", which are defined in the regulations. It is the subset of eligible services, known as "specified services", which are also defined in the regulations, that require prior authorisation. In effect, they are the more complicated and costly services; for example, when someone requires an overnight stay in hospital for

"medical treatment that involves ... Anaesthesia"

or services that need the use of

"specialised or cost-intensive ... medical equipment."

The grounds on which a health board can refuse authorisation where prior authorisation is necessary are very limited; the main ground, as set out in the regulations, is that a health board is able to provide the treatment at home without undue delay. To put it bluntly, if a health board says to somebody who asks to go to another European country for a hip replacement operation, "We can provide that here in Edinburgh in two weeks or a month," that would be a ground for refusing authorisation to go elsewhere.

Rhoda Grant: I am thinking about a particular case, although I obviously do not want to discuss the details here. It involved a situation where it

may have been beneficial to a patient to travel abroad for an operation because they would have had more support in another country and would not have had a language barrier. The health board refused consent and said, "We can provide this operation here. We think we can cope with your language barrier and it's not our business whether you've got support or not when you get home after the operation."

Nicola Sturgeon: Health boards will discuss circumstances with individual patients. I appreciate that you do not want to get into the individual circumstances; I would not be able to comment on them anyway. To refer to the law, it would be a ground for refusing prior authorisation if the board was able to provide the treatment at home without undue delay. If a service or treatment did not require prior authorisation and was an eligible service, boards could not refuse to reimburse the patient. Of course, though, the treatments and services that do not require prior authorisation are likely to be the most minor ones. I hope that that answers your original question.

Rhoda Grant: On that basis, if somebody applied to a health board for authorisation and it put them to the top of the waiting list, it could avoid its obligations under the regulations.

Nicola Sturgeon: I do not think that it would be accurate, legally, to say that the health board would be avoiding its obligations. The regulations say that if treatment can be provided here without undue delay, that is a ground for refusing prior authorisation. As members will appreciate, notwithstanding the laws that apply in different cases, health boards will always enter into discussions with patients about the most appropriate way of delivering services. My simple answer to your simple question is yes: a health board's being able to provide the treatment here, without undue delay, would be a legitimate and legal reason for its refusing prior authorisation. Of course, any patient in those circumstances would have the right to challenge the health board's decision, just as they would have the right to challenge all sorts of decisions. However, the reason of undue delay will exist in law if the regulations are passed.

Mary Scanlon (Highlands and Islands) (Con): I find the phrase "undue delay" problematic. I do not want to talk about a specific case but, during the waiting times debate on 27 May, I raised the issue of someone in the Highlands who was waiting for a hip replacement but whose operation was delayed by about three years. He needed three cortisone injections and eventually had to give up work because he could not walk. When he finally got on to the waiting list, although he was in agony he still faced a wait of 18 weeks, because everyone has to wait 18 weeks between referral and treatment regardless of how much pain they are in. I am, therefore, trying to understand the interpretation of "undue delay". Would that person, at the point at which he had to wait 18 weeks, although it was obvious that he needed the operation sooner, have been eligible for prior authorisation? Would that have been considered "undue delay"? Should that patient—or should I, on his behalf—have challenged the health board and asked that he get the treatment elsewhere if the health board could not provide it sooner?

Nicola Sturgeon: I will not comment on an individual case.

Mary Scanlon: No, I appreciate that.

Nicola Sturgeon: Undue delay is defined in the regulations—

Mary Scanlon: Yes, I see it here.

Nicola Sturgeon: I know that you can see it, but I will read the definition for the *Official Report*. Undue delay is defined as meaning

"that the services cannot be provided within a period of time which is acceptable on the basis of medical evidence as to the clinical needs of the eligible person, taking into account that person's state of health at the time the decision is made and the probable course of the medical condition".

It is an objective, medical assessment. It is clear, from the Watts case, that it is not acceptable, in and of itself, for a health board to say that, because its waiting time target is 18 weeks, it is acceptable for everyone to wait 18 weeks if, according to a clinical judgment, a patient should be treated sooner than that. It is a clinical decision. That obviously has to take into account all the circumstances, but it is important to stress that it is "undue delay" with reference to the clinical circumstances, not to whatever waiting time any Government or health board sets.

Mary Scanlon: There should not be a blanket 18-week waiting time; waiting times should be based on clinical need.

Nicola Sturgeon: Yes. Absolutely.

Mary Scanlon: That certainly was not made clear. I have a second point on an issue on which my colleague, Helen Eadie, has spoken several times. Not only are there long waiting lists for fertility treatment—the waiting time is still about three years in Grampian—but the treatment is age barred. Also, a couple of years ago, it took four years and seven months for someone with mental health issues to see a psychologist. There appears to be an undue delay for people who require treatment for certain mental health conditions and infertility. The older a woman gets, the less fertile she becomes. Would treatment for those two separate conditions be eligible for prior authorisation and cross-border finance?

Nicola Sturgeon: It is impossible to talk about all cases, as health boards are required to make a judgment in each individual case. Also, those judgments are challengeable, which is why I said that the regulations do not completely cut out the possibility of challenge. I refer you to the definition of "eligible services" in the regulations, which is services that are

"necessary to treat or diagnose a medical condition of the eligible person".

Cosmetic surgery, for example, would not fall into that definition because it would not be the treatment of a medical condition.

Mary Scanlon: I appreciate that.

Nicola Sturgeon: Within the definitions in the regulations, judgment requires to be applied. The regulations provide a framework in which decisions can be made on a case-by-case basis.

10:15

Mary Scanlon: I read the regulations carefully last night. Infertility is perhaps the only condition with an age bar for treatment, but there is nothing that applies to age in new section 75C, "Prior authorisation", which is inserted by regulation 3(3) into the National Health Service (Scotland) Act 1978. Is infertility not a medical condition?

Helen Eadie (Dunfermline East) (Lab): Doctors at Ninewells hospital have said that it is a medical condition.

Mary Scanlon: Helen Eadie is now giving evidence.

Nicola Sturgeon: I am not a doctor. I am aware that there are two doctors at the table who will be only too quick to correct me if I am wrong. Whether this is or is not a medical condition will depend on individual circumstances. I am sorry, but I have forgotten the point that I was going to make.

Mary Scanlon: It was on the age bar—

Nicola Sturgeon: Yes. The prior authorisation section simply determines which treatments and services require prior authorisation. Given the nature of fertility services—and notwithstanding all the other judgments that have to be applied—I am pretty sure that they fall into the category of treatments that require prior authorisation.

Mary Scanlon: And the age bar would be taken into account in terms of undue delay.

Nicola Sturgeon: No. You can get treatment abroad only for things that you are entitled to get under the NHS here. I will not go into specifics, but NHS regulations here say that fertility services for those over a certain age are not available on the NHS. You cannot go to another European country to get a service to which you are not entitled in your home country.

Helen Eadie: The reality is that each health board has a different age bar. That is an issue. If someone lives in Lothian, they will get treatment, but if they live in Fife, they will not. We have one NHS, but several different interpretations.

Nicola Sturgeon: I do not want to get into a completely separate discussion on fertility services. Given Helen Eadie's close interest in the matter, I know that she is aware of our work on this. Long and variable waiting times for fertility services are not new; they have been in existence for a long number of years. We are getting those waiting times down, albeit arguably—inarguably, perhaps—not as fast as we would all like. That is an issue. It remains the case that, in theoretical terms, if someone is entitled to something in their health board area, they are possibly entitled to it in another European county, subject to all the other conditions. If someone is not entitled to something in their health board area, they cannot go to another European country to get it.

The Convener: That has clarified the position.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Is the level of costs determined by the green book? Is there still a green book that lists the expected costs of an operation or procedure?

Nicola Sturgeon: With your permission, I will get you a detailed answer to the question. Health boards determine the equivalent cost of providing a treatment in their area. That cost determines the maximum level of reimbursement.

Dr Simpson: Right. And those costs vary from area to area.

Nicola Sturgeon: I think—

Dr Simpson: Perhaps you will come back to us on the matter.

Nicola Sturgeon: I think that the answer to the question is yes. I will come back to you with an absolutely specific answer.

Dr Simpson: Is there a recommended time period within which authorisation can be given? In other words, will health boards be told, "If you have an application, your decision must be reached within X days"? If we do not do that, there might be inordinate delay in reaching a decision that would enable the health board to say, "Actually, the operation will be done within a certain time," allowing them to refuse authorisation, whereas, if the board had reached a timeous decision, it would have had to authorise the application.

Nicola Sturgeon: We will produce guidance to back up the regulations. We are working with health boards on the detail. The general time

period for reaching a decision is 21 days. Obviously, if a board does not reach a decision timeously, the patient will have a possible ground for challenge.

Dr Simpson: That is helpful.

I turn to the issue of variation. An area of current interest to me is bariatric surgery. Over the past five years, NHS Fife has done five procedures whereas NHS Forth Valley, the neighbouring health board, has done 60. If someone lives in Forth Valley and has a condition that requires such surgery, they will be treated timeously, but they will not if they live in Tayside or Fife, both of which have seen fewer than 10 procedures carried out over the past five years.

That is too great a variation to be due to happenstance, so there must have been some sort of decision not to proceed with such procedures. Will that be taken into account? Will there be any guidance from the centre on the extent to which there can be such variations? With the significant achievements of the previous and current Administrations in reducing waiting times to their lowest levels ever, those variations have become much more evident.

Nicola Sturgeon: The procedures and treatments involved are obviously very different, but my comments to Helen Eadie about fertility services would also apply to bariatric surgery. Traditionally, we have had patchy and long waiting times for bariatric surgery, but we are taking action to address that and the Golden Jubilee is now doing operations. Of course, that kind of variation among health boards is pertinent to whether a particular health board could refuse to grant prior authorisation on the basis that the procedure could be provided without "undue delay". For bariatric surgery, that reason might be open to one health board but not to another, given the different circumstances that exist.

Dr Simpson: Finally, have we any idea—I do not suppose that we have at this stage—about the potential costs involved?

Nicola Sturgeon: The first thing to say is that we have no option but to comply with European law. The Scottish Government is not so much choosing as being obliged to introduce the regulations.

As might be expected, we will keep our assessment of the costs under very close review, both as the regulations are implemented and as the cross-border directive is finalised and comes into play, but we expect that the costs will be broadly neutral for a number of reasons. First, we expect that the numbers of people who take advantage of the regulations will be low. At the moment, fewer than 100 patients from Scotland each year access European health care through the E112 route. We do not have precise numbers on how many patients access treatment under article 56 of the European treaty, but the numbers using the article 56 route are also very small. We have asked health boards to start to collect those numbers. Secondly, health boards will be required to reimburse the cost only to the maximum of what the service would cost within their area. The regulations include provisions on travel expenses, but those are limited to situations in which patients would be entitled to travel expenses within Scotland, which is a very limited number of patients. Therefore, I think that the costs will be broadly neutral, but we will keep them under close review.

Helen Eadie: Ian McKee, Rhoda Grant and I are members of the Subordinate Legislation Committee, whose report on the regulations highlights the fact that

"the instrument makes significant amendments to primary legislation."

Given the significance of the proposed change, and given the debate that we know is taking place at EU level on prior authorisation, will it be easy to amend the regulations if the EU comes out in favour of no requirement for prior authorisation? If the committee agrees the motion today, the regulations will go through the Parliament relatively easily. Will it be possible to reverse the policy quickly if the EU agrees that the appropriate route to go down is to have no prior authorisation?

Nicola Sturgeon: Obviously, we all know what the procedures are for passing subordinate legislation. In those circumstances, we would act as quickly as parliamentary procedures allow.

It is fair to say that it is looking unlikely that the European Union will go down that route. Although the draft directive still has some way to go before it is finalised and implemented, there is political agreement around the broad framework. Clearly, a very strong part of the UK negotiating stance, which Scotland agreed and signed up to, was to insist on the need for prior authorisation, which is part of the political agreement. I would never say never, but it does not look as though that will be the direction of travel of the European Union.

Helen Eadie: When I spoke to Catherine Stihler last week, she advised me that the draft directive has gone back to the Council of Ministers, whereas it had been thought that the issue had been removed from the agenda, so to speak, following the most recent European elections. People are surprised that the issue is still making progress. Personally, I welcome any clarification that might be provided, which I think would also be welcomed by the European Court of Justice.

There are grounds for worry, as there was such a fine balance of votes when it came to the

European ministers, so we cannot be sure, and we need to be prepared. If there is not prior authorisation, it will be like signing a blank cheque on behalf of all of us in the United Kingdom for people going abroad. Perhaps that is a good thing; perhaps it is a bad thing—people need to make up their minds on it.

Nicola Sturgeon: Prior authorisation is important, and the UK has argued and will continue to argue that line strongly, with the full support of the Scottish Government. The draft directive has been up and down in terms of its progress and momentum. The Watts case was in 2006. We are now in 2010, putting in place the interim regulations. The reason why Scotland and the other countries in the UK did not do this much sooner after the Watts case was that we all expected the directive to be passed more quickly and to be in force by now. Its progress has been stuttering, however.

Since the European elections, the directive has picked up momentum and political agreement has been achieved. Although it still has some distance to travel, we expect it to maintain that momentum. However, these things are subject to complicated European negotiation, which is why it is important to put the interim regulations in place and to demonstrate that we are compliant with EU law.

Helen Eadie: Will the view change? When the Conservatives were arguing on the matter in the corridors of power in Brussels, they argued for no prior authorisation. Will the emphasis change with the change in Government? Might it be appropriate to write to United Kingdom ministers on the matter to clarify the point?

Nicola Sturgeon: I am in regular correspondence with UK ministers on the matter, and I have been for some time. There is no indication that the new Government is changing the parameters of the negotiating stance.

Helen Eadie: But the Conservatives were arguing in Brussels for no prior authorisation, so it is worth getting clarification.

Nicola Sturgeon: It is important to understand the timescale. I have just been passed Andrew Lansley's letter to me, from the Department of Health. As he makes clear, part of the UK negotiating stance is to

"protect the right of the home Member State to decide entitlements to healthcare"—

I was going to say, "blah, blah, blah," but I should not do that on the record.

The Convener: Unless the secretary of state actually wrote that.

Nicola Sturgeon: My sincere apologies to the Secretary of State for Health. The letter continues:

"ensure that Member States can operate a meaningful system of prior authorisation".

The political agreement in Europe that I mentioned was obtained following the general election.

Helen Eadie: What was the date of the letter from the secretary of state, if I may ask?

Nicola Sturgeon: It was 27 May.

Helen Eadie: Thank you.

The Convener: You have had a good bite at that cherry, Helen.

In bringing the evidence session to a close, I invite the cabinet secretary to move motion S3M-6477.

Motion moved,

That the Health and Sport Committee recommends that the draft National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010 be approved.—[*Nicola Sturgeon*.]

The Convener: We move on to the debate on the motion. Does any member wish to speak in the debate?

Mary Scanlon: No.

The Convener: Good.

Motion agreed to.

The Convener: I thank the cabinet secretary.

10:28

Meeting suspended.

10:29

On resuming—

e-Health Inquiry

The Convener: Item 4 is our inquiry into the clinical portal programme and the Scottish centre for telehealth. I refer members to paper 3, which sets out options for our consideration. I invite comments.

Mary Scanlon: I recommend option (ii) on the clerk's paper. Telehealth and clinical portals are subjects that we should not lose sight of. We made some very critical comments in our report, and I would welcome a debate and an update. The centre for telehealth is, as of this year, merged with NHS 24, and a debate on that in the autumn would be very helpful.

The Convener: Does the committee agree?

Members: Yes.

Helen Eadie: I agree.

The Convener: That is good. Even I agree.

Rural Out-of-hours Health Care Provision Inquiry

10:30

The Convener: Item 5 is on our inquiry into rural out-of-hours health care provision. We are invited to consider a response from the Scottish Government to our inquiry report. I refer members to paper 6, which sets out the committee's options. We also have the response from the Cabinet Secretary for Health and Wellbeing among our papers.

Mary Scanlon: The cabinet secretary has addressed most of our issues. The Scottish Government is looking into integration of and communication between the various services. It would be helpful to get updates and more feedback on the many things that we found in the course of our inquiry. Improvements are being made at the moment, and a debate on the subject in the autumn would be very helpful.

Ian McKee (Lothians) (SNP): We have received a letter on the topic from Mr Barbor-Might, and there are further issues to be explored.

The Convener: That is not a committee paper, although you may refer to it.

Ian McKee: Well, I have in front of me a letter that I have received from Mr Barbor-Might, which I believe other committee members have received, although it is not a committee paper.

The Convener: That is correct—thank you.

Ian McKee: He expresses some concerns, which I share to an extent, and I think that they need to be explored in debate. I support what Mary Scanlon said about having a debate on the subject. We should explore the matters in the chamber, rather than here and now.

The Convener: I can put in a bid for one debate of two or two and a half hours, or I can bid for two and a half hours to be split into two debates, rather like the arrangements for tomorrow. I will make that a B plan. Do we want a debate of two or two and a half hours, or shall we split our time to have two separate, short debates?

Ian McKee: Both the subjects that we have just discussed are very important topics for the future of Scotland—vast swathes of Scotland are rural areas, and they have their own problems; telehealth and telemedicine offer enormous opportunities for the health of Scotland. That is much too important for a short debate.

Rhoda Grant: Having two longer debates—

The Convener: But if that is too much to ask—if we are not going to get two debate slots—do you

want me to have our time split into two, or should we make a choice between the two subjects?

Helen Eadie: You should say that we will pass a motion of censure against the Conveners Group if it does not agree.

The Convener: You go for it, Helen. Do members want me to split our one time slot if we do not get the two debates, however?

Helen Eadie: No.

Rhoda Grant: Yes. Rather than—

Ross Finnie (West of Scotland) (LD): Given that we have a health debate every week, I cannot believe that we will find it impossible to secure two committee debates.

The Convener: I never said that—I just want to have a B plan.

Dr Simpson: A second debate could replace some of the less meaningful debates that we are subjected to.

The Convener: So you want me to go for broke.

Ross Finnie: Go for broke.

Members *indicated agreement*.

The Convener: That is very robust—I will try to secure a debate on each topic.

Mental Health Services (Deaf and Deaf-blind People)

10:33

The Convener: Item 6 on the agenda is on improving services for people with mental health problems and sensory impairment. We have for our consideration some correspondence from the Minister for Public Health and Sport regarding specialist in-patient services. I refer members to paper 8, which sets out the committee's options. I seek members' views.

Mary Scanlon: I suggest that we choose option (i):

"Note the response from the Minister".

The Convener: Is that agreed?

Members *indicated agreement*.

10:33

Meeting continued in private until 11:11.

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