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Official Report

HEALTH AND SPORT COMMITTEE

Wednesday 2 March 2011

Session 3

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HEALTH AND SPORT COMMITTEE
4th Meeting 2011, 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:

Shona Robison (Minister for Public Health and Sport)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 3

Scottish Parliament

Health and Sport Committee

Wednesday 2 March 2011

[The Convener *opened the meeting at 10:02*]

Subordinate Legislation

Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2011 (Draft)

The Convener (Christine Grahame): Good morning and welcome to the 4th meeting in 2011 of the Health and Sport Committee. I remind everyone to switch off all mobile phones and other electronic equipment. No apologies have been received.

Item 1 is an oral evidence-taking session with the Minister for Public Health and Sport and Government officials on an affirmative instrument, the draft Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2011.

Members have received a cover note that sets out the purpose of the regulations and comments made by the Subordinate Legislation Committee. I welcome Shona Robison, the Minister for Public Health and Sport, and Shaun Eales, policy officer for care at home and free personal and nursing care in the Scottish Government. I invite the minister to make brief opening remarks on the regulations.

Shona Robison (Minister for Public Health and Sport): The draft regulations reflect the Scottish Government's commitment to increase free personal and nursing care payments in line with inflation. The regulations, if approved, will benefit vulnerable older people.

Last year, we increased the personal and nursing care payments for residents in care homes in line with inflation. The regulations will further increase—in line with inflation—the weekly payments for personal care by £3, to £159 per week, and the additional nursing care payments by £1, to £72 per week.

In line with our concordat with local government, councils will meet the costs of the inflationary increases, which total about £1.8 million across all councils, from within their agreed settlement allocations.

The free personal and nursing care policy continues to command strong support. I hope that the regulations receive the committee's support. I am happy to take any questions.

The Convener: Thank you, minister. As there are no questions, we will move to item 2, which is a debate on the motion to approve the regulations. If no member wishes to speak in the debate, I ask the minister to move motion S3M-7889.

Motion moved,

That the Health and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2011 be approved.—[*Shona Robison*.]

Motion agreed to.

Public Services Reform (Scotland) Act 2010 (Consequential Modifications) Order 2011 (Draft)

The Convener: Item 3 is a debate on the motion to approve an affirmative instrument on which the committee took oral evidence at its previous meeting. The draft order relates to the establishment of healthcare improvement Scotland and social care and social work improvement Scotland.

If no member wishes to speak in the debate, I ask the minister to move motion S3M-7874.

Motion moved,

That the Health and Sport Committee recommends that the Public Services Reform (Scotland) Act 2010 (Consequential Modifications) Order 2011 be approved.—[*Shona Robison*.]

Motion agreed to.

Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (Draft)

The Convener: Item 4 is a debate on the motion to approve regulations that also relate to the establishment of healthcare improvement Scotland and social care and social work improvement Scotland, and on which the committee also took oral evidence at its previous meeting.

Does any member wish to speak in the debate? I shall take the silence as a no.

I ask the minister to move motion S3M-7882.

Motion moved,

That the Health and Sport Committee recommends that the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 be approved.—[*Shona Robison.*]

Motion agreed to.

National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Regulations 2011 (SSI 2011/55)

The Convener: Item 5 is an oral evidence-taking session with the Minister for Public Health and Sport, and Government officials, on a negative instrument. A motion to annul the regulations has been lodged and will be considered formally at item 6.

Members have a cover note setting out the purpose of the regulations and the comments made on them by the Subordinate Legislation Committee. The minister is joined by Scottish Government officials Tom Wallace, policy manager at health and healthcare improvement; Dr Catriona Hayes, statistician at health analytical services; and Nicholas Duffy, solicitor in the health and community care division. I invite the minister to make some brief opening remarks about the regulations.

Shona Robison: I have been in this position on a number of occasions now, both in plenary sessions of the Parliament and before the committee. I again welcome the opportunity to discuss with the committee the abolition of prescription charges.

I do not want to go over too much old ground, but I would like to re-emphasise that the policy will benefit everybody who must pay for their prescriptions. It will be of particular benefit to those with poorer health and to those with long-term conditions. Some people have said that the policy will benefit only rich people, but that is to ignore the thousands of ill people on modest incomes who are already better off as a direct result of the policy.

Patients should not be deterred from following the clinical judgment and guidance of their general practitioners—if that happened, the benefits that people receive from taking all of their medication would be lost. We believe that free prescriptions are a long-term investment in improving health. If, for financial reasons, people are put off seeking appropriate care, their health will not improve. If patients are able to get the treatment that they need, not only will it help their health, it will ultimately help to reduce the longer-term costs to the health service.

The abolition of charges will help people whose long-term conditions currently do not entitle them to exemption. Our approach ensures that all people with any condition will benefit. The approach is widely supported by doctors, patient organisations and other key representative groups. By abolishing prescription charges, we will make a significant contribution to achieving the healthier Scotland that we all want. Cost will no longer put people off consulting their doctors or collecting the medications that their doctors have judged necessary. I strongly believe that the amount of money associated with this policy is a price worth paying to ensure that patients take all their prescription medication.

These are difficult economic times. Removing barriers to good health and putting money back into people's pockets—especially people who are struggling to make ends meet—have never been more important.

I am happy to take questions.

The Convener: I invite questions from all committee members, but I will start with Mary Scanlon, as she has lodged the motion to annul, then I will come to Richard Simpson.

Mary Scanlon (Highlands and Islands) (Con): Scottish Conservatives acknowledge the huge pressures that will face the national health service over the coming decades. That is why we have pledged to protect health spending in Scotland. However, in these difficult times, it is more important than ever to consider how every pound is spent, and to examine whether that spending represents the best use of limited resources. We have to consider the opportunity costs of allocating money to the abolition of prescription charges.

The Convener: I point out that we are looking for questions for the minister, not a consideration of the motion to annul.

Mary Scanlon: I thought that you said that you were taking item 6 as well.

The Convener: No, this is questions. We will then go on to a debate on the motion.

Mary Scanlon: All right. I will leave it at that.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have one or two questions, the first of which regards the minor ailment service. Until now, the outdated and outmoded prescription charge exemption system has also been the basis for inclusion in, or exclusion from, the minor ailment service. As the minister will know, I have repeatedly asked questions on this matter since the announcement of the Government's policy initiative. At the moment, the minor ailment service costs £16.2 million per annum. If the massive bureaucracy surrounding the current scheme is maintained and continues to restrict access to services for minor ailments, you will lose part of the benefit of getting rid of prescription charges.

We do not need a massive bureaucratic system asking whether people qualify on this ground, that ground or the next ground. My understanding from the Government's response—I want to ask whether this is still your position—is that that entire bureaucracy will remain in place for the minor

ailment service and the system will not be modified to simplify it.

Shona Robison: First, we would never leave anything frozen in time. It is always worth examining whether modifications and changes are required to the minor ailment service, but it is, of course, more of a patient management system, because it targets vulnerable groups and helps to avoid them going to their GP. Those are the people who are most likely to have minor ailments, and the basis of the minor ailment service is to avoid them taking up the time of GPs. There is therefore still very much a role for a system that tries to manage patient flows away from GPs.

If you are asking me whether the system will stay the same for ever, of course it will not—it would be silly to say that it will. It might be worth looking afresh at the service to ensure that its purpose—which is patient management and patient flow—is maintained, and to establish whether the system requires modification in the light of the abolition of prescription charges. We are happy to consider the matter.

Dr Simpson: We concur with the Government on the fact that the current prescription charge system is outdated and outmoded, but to get totally free prescriptions and to have access to the minor ailment service simply because you have a thyroid condition does not seem to us to be appropriate. We think that the Government has missed an opportunity—which I have been trying to warn it about since its policy to abolish prescription charges was first introduced—to modify the MAS, so I welcome the minister's relatively conciliatory tone. However, I urge her strongly, given the current period of austerity, to look closely at the MAS to ensure that people who are vulnerable and unable to afford to treat minor ailments can access it, but those who are wealthy and do not need to access it are in some way restrained. I urge a more urgent approach than the Government has hitherto indicated.

I have a second question, convener.

The Convener: That was pre-emptive. You are, of course, allowed to ask it.

Dr Simpson: My second question is the one that I asked when the policy was originally introduced. At the time, I was not concerned about getting rid of the scheme—I have said all along that that is an entirely appropriate measure—but I am concerned that the cost of drugs is rising, and I am concerned about whether we have a robust enough system in place for orphan drugs and, in particular, for ultra-orphan drugs. I am not convinced that we currently have an adequate system.

Given the additional financial pressures that the abolition of prescription charges will put on the system, I would like an undertaking from the Government that it will look again at the ultra-orphan system to ensure that patients with the potential for metastatic osteosarcoma in childhood, for example, will get the appropriate treatment, because the current system of quality-adjusted life years, which the Scottish Medicines Consortium uses in determining whether ultra-orphan drugs will be approved, is totally inappropriate for conditions that affect 10 or fewer patients a year. I do not believe that we have got the ultra-orphan system correct.

The Convener: I think that a question was buried in there.

Shona Robison: I think that there were two or three. First, on the system for approving ultra-orphan drugs, improvements were made following strong representations through the petitions system. I think that we all acknowledge that that led to a much-improved system. Is there further to go? These matters must always be kept under review, but we are in a better place than we were previously.

The general cost of drugs is an important issue. We have introduced a number of management systems to try to ensure that prescribing is appropriate and to move on to more generic prescribing. The gross and net ingredient costs have stabilised a bit during the past couple of years. Nevertheless, the drugs budget as a whole is a major element of the health budget. We have to ensure that we constantly look for new ways of containing that cost.

You asked a number of questions, and I hope that I have given you some reassurance.

10:15

Dr Simpson: Partially. I welcome the exceptional needs programme, which will come in fully in April. However, the problem with an exceptional needs system is that for someone to have an exceptional need, they have to be different from the generality of patients who are seeking the treatment. If there are only four or five patients with the condition in Scotland, the opportunity for defining an exceptional need is limited.

I do not want to decry the Government's exceptional needs programme. We have made progress, although it has been slower than I would have liked. Things happen in Government and sometime it cannot move as fast as it would like to. However, I urge the Government to re-examine the ultra-orphan system, because it is important.

The minister will be aware that I have submitted two parliamentary questions—which I will not ask her to answer today, but which I want to put on the

record—on the current consultation on changing the price of drugs in England, because that will change prescription costs, which is important and relevant to this debate. I hope that she will put into the Scottish Parliament information centre the Government's submission to that review.

The Convener: I was waiting for that bit at the end, because I am allowing a rather broader set of questions about the consequences of free prescriptions.

Helen Eadie (Dunfermline East) (Lab): I echo everything that Richard Simpson has said. I also want to make the minister aware that I have submitted a freedom of information request to all the health boards in Scotland. The evidence in the responses that I have received points to the fact that the drug costs in the minor ailment service have quadrupled during the past four years. I also requested any guidance that the health boards had received about the minor ailment service, and they said that they had not received any. The minister should be aware of those two matters when she is conducting her deliberations.

Shona Robison: Okay; thank you for that.

The Convener: That is the end of the evidence session.

Item 6 is a debate on the motion to annul the regulations. I take it that Mary Scanlon wishes to speak in the debate.

Mary Scanlon: Yes.

The Convener: Under standing orders, the debate can last for a maximum of 90 minutes. I ask Mary Scanlon to open the debate—

Dr Simpson: That is a challenge.

The Convener: That was not an invitation to speak for 90 minutes; those are just the rules. I invite Mary Scanlon to move and speak to the motion.

Mary Scanlon: I do not think that I will take 90 minutes. I will just start where I finished off earlier.

The question that we face today, which comes against a background of efficiency savings and cuts in the health service, is: should the Government reduce from £3 to nil the cost of prescriptions for those who can afford to pay?

Every penny spent has an opportunity cost. In a recent debate on early intervention, the Conservatives suggested that the money could be used to fund a universal health visiting service to ensure that every child under the age of five gets the vital health and development checks that this committee recommended in our report on child and adolescent mental health services. The importance of early childhood development and the impact of early intervention in determining future health, social wellbeing and educational achievement is widely recognised, and that is what we want to use the money for.

The independent budget review, which was established by the Scottish Government, stated in July 2011—

The Convener: Sorry, but it cannot be July 2011, because we have not reached it yet. Maybe you have, Mary. You are faster than the rest of us. [*Laughter*.]

Mary Scanlon: I am sorry, I meant 2010.

The independent budget review stated:

"The Scottish Government currently plans to abolish prescription charges entirely from April 2011 at an additional net cost of £25 million when compared with the income expected in 2010-11 ... In the current financial climate, the Panel considers that there is a pressing need to reconsider the planned abolition of prescription charges in Scotland."

The British Medical Association Scotland stated in its submission to the independent budget review:

"There is an urgent need for an honest and open debate on what the NHS can and cannot afford, and a number of difficult questions may need to be asked: is the move to free prescriptions still affordable?"

I trust that the minister will respond to those comments.

Between 2007-08 and 2008-09, the number of items dispensed to patients who were exempt from paying any charge increased by 4 per cent to 74.4 million. In 2008-09, only 6 per cent of prescriptions were subject to the full charge; 88 per cent were exempt and pre-payment certificates, which rightly cap the charges that patients must pay, accounted for a further 6 per cent.

Over the past decade, the cost of prescribed items to the NHS has increased significantly, from £598 million in 1998-99 to £1.074 billion in 2008-09—the cost has more or less doubled—and that was while a prescription charge was in place. It is also worth noting the figures that ISD Scotland released in December 2010 that showed that 10 per cent of the population of Scotland are on antidepressants and that the number of drugs prescribed increased by 7.6 per cent from the previous year, despite the Government commitment to reduce antidepressant prescribing. We need to ask, will those statistics be affected by the abolition of prescription charges?

Returning to early intervention, we are clear in our commitment that the money saved from abolishing prescription charges should be used to develop a national health visiting strategy. That would be a truly worthwhile use of £20 million that would see significant benefits for children and families in generations to come.

The issue of wastage has been raised in the past at this committee. Health boards have recently been set new efficiency targets to free up £300 million for investment in improving health care. In principle, driving down inefficiencies is to be welcomed, as there is no reason to believe that efficiency savings would automatically have a negative impact on front-line services, and the challenge for the NHS is to ensure that savings can be made and that front-line services can be protected. However, the question remains, how can the minister promote measures to tackle waste while at the same time push ahead with the abolition of prescription charges, which has questionable benefits for front-line care and people who are most in need?

We need more clarity around the abolition of prescription charges. Richard Simpson raised points about the minor ailment scheme, so I will not repeat them.

I move,

That the Health and Sport Committee recommends that nothing further be done under the National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Regulations 2011 (SSI/2011/55).

Shona Robison: Mary Scanlon has raised a number of points. On the opportunity costs, political judgments and decisions are involved. We believe that there is a strong argument for the abolition of prescription charges. I will not rehearse what I said in my opening remarks, but I remind members that at least two thirds of medicines are dispensed to treat long-term conditions, and the remaining third goes to patients with acute conditions. Some medicines go to the many patients who are on low or modest incomes. We have referred on a number of occasions to the 600,000 adults who are living in families with an income of less than £16,000 who currently must pay for prescriptions.

The fundamental issue is that the previous system was unfair, which was the conclusion that our colleagues in Wales and Northern Ireland came to. We have steadily worked towards the abolition of prescription charges, and this is the last stage. We believe that this is the fairest and most equitable system. Trying to come up with another list of exemptions would just create new inequalities.

I find it interesting that in opposing the abolition of prescription charges, Mary Scanlon has not mentioned the fact that, to cover their commitments on early intervention and, of course, the cancer drugs fund, the Conservatives would actually have to put charges back up to £5. As a result, this debate is not just about abolishing charges; it is also about increasing them. These are political judgments, and we believe that such a move would be wrong. That said, I very much agree with the comments about early intervention. Indeed, in the budget, we put aside new resource to try to implement many of the early intervention measures that we all want. Of course, we recently had a useful debate in the Parliament on some of those issues, on which there is a lot of consensus.

With regard to Mary Scanlon's remarks about the number of items dispensed, I point out to the committee that in 2009-10 the number of prescribed items dispensed increased by 3.9 per cent or around 3.3 million items. However, the majority—3 million—went to patients who were already exempt, and we would not expect any more of an increase as a result of this policy. The other 300,000 items—or about 0.3 per cent of the total—were dispensed to non-exempt patients, which we should consider alongside indications from the first half of 2010-11 that the increase in the number of items dispensed to non-exempt patients has slowed to less than 2 per cent. We really must put the issue into some context. Also, there is no evidence from Wales, where prescription charges were abolished a while ago, of a huge upsurge in the number of items prescribed to previously non-exempt people.

I acknowledge that antidepressant prescribing is a really tough nut to crack and has been a challenge to successive Governments. We have sought to look at the problem from the other end of the telescope by investing significantly in psychological therapies and ensuring that viable alternatives to prescribing antidepressants are available, particularly to general practitioners, who have to make decisions about the best way forward for the patient who is sitting in front of them.

Finally, I agree that we must remain vigilant in reducing drug wastage either in the system or through patient use, and in that respect we have implemented a number of schemes and systems. I have already referred to the importance of appropriate prescribing and of generic drug prescribing, neither of which will be changed in any way by the abolition of prescription charges. They are and will remain important.

I think that that covers most of the points.

The Convener: We can come back to you, if necessary, minister.

Dr Simpson: As I have already made clear, my party agrees that the current system is outmoded and outdated and that any attempt to alter the list of exemptions would have been bound to get into trouble. Putting boundaries between conditions does not seem appropriate in this day and age, particularly when long-term conditions are the major problem. After all, when prescription charges were first introduced in the 1950s—at a

time of austerity, I should add—the system related more to acute conditions.

I come at this issue from a more personal point of view, as a general practitioner who experienced the deaths of individuals who failed to take the full medication that was set out in multiple prescriptions. Indeed, I know of one student who died when he failed to take his prescription for steroids. I was not involved in that case, but the doctor in question was devastated to find that, despite his admonition to the patient that he had to take the medication, the student decided that he could not afford it. The student would have been exempt under the system, but the application form, which I draw to the attention of members who have not seen it, is about 35 pages long and for students has to be completed every six months. The bureaucracy involved is massive—the whole operation is massive—so I very much support the Government's approach of abolishing prescription charges.

10:30

Other savings will be made. Not only will there be fewer deaths—clearly, one death is one death too many—there will be fewer admissions to hospital because of compliance failures. No calculations have been done on that, and I regret the fact that we do not have more research to support the very good political case that the Government has made.

There are concerns. This is not the first time that we have reached this point. On the basis of its values and principles, Labour previously abolished prescription charges. We did not introduce them in 1948 because we did not feel that they were appropriate. We were forced to do so in the 1950s, although Bevan himself resigned over the issue, as did Harold Wilson. They were then abolished by the Labour Government, but there was a substantial rise in the costs and numbers of prescriptions.

Again, to give the Government credit, it has followed the Labour Party in Wales in adopting the salami-slicing tactic of gradually reducing the prescription charge to zero. That has had the benefit of getting people to adjust, and it may prevent the massive rise that we experienced when we abolished the charges in the past. However, I add a note of caution. I do not think that the early figures from Wales are as good as the minister is suggesting. There are some early indications that there have been rises, particularly in minor prescriptions—which, thank goodness, do not cost a large amount—and in people switching to free prescriptions for minor ailments and therefore going to their general practitioner.

Again to be fair, the Welsh do not have a minor ailment system. I spoke to Rhodri Morgan when the Scottish Government first mooted that policy, and I asked him whether he would introduce such a system because, as the minister has said, it brings clear benefits in patient flow and reduced consultation with GPs. He said no, because he had received strong advice that to introduce a minor ailment scheme would be massively expensive on top of the abolition of charges and he felt that the Welsh could not do both things at the same time. The jury is also out in Northern Ireland. I therefore ask the minister to undertake today to maintain robust monitoring of what happens with repeat prescriptions and the costs of prescriptions.

Mary Scanlon raised the matter of waste. In my view, there is enormous scope for reduction in waste, which we have not yet tackled. No Government since devolution has taken on the task in a robust way. Pilot projects in Lothian have demonstrated substantial savings from changing the prescribing system, and we will need to follow that up, whoever is in government after May.

I have two final points—you will be glad to hear that I will not use the full 90 minutes, convener. We are disappointed that, despite our encouraging the Government, patients in Scotland with cancer were not exempted from charges at the same time as patients in England were. Frankly, that was unacceptable. It would have been a simple measure. We know that cancer patients have massive problems with poverty. Macmillan Cancer Support has established that fact, and Labour has committed itself to a partnership with Macmillan to ensure that there is poverty support for cancer patients in future. However, this Government could have introduced that policy without great cost. To me, it took a political decision that was inappropriate and regrettable.

My last point—if I can read my own writing—

The Convener: You are a doctor, after all.

Dr Simpson: Yes.

My final point is about bureaucracy. When we have changed the prescription system substantially on previous occasions, all the existing prescription pads and print-off systems have been destroyed and replaced by new ones. In a time of austerity, I strongly encourage the Government to ensure, if it has not already done so, that we simply acknowledge that people no longer have to fill in the back of the form and we therefore do not change the form until existing supplies run out. I know that we are not talking about megabucks, but I want it on the record that I hope that that will be taken into account. I can tell members that it causes massive irritation among doctors. In the old days, the changes meant

throwing out literally thousands of prescription pads; now, it would perhaps mean throwing out hundreds, if not thousands, of rolls of pre-printed computer paper.

Ross Finnie (West of Scotland) (LD): It seems to me that there are two debates running in parallel here. There is the philosophical debate about whether to abolish prescription charges, for the reasons that have been articulated, whether today or at another time. There is also the debate about the position that the Liberal Democrats and I have taken for over a year now in our budget presentations, which is that, because of the grave change in the economic circumstances, we should pause, reflect and take a different view on a number of measures, including prescription charges and free school meals. We repeated that position throughout our budget presentation this year and it would therefore be wholly inconsistent for us to change our view now, because it would raise questions as to how we would pay for the matters that we talked about.

The minister posited in her remarks that Mary Scanlon's approach is a move to increase charges. That might be the case in relation to matters on which Conservative Treasury spokesmen have made commitments, but my support for Mary Scanlon's approach is confined solely to the matters on this meeting's agenda, which have no relationship to any proposal for there to be an increase in charges.

Richard Simpson raised the issue of cancer drugs. I am bound to say that I was much more supportive of what he said earlier. On this difficult issue of approving, exempting or doing whatever you do with particular drugs, we must have a robust, objective basis for whatever is done. If one thinks that there ought to be different treatment for a cancer drug, one does not simply say, "Oh, well, we're exempting cancer drugs." I am not suggesting that Richard Simpson said that, but I am not happy with that position.

If one is concerned about the methodology that is adopted by the SMC or whomsoever, that is the point at which the intellectual argument ought to be mooted and we ought to be clear. It is not satisfactory for political parties and ministers simply to decide on a whim which drug ought to be exempt. Richard Simpson's view may well be right that there are certain issues that ought to be addressed in that system and that the Public Petitions Committee has not wholly done that. I do not demur from that position; I merely observe that the system ought to make decisions on an accepted, objective basis. There may be different elements to that and it may mean that the current system needs to be expanded. Liberal Democrats would certainly be much more content to go down that road.

For the economic reasons that I articulated last year and which, consistent with our position, I have repeated today, I will support Mary Scanlon's motion.

Ian McKee (Lothians) (SNP): I believe strongly in a health service that is free at the point of need, but I do not expect all the Opposition parties to agree with me on that. I want to discuss the issue from a rational perspective.

We have a health service where many things are free and easily accessible. For example, a few months ago I asked for an appointment to see a physiotherapist and I got a 40-minute appointment, not because I am an ex-doctor but because anyone can ask for such an appointment and get it. There is no bar to overcome and no one to ask whether it is a reasonable request—you just do it. Further, if you go into hospital for a week or so, you are fed—you are saving money, because you would have had to eat at home, but no one even dreams of charging you. Yet we are considering putting a charge on a prescription that a doctor has decided is necessary for your health. That seems to me an illogical way of tackling challenges in the health service.

I can see three main reasons for the drug bill going up. First, the pharmaceutical industry is inventing new drugs for conditions that either are not being treated very well or are not being treated at all. Obviously, that leads to extra expense. Secondly, we are all living longer. If we were all good enough to have a heart attack and die at 65, we would save the country a fortune—not only in benefits but in the drug bill. Thirdly, there is inefficient prescribing. The first two reasons are good things but, if there is inefficient prescribing, it is our job to tackle those who are prescribing inefficiently. That is what is being done.

If patients have been recommended a drug by a doctor, I cannot see how it is their responsibility not to take the drug so that they can save the country money. Examples relating to antidepressants quite amaze me. I have been to several meetings of professionals at which good evidence has been presented that we are actually underprescribing antidepressants in this country. That leads to a different argument, but trying to cut down the expense of antidepressants by persuading some people with depression not to take the antidepressants that are prescribed to them is, to my mind, applying the pressure to reduce costs at entirely the wrong point in the system. It is the prescriber who is responsible for the prescriptions, not the person for whom the medication was prescribed.

Richard Simpson's remarks about cancer patients were a little bit of a fig leaf for things that Labour did not do in England during its many

years in power. I agree with Ross Finnie's remarks about that.

This is the wrong place at which to charge people. I do not think that we should levy charges but, if we are going to do so, there are many other better places. This is one place where there should not be charges. If someone takes a drug that is not recommended for them, that is a bad thing—and it will probably be more expensive to the health service in the long run as well.

Helen Eadie: People around the table may have seen in the news this morning that many patients cannot afford the dental treatment that they so badly need. If a person does not have good dental health, it can impact on their heart condition and on a variety of other conditions. The Government has taken a welcome step; that is excellent and I am not going to criticise the Government for it. However, there are areas in which all of us in this room could do much better—especially in relation to the point that I have just made.

Everyone here knows that I have worked for many years with Skin Care Campaign Scotland, which has many facets—for example, I have worked with Alopecia Help and Advice (Scotland). I congratulate the minister on the work that she has done, because she ensured that the prescription charges gradually came down from, I think, £350 a year to £6.50. However, a concern was put to me by the special working group that the minister set up. She has not come back to that group to ensure that patients who need real-hair treatments—as opposed to acrylic-hair treatments—receive them. I hope that she will address that issue through regulations. The committee of management certainly feel aggrieved that the minister has not come back to the group. I do not say that in a mean way, and I acknowledge everything that the minister has done.

The Convener: Mary Scanlon said that people who can afford to pay for prescriptions should do so. That is an easy thing to say, but it is extremely difficult to define what "can afford to pay" means. In the debate in the chamber on prescription charges, I asked the Conservative finance spokesman, Derek Brownlee, what level he would attach to that. I admit that he was speaking off the cuff, but he gave a figure of £21,000. That is not a lot of money in today's society, and I do not know whether the figure was net or gross. However, the line has to be drawn somewhere, and Derek Brownlee drew it round about there.

As people have already said, there are additional costs associated with being ill—for example, for heating and transport—and a person's income may fluctuate over the period of being ill, because of days off work. Richard Simpson mentioned the complexity of the forms; how often would they have to be completed during a year as the person's—and their family's—income fluctuated? Means testing is complex, costly and very unjust. It can make a huge difference where the line is drawn.

10:45

The minister gave a percentage for the number of people who have long-term conditions and who are paying for prescriptions but, during our debates, we have pretty well agreed that it is almost impossible to draw up a comprehensive and fair list of long-term conditions, which makes the arguments difficult.

Ian McKee raised the moral or ethical position. If a person is in hospital and is prescribed drugs, they get them free but, if the person is at home, having been discharged from hospital or having not been in hospital in the first place—and we are trying to stop people going into hospital unless it is necessary—they will be charged for their drugs, and means tested. I cannot comprehend that.

I hope that many people would agree that access to health care should be free at the point of need. We pay our taxes for people to have free health care. I hope that I will hardly ever have to go to hospital, but I pay my taxes willingly—and I hope that others do, too—so that other people may have those services.

I entirely support the abolition of prescription charges, especially at a time of economic recession. Because of job losses and so on, more and more people may require access to medication. Prescription charges should not be levied on them at a time when they are losing income.

Shona Robison: I shall try to answer as many as possible of the questions that members have raised. There were a lot.

I do not want to get into a huge discussion about Wales, but there is no evidence yet of an unusual increase in the number of prescriptions being issued there. The Welsh Assembly Government has said that the policy has had no notable effect on the amount of prescribed medicine that has been dispensed over the counter. I reassure Richard Simpson that we will monitor all these matters robustly. I also reassure him that we are doing what he suggested about bureaucracy. A small change to forms will allow existing stocks to run down, and we have no intention of doing anything more than that.

I agree with Ross Finnie that it would be a retrograde step if ministers were to get involved in any decisions on which drugs should be approved or not approved. We must maintain an objective and independent system.

Ian McKee made a number of very important points, and I will pick up on what he said about the prescribing of antidepressants. I was surprised by the robust reports that showed that the prescribing of antidepressants is appropriate in the vast majority of cases. Some people may have thought that the opposite would be true, but the evidence does not support that. However, the lack of an alternative was affecting the decision-making process, and we felt that making psychological therapies more readily available would offer that alternative.

Helen Eadie raised a number of issues, and I thank her for acknowledging the progress that has been made. On the issue of wigs, I will have another look into the point that she made about real-hair treatment.

I will pick up on an important point that was made by Christine Grahame. Earlier, I mentioned the 600,000 adults with an annual income of less than £16,000 who must pay for prescriptions. If a figure of £20,000 is used, the number of adults who are not exempt reaches 760,000; and if a figure of £25,000 is used, the number of adults concerned reaches 960,000. Many people have incomes that do not allow them to live in what might be considered the lap of luxury, but they do not have an income that is low enough for them to avoid having to pay for prescriptions.

My apologies if I have not picked up on every point that members raised, but I have tried to consider the main ones.

The Convener: I have not forgotten Mary Scanlon; I was letting her hear the complete picture before asking her to wind up the debate.

Mary Scanlon: I thank colleagues and the minister for their contributions.

Obviously, there is much that we agree on. I refer in particular to the minister's commitment to reduce drug wastage and the point that Ian McKee made about inefficient prescribing. Richard Simpson was not far away from us when he talked about the scope for reducing waste. We have to be mindful of that as we face the abolition of prescription charges, particularly given the financial constraints that we are under.

My party and I in this committee have always fully supported reducing pre-payment certificates for people with long-term conditions, but it would be naive not to acknowledge the difficulties involved. I remember raising the difficulties with exemption and the fact that people with diabetes and epilepsy got free prescriptions while people with Parkinson's disease or asthma did not. I used that comparison quite often. Therefore, we acknowledge the difficulties with exemption.

It is important to put on the record that today's debate is about abolition. For the sake of the *Official Report*, I point out that my motion states:

"That the Health and Sport Committee recommends that nothing further be done under the National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Regulations 2011 (SSI/2011/55)."

That is nothing to do with introducing any charge. I appreciate that Ross Finnie picked up that point, but it is important to be clear about that. Members will notice that my remarks in the debate have been strictly to do with abolition.

The question is whether what has been proposed is the best use of national health service money and whether this is the best time for it. I heard what other committee members said, although I am not sure that I got an absolutely clear answer from the minister. The efficiency savings and the wastage aside, we need to know what the other savings will be in future, whatever happens in May. I think that Richard Simpson made that point. For example, if there are fewer admissions to hospitals and fewer visits to GPs, it is important to have information about that. It is important for decision makers to have that information so that we understand not just the costs but the savings.

I remind Ian McKee that the health improvement, efficiency, access and treatment target was a Government target to reduce the annual increase in antidepressants. It was not a target that I set; it was a Government target. As the minister knows, I have always supported the option for some people to have alternative therapies, such as psychiatry, psychology and cognitive behavioural therapies and counselling. There has been some movement in that respect, but that does not mean in any way that I do not believe that antidepressants are not appropriate. I understand the difficulty of reducing their use but welcome the fact that people with stress, anxiety or depression will be given more options in future rather than just a prescription for antidepressants.

Finally, Christine Grahame talked about the expression "can afford to pay". I appreciate that it can be interpreted in many ways, but remind her that ISD figures for 2008-09 showed that 6 per cent of prescriptions were paid for at the full charge.

The Convener: Thank you very much. That concludes the debate.

The question is, that motion S3M-8011 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Finnie, Ross (West of Scotland) (LD)
Scanlon, Mary (Highlands and Islands) (Con)

Against

Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

The Convener: The result of the division is: For 2, Against 6, Abstentions 0.

Motion disagreed to.

National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 (SSI/2011/32)

National Health Services (Superannuation Scheme and Pension Scheme) (Scotland) Amendment Regulations 2011 (SSI/2011/53)

Natural Mineral Water, Spring Water and Bottled Drinking Water (Scotland) Amendment Regulations 2011 (SSI/2011/94)

Food (Jelly Mini-Cups) (Emergency Control) (Scotland) Revocation Regulations 2011 (SSI/2011/95)

Food Additives (Scotland) Amendment Regulations 2011 (SSI/2011/99)

Health Professions Council (Registration and Fees) (Amendment) (No 2) Rules 2010 Order of Council 2011 (SI/2011/210)

The Convener: Item 7 is consideration of six negative instruments, which cover various issues. Members have a note from the clerk that sets out the purpose of each instrument. The Subordinate Legislation Committee had no comments to make on any of them. As no member wishes to debate them, are members content not to make any recommendations to the Parliament on them?

Members *indicated agreement.*

10:54

Meeting suspended.

11:02

On resuming—

Certification of Death (Scotland) Bill: Stage 2

The Convener: We move to stage 2 consideration of the Certification of Death (Scotland) Bill. Members should have a copy of the bill, the marshalled list of amendments and the list of groupings for debate. I welcome the Minister for Public Health and Sport, who is so fond of us that she will remain with us for the rest of the day.

Section 1 agreed to.

Schedule 1—Status and appointment of medical reviewers

The Convener: Amendment 1, in the name of the minister, is grouped with amendments 2, 3, 4, 6, 7, 8 and 10.

Shona Robison: The committee raised the issue of where responsibility for checking, prior to disposal, certificates that are associated with deaths abroad should lie. I reflected on the matter and listened to stakeholder concerns about the proposals in the bill to give that function to superintendents at local burial grounds and crematoria. As a result of that reflection, I lodged amendments 1 to 4 and 7, to require the medical reviewers office to carry out the function instead. I hope that the amendments will address the concerns of stakeholders and the committee.

The task of ensuring safe disposal for cremations is currently performed by medical referees. In future, the revised medical certificate of cause of death form will have the relevant information about implants and other devices, and that information will be transposed to the registration of death form. For deaths abroad, an application will have to be made to the medical reviewers, who will ascertain the presence of such devices.

Amendment 6 will ensure that the medical reviewers have powers to make any additional inquiries that may be necessary. Amendment 8 is simply technical, to provide consistent language in the bill. Amendment 10 confirms that we will not charge a fee for the change of responsibility for verifying foreign death certificates to the medical reviewers office.

I urge members to support the amendments in the group.

I move amendment 1.

Dr Simpson: I would like a little more explanation of how the medical reviewer will ascertain the presence of implants in people who

died abroad. Will he simply ask about that? The issue is tricky.

Shona Robison: I presume that investigations would be made and that some information on the death would be gathered in situ, wherever that might be. Paperwork might or might not reveal the presence of implants. If necessary, and if doubts remained about whether devices were present, medical reviewers could seek advice and expertise. In many cases, medical reviewers will be able to ascertain through paperwork that a person has a device—because of their medical history, for example. However, as a fallback position, further investigations could be made if required.

It is worth adding that most people who die abroad are on holiday and are registered with a GP in Scotland, so much of the paperwork about medical devices that have been fitted is available. However, the fallback is that external advice can be sought.

Dr Simpson: That is helpful. I support the amendments, but problems exist. I suggest that the minister seeks advice before stage 3. About 250 deaths a year occur abroad and the number of those people who have implants is of course small. However, any cremated implant would be explosive—the situation is really dangerous. Funeral directors abroad might check for implants—systems will be in place—but will the minister tell us at stage 3 how the issue will be dealt with? Would it be better to have a register of individuals in Scotland who have such devices, which the reviewer could access automatically? That suggestion might be impractical, but it has been raised with me for consideration.

Helen Eadie: Richard Simpson reminds me of a case that I dealt with that involved a young man who went to work in Thailand, where he stayed for several years. His parents were my constituents and came to seek my help when he died as the result of an accident in Thailand, because the costs of bringing his body home were enormous. In the end, they had him cremated, which reduced the costs significantly. I had to work closely with the embassy in Thailand, which made no comment on any of the checks that the minister talked about. As Richard Simpson said, perhaps the minister might consider the point further before stage 3. In my experience, it has been an issue.

Shona Robison: I am happy to undertake to give more information on the process. Guidance will be issued on such matters.

Amendment 1 agreed to.

Amendments 2 to 4 moved—[Shona Robison]—and agreed to.

Schedule 1, as amended, agreed to.

Section 2—Referral of certain medical certificates of cause of death for review

The Convener: Amendment 15, in the name of Helen Eadie, is grouped with amendments 17, 18 and 20. I draw members' attention to the pre-emption information. Amendment 15 in this group and amendment 16 in the next group are direct alternatives.

Helen Eadie: For the record, I state that I lodged my amendments because I was approached to do so by the British Medical Association and the National Association of Funeral Directors—I met the funeral directors just before the meeting.

Why is amendment 15 important in the associations' eyes? It acknowledges that the Government recently re-examined the numbers and decided that the number of reviews needs to be increased, but it believes that that is still not enough. In England and Wales, 100 per cent of death certificates will be seen by more than one doctor. In the associations' eyes, that is an improvement on the current system, in which all certificates for cremations—which represent 67 per cent of deaths—are seen by more than one doctor.

However, Scotland is moving to a system under which only 25 per cent of certificates will be seen by more than one doctor and only 4 per cent will be examined in any depth. The amendments that the minister has offered would mean that approximately 75 per cent of funerals—be they burials or cremations—will go ahead with only one doctor seeing the death certificate or the body.

The BMA and the funeral directors by no means question the ability or professionalism of doctors, but they recognise that the proposed system is significantly less robust than the current system or the new one in England and Wales. They believe that the bill provides no reassurance to the public and that it would be preferable to set the benchmark to the current number of cremation cases rather than burials.

The resources for general practice that are aligned with amendment 15 are imperative to avoid any disruption to patient care and protect patient services.

I move amendment 15.

Ross Finnie: I am not minded to support Helen Eadie on amendment 15, but I repeat the position that I made clear at stage 1, when I invited the Cabinet Secretary for Health and Wellbeing and the minister to endeavour to produce for the committee at stage 2 or 3 a more statistical and analytical basis for the minister's doubling of the number of checks that are to be carried out.

Although we heard in evidence from Professor Fleming that a figure of 10 per cent might be appropriate, I made it clear that I did not necessarily think that it was. He based that estimate on past experience, but I thought that it would be helpful to the committee to have a more mathematical assertion of how our degree of confidence in the system could be described in statistical terms.

I understand where the BMA and Helen Eadie are coming from with amendment 15 but, on the other hand, I wish to have some assurance about the statistical basis for the numbers that we would use under the minister's proposed amendment.

Michael Matheson (Falkirk West) (SNP): I am conscious that death certification is to be largely self-financing. It would be interesting to know from the minister what the cost implications would be for the issuing of death certificates if Helen Eadie's amendment 15 were agreed to.

Ian McKee: I have a great deal of sympathy with the sentiments that Helen Eadie and Ross Finnie expressed, but I cannot support amendment 15 because moving to a system in which all cases were referred would involve a great deal of expense.

I hesitate to use the word overkill in this context—

Michael Matheson: You just have.

Dr Simpson: It was not a great hesitation.

The Convener: Can that be the first and the last of the grim reaper remarks, please?

Ian McKee: I could not resist it. I beg your pardon.

Referring all cases is more than is needed to ensure the system's integrity and would be expensive. As my colleague Michael Matheson said, if the system is meant to be largely self-financing, 100 per cent referral would impose a large financial burden on patients.

I am reassured by the fact that the proposed legislation would allow ministers to direct that more death certificates be reviewed. I hope that that will be the case, because I have concerns about the low level that has been proposed so far.

11:15

Dr Simpson: The bill as introduced would have given us considerable difficulties, but the Government has moved a considerable way and 25 per cent of certificates will have level 1 reviews, with a further 25 per cent being reviewed because the death is reported to the procurator fiscal. I feel strongly that even the 100 per cent review system in England and Wales will not necessarily prevent another Shipman. We need to bear that in mind. In trying to create certainty, we may mislead the public in that respect. I believe that the Government's proposed measures are proportionate and cost effective.

I also hope that reviewers or the procurator fiscal can involve not just GPs but relatives of the deceased. My colleague Dr McKee may return to that point at a later stage.

Reviewers can focus on areas of concern, but I regret that an electronic approach will not be taken, although the bill does not exclude that approach and the Government has made positive noises about it. I believe that an electronic approach is necessary to underpin the whole system. Well-written software will lend itself to analysis that might demonstrate outliers much more effectively than any random review system, which is unlikely to pick those up. I hope that whoever is in Government after May will consider carefully whether we pilot a flawed paper system or delay the pilots until there is an electronic system; otherwise, a piloted paper system might have to be followed by an electronic system pilot.

Shona Robison: I understand the motivation behind the amendments in this group, but I regard them as disproportionate and unnecessary. They also have major cost implications. To answer Michael Matheson's question directly, based on the BMA's proposed model the costs to the public purse would be £15.3 million annually or, if the public was charged, that would result in a fee of £285 per case, a not insignificant cost. In contrast, our proposals in the bill cost £30 per case, plus an additional £640,000 a year for the increased reviews, which, as I said, will be paid for by the Scottish Government, bringing total annual costs to £1.84 million.

The Scottish Government has always preferred the medical reviewer model, which is a much strengthened version of one of the options proposed by the independent expert review group. I stand firm on my reasons for this. I am confident that the number of reviews currently proposed will allow a reliable assessment of the accuracy and quality of death certification and will introduce a proportionate and robust level of deterrence while introducing a number of changes that will make the new death certification system fit for the 21st century rather than the 19th century. However, Richard Simpson is right to say that no system, no matter how good it is, can be failsafe. We should acknowledge that.

We have worked closely with expert statisticians and I am happy, to address Ross Finnie's point, to get a bit more from them at stage 3 about their calculations, but we are content that the 1,000 random reviews that are proposed will give us a Scotland-wide benchmark for the quality of death

certificates in the first year of operation, and we will monitor improvements after that.

The system must be seen as a whole package. As well as the 1,000 comprehensive, random, real-time level 2 reviews, the medical reviewers will carry out additional targeted reviews where they believe that there may still be cause for concern. Crucially, the bill will, for the first time, empower individuals to request a review where they have concerns. All those levels of review will be part of a systematic quality improvement approach.

We agreed with the committee that there would be additional level 1 reviews for 25 per cent of all deaths. That will provide additional deterrence, public reassurance and independent scrutiny. Together with the deaths being reported to the procurator fiscal, which amount to around a further 25 per cent a year, this means that around 50 per cent of deaths will be subject to scrutiny under the new proposals. That means that every doctor has a one in two chance of their actions being scrutinised, which I hope reassures the committee on deterrence and public reassurance.

Our approach, coupled with the safeguards provided by random and targeted scrutiny and national statistical analysis of deaths data, will achieve more effective outcomes than a second signature on all certificates, which can lead to a focus on checking, rather than driving up quality at source.

Our proposals will also maintain an appropriate balance between cost and scrutiny. The need for such balance was acknowledged by more than one speaker in the stage 1 debate. There is sufficient flexibility in the system to allow the number of reviews to be adjusted up or down in future in response to the test site information and the early operation of the system. However, that would be firmly based on evidence.

If the amendments to require scrutiny of 100 per cent of certificates were agreed to, it would lead to a huge increase in costs, either to the taxpayer or to bereaved families, through a massive increase in the fee, which is not justified by the benefits. I hope that I have managed to illustrate why I believe that our proposals make that unnecessary and unnecessarily expensive. For the reasons that I have outlined, I believe that our approach is correct. I do not support amendment 15 or the other amendments in the group and I ask Helen Eadie to withdraw amendment 15 and not to move the others.

Helen Eadie: I am grateful to colleagues and to the minister for taking my concerns so seriously. I am also grateful to Ross Finnie for reminding us that the committee requested the statistical analysis and it is good to hear that the minister will bring the expert statistician's report to the Parliament for stage 3.

On that basis and because of what I have heard about the degree of sympathy or otherwise around the committee table for the points that I have made this morning, I seek leave to withdraw amendment 15.

Amendment 15, by agreement, withdrawn

The Convener: Amendment 16, in the name of Mary Scanlon, is grouped with amendment 19.

Mary Scanlon: I appreciate that amendment 16 is similar to Helen Eadie's amendments, although it focuses on cremation. There is no doubt that the main concern at stage 1 was that there would be what witnesses described as a much less rigorous system than exists at the moment. It was unusual and unfortunate that the Government's response to the stage 1 committee report on the bill was not available until after the debate. However, although the bill will introduce a single system of independent scrutiny of medical death certificates that do not require procurator fiscal investigation, I am not yet convinced that it will succeed, as the minister states, in providing us with a robust and modern approach to the scrutiny of death. I feel that we need further information and reassurances as well as clarity before we agree to this part of the bill.

I welcome the plan that, for the first time, will allow individuals to request a review of the death certificate. That proposal is very welcome, but in comparison with the current system the new proposals just do not stack up. Moving from a system that requires three doctors to countersign cremation forms, which are required for 62 per cent of deaths in Scotland, to a system in which only 1,000 random level 2 reviews will be carried out each year, and in which 25 per cent of all death certificates will have a level 1 review, is a significant change. On that basis, I still find it difficult to be convinced that that level of scrutiny will deliver the deterrent that we are seeking or that it will be proportionate. The quality remains questionable.

As others have said, the proposed system contrasts with the English proposal, which is, I understand, to review 100 per cent of cases. The proposed system might be more cost effective, and I appreciate that that is a huge consideration, but I need to know that we are doing the right thing.

As I am not an expert on death certificates, I will quote from the responses of two of our stage 1 witnesses and the Government's response to our stage 1 report. Professor Stewart Fleming, who is professor of cellular and molecular pathology at Ninewells hospital in Dundee, said:

"I welcome the new proposals as a step in the right direction but believe they still fall short of what I would consider safe and accurate death certification. The level 2 review is more detailed than the current cremation confirmatory procedure but the level 1 review of 25% of deaths is less detailed than currently required."

Ishbel Gall, from the Association of Anatomical Pathology Technology, said:

"The proposals to remove the current scrutiny prior to cremation should not be about cost to the bereaved rather it should be about an improvement to what is current practice."

She went on to say:

"I am most concerned that there will be less scrutiny than there is presently where the deceased is to be cremated. The Bill also needs to address the issue of whether or not it is to be mandatory that the doctor issuing the MCCD should examine the deceased. For disposal, especially by cremation, to proceed without any examination of the deceased would seem to be a backward step."

I ask the minister to address the issues that I raised and, in particular, the responses from experts in the field.

I move amendment 16.

Ian McKee: I have a great deal of sympathy with the sentiments behind the amendments in Mary Scanlon's name, because I, too, am concerned about the proposed low number of deaths that will be subject to level 1 and level 2 scrutiny. I am a little worried about evidence from test sites, because if we are missing things we do not have the evidence—because we have missed it. However, I am consoled by the bill's provision for the ability to increase quite swiftly the number of deaths that are scrutinised, and I hope that the provision will be used.

I am concerned about amendment 16, because I strongly believe in random selection, which is the best way of finding out imperfect practices. If we are to go to a system whereby we have high standards for cremations while also scrutinising deaths when there is to be a burial, we will get back to the situation that we discussed in the context of Helen Eadie's amendment 15, in which the system would be very expensive. Therefore, I think that we can have a trade-off, whereby not every cremation gets the full inspection but we start to include in the selection people who are being buried. I prefer the mechanism whereby the Scottish ministers can direct that there should be an increase in the number of MCCDs that are scrutinised to the requirement that Mary Scanlon proposes including in the bill.

Rhoda Grant (Highlands and Islands) (Lab): I wonder whether there is merit in having different levels of scrutiny for cremations and burials. I think that that is what amendment 19 seeks to achieve. I am not keen on amendment 16, but amendment 19 might be helpful. Under the current system there is much greater scrutiny in cremations, given that when a body has been cremated evidence is lost. I suppose that there is a fear that if someone were trying to cover up a crime, cremation would be the preferred option. It might be helpful to raise the level of scrutiny of cremations—I am just thinking around the issues.

Ross Finnie: May I make a quick request to the minister, convener? Minister, you said that before stage 3 you would make available information on the statistical basis for the proposed amount of scrutiny. I take it that you will do that before the final date for lodging amendments, because I think that the possession of such information will be material in deciding whether amendments are needed on the issues that Helen Eadie, Ian McKee and Rhoda Grant raised. An assurance in that regard would be most helpful.

The Convener: That was a timeous request.

11:30

Shona Robison: Starting with that last point—yes, we will get that information to you as quickly as possible.

Regarding the two amendments before us, for the reasons that I outlined earlier in response to Helen Eadie's amendments, the Scottish Government has always preferred the medical reviewer model and I stand firm on my reasons for that.

Referring to the points that Mary Scanlon made, the proposed measures very much involve an improvement in current practice. It is not a matter of having less scrutiny; it is about more proportionate scrutiny. There is already flexibility in the system, so that the number of reviews can be adjusted. I explained earlier why that is important, and I outlined the rationale for our proposals.

I will explain why the bill specifies a random system of sampling—and this comes back to Rhoda Grant's point. A random selection of certificates through the General Register Office for Scotland's computer system is important for deterrence, as it will ensure that there is no selection bias or undue interference. Random selection will roughly reflect the proportion of cremations, so that we expect about two thirds of cases to be deaths for which the chosen method of disposal is cremation. At the time of issuing the MCCD and registering the death, such information is not always available. It is therefore not clear how the proposal in amendment 19 to select a minimum number of cremation cases for independent review can be implemented in practice. It would be extremely difficult.

On a more general point on the signing of the MCCD without examining the deceased, although

there is currently no express requirement on doctors completing the MCCD to view or examine the body, they would have to do so if they considered it necessary to ascertain the cause of death. We are not making any changes to that. In instances where the cause of death is unclear, the case would be referred to the procurator fiscal.

As I said earlier, 25 per cent of deaths are reported to the PF. Every person's death is already confirmed by a trained professional—a doctor, nurse or paramedic, who will examine the body to verify that life is extinct.

It is important that there is no evidence that a new requirement on certifying doctors to externally examine bodies will prevent or detect anything except the most apparent criminal activity or malpractice—and such a requirement certainly would not have detected what Harold Shipman did.

Bearing all that in mind, and for the reasons that I outlined earlier, I do not support amendment 16. I ask Mary Scanlon to withdraw it and not to move amendment 19.

Mary Scanlon: I do not know whether I made myself clear about this. The minister has spoken about a more robust and accurate system. Professor Fleming acknowledged that the level 2 procedures were more detailed than the current procedure. He also stated that the level 1 procedures are much less detailed than what is currently required.

I thank all my colleagues for their responses. Rhoda Grant spoke about increasing the number of cremations to be reviewed, and I hope that we can consider that again at stage 3. The main factor concerns statistics, as was discussed by Ross Finnie. I would certainly find it helpful to have further information, and in plenty time, so as to lodge amendments prior to stage 3.

On the basis that we will get another opportunity to address the matter, and noting that committee members are uncomfortable with many of the proposed changes, I am happy to withdraw amendment 16 and not to move amendment 19.

Amendment 16, by agreement, withdrawn.

Amendments 17 to 19 not moved.

The Convener: Amendment 5, in the name of the minister, is grouped with amendment 11.

Shona Robison: I have carefully considered the delegated powers in relation to the bill. The rationale for using the negative procedure to make orders suspending the review system during an epidemic was to ensure that, if necessary, the referral of certificates to medical reviewers can be suspended almost immediately during an epidemic or a situation in which an infectious disease or contamination is spreading rapidly, particularly if there are large numbers of deaths.

In such circumstances, funerals may need to take place straight away to prevent the development of a danger to public health if there is risk of infection or contamination. In addition, certifying doctors and medical reviewers may need to be redeployed to provide front-line assistance. However, in response to the suggestion that was made by the Subordinate Legislation Committee, I have considered the matter further and I am content to amend the bill so that emergency affirmative procedure can be used, discounting periods of recess from the period before approval. I am reassured that that is appropriate and will allow an order to come into force immediately and remain in force despite a long parliamentary recess.

I move amendment 5.

Helen Eadie: The minister is making Ian McKee, Rhoda Grant and I feel very good about the work that we do on the Subordinate Legislation Committee.

The Convener: The Health and Sport Committee always gives plaudits to the Subordinate Legislation Committee. With three of our members on that committee, what else can we do?

Amendment 5 agreed to.

Section 2, as amended, agreed to.

Section 3 agreed to.

Section 4—Application for review of certificate by interested person

Amendment 20 not moved.

Section 4 agreed to.

Sections 5 to 13 agreed to.

Section 14—Power to require documents

Amendment 6 moved—[Shona Robison]—and agreed to.

Section 14, as amended, agreed to.

Sections 15 and 16 agreed to.

Before section 17

Amendment 7 moved—[Shona Robison]—and agreed to.

Section 17—Medical reviewers to authorise cremation

Amendment 8 moved—[Shona Robison]—and agreed to.

Section 17, as amended, agreed to.

Sections 18 to 22 agreed to.

Section 23—Fees in respect of medical reviewer functions

The Convener: Amendment 9, in the name of the minister, is grouped with amendment 12.

Shona Robison: When I outlined the additional reviews—first, the doubling of the random level 2 reviews and then the new level 1 reviews—I made a commitment that the costs associated with those will be borne by the Scottish Government. The fee that is expected to be charged to the public therefore remains £30. For those who currently pay cremation fees—which is around 60 per cent of the public—that represents a substantial saving of about £120. I appreciate the committee's positive comments about the setting of the fee and the abolition of the higher cremation fee in favour of a lower universal fee for all deaths.

Section 23(5) provides currently that Scottish ministers must have regard to the reasonable costs of the revised functions when setting a fee. We have decided to amend that to make it clear that the fee can be set below cost recovery levels. Likewise, I am content to accept the Subordinate Legislation Committee's recommendation to change the affirmative resolution procedure, which we originally proposed be used for the power to set the amount of fees and prescribe arrangements for the collection of those fees, to the negative resolution procedure because, as the Subordinate Legislation Committee notes, the arrangements

"would more usually be subject to negative resolution procedure."

I move amendment 9.

Amendment 9 agreed to.

Amendment 10 moved—[Shona Robison]—and agreed to.

Section 23, as amended, agreed to.

Section 24 agreed to.

After section 24

The Convener: Amendment 21, in the name of Mary Scanlon, is grouped with amendments 13 and 14. I call Mary Scanlon to move amendment 21 and to speak to all the amendments in the group.

Mary Scanlon: Sorry—I have so many papers and I am not prepared. Can I just say, "Not moved"?

The Convener: You have to move the amendment.

Mary Scanlon: All right—I will just move it. It relates to my previous comments.

I move amendment 21.

The Convener: Mary, I take it that you wish to withdraw the amendment. I know that it is a technicality, but we have gone through the necessary hoops. Is it agreed that amendment 21 be withdrawn?

Douglas Wands (Clerk): The minister must be given the opportunity to speak first.

The Convener: Sorry—I beg your pardon, minister. I am so desperate to whizz on. I call the minister to speak to amendment 13 and the other amendments in the group.

Shona Robison: Given that it is proposed to withdraw amendment 21, I will not refer to it.

Amendments 13 and 14 are technical amendments that update the regulation-making power in the Cremation Act 1902 and the related provision in the Cremation Act 1952, as a result of the new arrangements that will be brought in under the new certification of death system in Scotland.

Amendment 13 adjusts the existing power of Scottish ministers to make regulations on the burning of human remains so as to remove aspects of the power that will become redundant as a result of the bill. It also adjusts the power to prescribe the notices, certificates and applications that are specific to cremation cases to make that discretionary rather than mandatory.

The amendment confirms that regulations made under the 1902 act are subject to negative procedure. That is a restatement of the current position, which is dealt with in the Cremation Act 1952. Consequential on amendment 13, amendment 14 repeals the relevant part of the Cremation Act 1952.

I ask members to support amendments 13 and 14.

Helen Eadie: This morning I met representatives of the National Association of Funeral Directors, who expressed concerns about a situation in which they find themselves. They have in their offices virtually a mountain of ashes, going back many years, which they cannot dispose of. They mentioned the issue in evidence to the committee but they feel that we have overlooked it. I put my hand up as one of those who are culpable in that regard. The NAFD is seeking to be allowed to dispose of the ashes that no one has claimed after a reasonable time has passed. It may not be possible for the minister to address the issue at this stage, but perhaps it could be addressed at stage 3.

Shona Robison: I thank Helen Eadie for raising that important and sensitive issue. I would like to reflect on the issue and perhaps I can get back to

the member on it. I do not know whether we can do anything in the short period before stage 3, but I will certainly consider the issue.

Ian McKee: Under the proposed section entitled "Forms of documentation for burning", is it the minister's intention to define in the regulations what human remains are? After all, if a leg is amputated it is often just chucked into the incinerator. Is that a human remain, or does a human remain have to be a certain proportion of the body? It would be useful to know, although I do not expect the minister to provide an answer at the moment.

Shona Robison: I will have to get back to you on that. I was just asking whether the definition would be the same as in previous legislation.

The Convener: I was ahead of myself earlier. It is now time for Mary Scanlon to withdraw the amendment. We are both doing things twice this morning—it comes with my age, Mary, not yours. Do you wish to wind up?

Mary Scanlon: No. All the points were made earlier.

Amendment 21, by agreement, withdrawn.

The Convener: We are back on script now.

Sections 25 and 26 agreed to.

After section 26

The Convener: Amendment 22, in the name of Ian McKee, is in a group on its own.

Ian McKee: Amendment 22 is a probing amendment. No one can doubt that the tasks undertaken by nurses have increased in complexity and responsibility over the years. When I was a junior doctor working in Edinburgh's royal infirmary, nearly all the nurses were university graduates, yet I had to be called out of my bed in the middle of the night to authorise the prescription of a couple of paracetamol tablets for minor pain relief.

Today, specialist nurses run cardiovascular risk clinics, supervise drug misusers, have responsibility for much maternity work and play a leading role in palliative care, to name but a few tasks that they undertake. The most recent prescription that I got from my GP was signed by the nurse. As we move forward into the remainder of the 21st century, it is obvious that those roles will increase in number and complexity. When that happens, it is possible to envisage a situation in which signing a death certificate will be a logical extension of a specialist nurse's duties, thus allowing more sympathetic handling of a relative's grief, greater accuracy in what is recorded and greater efficiency in the running of the health service.

11:45

I had hoped with amendment 22 to allow the opportunity to add to the duties of a minuscule number of nurses the ability to sign death certificates. It was not my intention that that should happen now, nor that all nurses should routinely have that function, but merely that it should be given to specialist nurses who are in a position such that it would be beneficial to society and the running of the health service.

I appreciate that the suggestion will not always meet with mass approval in the health professions as a whole and it has not been put out to consultation. I would therefore be happy to withdraw the amendment later, but our discussion should be on the record because I feel that we will need such a development to take place in the future.

I move amendment 22.

Dr Simpson: I welcome amendment 22 and Ian McKee's current intention to withdraw it, although we may need to reconsider the matter at stage 3. Despite the amendment being withdrawn, might we seek to take some evidence on it? I appreciate that time is extremely short.

I will add two points to Ian McKee's remarks. First, there may well be an increasing reliance in remote and rural areas on nurse practitioners who, as Ian McKee said, are able to prescribe. Secondly, some practices in England are nurse led. Such practices are already in existence so, as Ian McKee said, we are moving into a new situation. When we discuss the primary legislation, we should give future sessions of Parliament and future ministers the scope to allow the extension that is proposed, if that seems to be appropriate and proportionate.

The Convener: On your question about taking evidence, we can look at the remainder of our programme and discuss whether we have space between now and going into purdah to deal with the issue. That is not a matter for this debate, but we can certainly look at it.

Rhoda Grant: I, too, have sympathy with amendment 22. Richard Simpson mentioned rural areas. When someone is terminally ill, it is usually a community nurse or the like who spends time with that person and with their family and builds a close relationship with them. In that situation, having to wait until a doctor arrives to certify a death is perhaps not appropriate and does not help the family.

I would like to consider widening the provision as suggested in amendment 22, but I am well aware that we may need to take more evidence. If we do not have time to take evidence, would it be possible to lodge an amendment to allow that to

happen, perhaps through a super-affirmative procedure, so that the Parliament could scrutinise any such decision? We could perhaps consider at stage 3 whether such an approach would give us the appropriate safeguards.

Obviously, we do not want to change things dramatically without having taken evidence and scrutinised the issue properly, because there are always unintended consequences. However, the amendment makes a fair and reasonable suggestion that we should have the opportunity to work through. The stage that we are at in the parliamentary timetable might not allow for that to happen, but if the proposal could be scrutinised and legislation brought forward in the new session that may be worth while.

Shona Robison: The Scottish Government has considered Ian McKee's amendment 22, which would incorporate nurses within the definition of "registered medical practitioner" to give them the power to certify cause of death.

I agree with Ian McKee's comments on the role and contribution of nurses, which have changed considerably over time. We very much acknowledge the importance of that, both to the NHS and to nurses themselves in having fulfilling and rewarding careers. However, that aim also has to be aligned with the current requirements of the service and the needs of the public. Weighing up the pros and cons of the proposal, I do not think that we are yet in a position to know whether there is a demand for such a fundamental change. I understand that the Royal College of Nursing had a very limited consultation on the matter and got a very limited response.

In addition, putting the proposal in place would have a significant impact on the operation of the review system in the bill, because it is designed to deal with the review of medical certificates of cause of death completed by doctors.

A benefit of the new system lies in its links between the review system and the systems of clinical governance, annual appraisal and revalidation that are applicable to doctors. Full consideration must be given, in the light of discussions that we have had on other amendments, to how those aspects will work together to ensure that completed certificates are effectively scrutinised and standards improved.

Some of those links, such as revalidation, do not apply to nursing staff and further thought would have to be given to how those aspects could be accommodated in the new review system. That could prove to be very complex and there may be additional costs. For example, separate random checks of death certificates provided by nurses and doctors would need to be done as the numbers that would be required to give confidence in the system would be quite different. As that illustrates, the proposal represents a significant departure from current policy and is therefore not simply a technical issue, nor is it about future proofing the bill.

Although I do not disagree that there may be valid reasons to consider the issue further, I believe that it would not be correct to create a statutory power to give nurses the power to certify cause of death without further detailed public consultation on the issue and further consideration of the policy implications, some of which I have briefly outlined. I therefore ask Ian McKee to withdraw amendment 22.

Ian McKee: I will add to what the minister said. I am not very concerned about the low number of respondents to the RCN's poll of its members. A vast number of nurses would not be affected at all by the proposal, so it is not surprising that they did not respond. I am talking about a very small number of nurses and we should judge the proposal on an intellectual and practical basis rather than on a poll of nurses, most of whom would not be involved.

However, I accept that the proposal is fairly radical and that it would be unfair to introduce it by means of a stage 2 amendment. I therefore seek leave to withdraw amendment 22.

Amendment 22, by agreement, withdrawn.

Section 27 agreed to.

Section 28—Orders and regulations

Amendments 11 and 12 moved—[Shona Robison]—and agreed to.

Section 28, as amended, agreed to.

Section 29 agreed to.

Schedule 2—Minor and consequential modifications

Amendments 13 and 14 moved—[Shona Robison]—and agreed to.

Schedule 2, as amended, agreed to.

Sections 30 and 31 agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the bill. I thank the minister for her attendance.

As previously agreed, we move into private session.

11:52

Meeting continued in private until 11:59.

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