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Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 19 December 2012

Session 4

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CONTENTS

PUBLIC AUDIT COMMITTEE
19th Meeting 2012, Session 4

CONVENER

*Iain Gray (East Lothian) (Lab)

DEPUTY CONVENER

*Mary Scanlon (Highlands and Islands) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*James Dornan (Glasgow Cathcart) (SNP)
*Mark Griffin (Central Scotland) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Tavish Scott (Shetland Islands) (LD)
*Sandra White (Glasgow Kelvin) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Sir Harry Burns (Scottish Government)
Derek Feeley (Scottish Government)
Caroline Gardner (Auditor General for Scotland)
Phil Grigor (Audit Scotland)
Donald Henderson (Scottish Government)
Claire Sweeney (Audit Scotland)

CLERK TO THE COMMITTEE

Roz Thomson

LOCATION

Committee Room 6

Scottish Parliament

Public Audit Committee

Wednesday 19 December 2012

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

Decision on Taking Business in Private

The Convener (Iain Gray): I welcome everyone to the 19th meeting in 2012 of the Public Audit Committee. We have received apologies from Tavish Scott. I ask everyone to ensure that their phones are switched off.

Agenda item 1 is a decision to take in private item 4, which is consideration of how we take forward the Audit Scotland report on health inequalities. Are members agreed?

Members *indicated agreement.*

Section 23 Reports

"Health inequalities in Scotland"

10:00

The Convener: The first substantive item on our agenda is consideration of "Health inequalities in Scotland", a joint section 23 report by the Auditor General for Scotland and the Accounts Commission.

I welcome to the meeting the Auditor General for Scotland and her Audit Scotland colleagues Claire Sweeney, portfolio manager, and Phil Grigor, project manager, both from the performance audit group. I invite the Auditor General to introduce the report.

Caroline Gardner (Auditor General for Scotland): Thank you, convener.

Scotland's health inequalities are long-standing, complex and difficult to solve. Addressing the problem is not only the responsibility of health services; it requires a range of public bodies to work together. In the report, we look at how public bodies are working together to target resources at those most in need and the extent to which they are monitoring their collective performance.

Although we found long-term increases in average life expectancy and major improvements in overall health in Scotland, there are still major differences among different groups of people. The key determinant of health inequalities is deprivation, but age, gender and ethnicity are also factors.

People in Scotland are living longer, but average life expectancy remains lower than in other parts of the United Kingdom. On average, men who live in Scotland's most affluent areas live around 11 years longer than those who live in the most deprived areas, and the corresponding difference for women is around 7.5 years. For average healthy life expectancy, which is the number of years that people can expect to live in good health, the gap between the most deprived and the most affluent areas is even wider, at around 18 years.

People in more deprived areas have higher rates of coronary heart disease, mental health problems, obesity, alcohol and drug misuse problems, diabetes and some types of cancer, and children in deprived areas have significantly worse health than those in more affluent areas. For example, they have lower average birth weights and breastfeeding rates, have poorer dental health and are more likely to be obese. Although reducing health inequalities has been a priority for

successive Governments in Scotland, most indicators show that they are not going down.

We looked at the amount of money spent on tackling inequalities and what we get for it. The Scottish Government takes account of local needs, including deprivation, in its formulae for allocating funding to national health service boards and councils, but it is not clear how NHS boards and councils then allocate resources to target local areas in greatest need within their overall areas.

It is also difficult to track spend on health inequalities by the NHS and councils. In 2011-12, the Scottish Government allocated around £170 million to NHS boards directly to address health-related issues associated with inequalities, including around £15 million for the keep well programme, which delivers health checks to the over-40s, and the childsmile dental health programme. Both programmes are aimed at reducing health inequalities by targeting particular groups in the population.

Primary care also plays a particularly important role in helping to reduce health inequalities. The distribution of certain primary services such as dentists and community pharmacies reflects higher levels of need in more deprived areas, but the distribution of general practitioners, who for most people are the first point of contact with healthcare services, does not fully reflect the levels of ill health in more deprived areas. People in more deprived areas also tend to have poorer access to hospital services, receive fewer treatments, have worse outcomes and be more likely to miss appointments.

We looked at the arrangements for tackling inequalities, and we think that there is some room for improvement there too. Many organisations are involved in trying to tackle health inequalities locally, including health boards, councils, community planning partnerships, voluntary organisations and general practices. That means that it is essential to co-ordinate effort well, and community planning partnerships need to ensure that all the local organisations—not just the health boards—understand their responsibilities in tackling the problem.

Successive Governments have introduced a range of strategies that aim to improve health and reduce inequalities. It is clear that measuring the success of those strategies is difficult, because many interventions are long term and it often takes a generation or longer before significant improvements can be seen. Measurements for short-term and medium-term improvements are needed in order to demonstrate progress and ensure that the actions that are being taken are having the desired effect.

Some local initiatives have been effective in reducing health inequalities, but most have lacked a clear focus on cost effectiveness and outcome measures. That means that assessing value for money is difficult.

The range of performance measurement and reporting arrangements that relate to health inequalities makes it difficult to establish a clear picture of progress. In particular, the reports from community planning partnerships on delivering on single outcome agreements are weak in the quality and range of evidence that they use to track progress in reducing health inequalities, so a Scotland-wide picture is hard to identify.

Our report contains a number of recommendations that are targeted at the health service, community planning partnerships and the Government to move things forward and improve that picture. My colleagues and I will do our best to answer any questions that you and your committee colleagues have.

The Convener: Thank you. I will kick off with a question on the background part of the report.

I think that everyone would be most concerned about the human cost that the statistics show, such as the disparity in life expectancy. However, at paragraph 4, you identify an economic cost to the health inequalities, and the figures are quite startling:

> "if the death rate in the most deprived groups in Scotland improved then the estimated average economic gains would be around £10 billion (at 2002 prices); and if the death rate across the whole population fell to the level in the least deprived areas, the estimated economic benefit ... could exceed £20 billion."

Those are huge figures for the economic loss—or the economic cost—from health inequalities. How did you arrive at them?

Caroline Gardner: As you say, convener, we will all be concerned about the human cost, but those are staggering numbers. They are derived from the influential Marmot review on health inequalities that was published in 2010. I will ask Phil Grigor, who is our expert on that, to talk you through how we derived an estimate for Scotland from that review.

Phil Grigor (Audit Scotland): Those are pro rata comparisons with the figures that were produced for the Marmot review. The figures of £10 billion and £20 billion in relation to improving life expectancy are based on a concept called the value of statistical life, which is the amount that society is willing to pay for the cost of saving lives.

The estimate is a conservative one because it does not include actual health improvements. A separate estimate was done for the Marmot review, which suggested that an extra £60 billion

would be saved UK-wide by improving the health of the population, based on taxes, productivity, lower healthcare costs and that kind of thing. The pro rata comparison for Scotland would amount to an extra £6 billion.

The Convener: So the real figure is likely to be £26 billion—that is the economic cost.

Phil Grigor: The £10 billion figure was at the lower end of the estimate, and the £20 billion figure was at the higher end. The paper that was produced for the Marmot review said that those are likely to be very conservative estimates.

The Convener: Right, but you said that there is a further £6 billion that is not included in the £20 billion, so we could be looking at as much as £26 billion or £30 billion of economic cost.

Phil Grigor: Based on the pro rata comparisons with the Marmot review, that would be the figure.

The Convener: Okay—thank you very much.

My other question is on what has happened over time. The report looks at the economic inputs that are made to try to deal with health inequalities, and it mentions two figures, which I will come back to. The part that struck me relates to what the direct funding to address health inequalities is actually spent on.

The report makes the point that the inequalities have persisted for around 50 years, and I was struck that one of the inputs is the childsmile programme. I can remember being in the happy smile club 50 years ago—in fact, I rather fear that my mother could still find my happy smile club badge. My question is: if we have known about these inequalities for as long as 50 years—certainly for the past 10 or 15 years—and if for the past 10 or 15 years Administrations of different political stripes have said that tackling them is a priority, have we actually increased the investment that we are making? Have we changed at all what we are doing to address those inequalities?

For example, exhibit 11 tracks the total funding allocated through not just the health service but other initiatives to do with things such as fuel poverty. There are figures for three years, which run from £586 million in 2008-09 to £607 million in 2010-11. That looks like a real-terms decrease over the piece, perhaps marginally. It is a slight cash increase, but with the deflator there would be a real-terms decrease over those three years.

Another figure in the report is £167 million, which I think is the money spent in the health service on tackling inequalities in a single year. Were you able to find any evidence at all that targeted spending is increasing, decreasing, or staying the same?

Caroline Gardner: You are absolutely right that these problems are of very long standing and have been a priority for successive Governments. One of the main things that we found is that it is very hard to be clear about what is spent on tackling exactly that problem. A range of things are happening, one of which is that it has become clearer over the past couple of decades just how important inequality is in terms of deprivation leading to and contributing to health inequality. That focus has started to sharpen over time.

It is also clear that the amount of money spent on health services, which has been our primary focus in this report, needs to be targeted on the people who are at most risk: people who are deprived and suffering ill health. That is the case both in terms of prevention over time, which is Government policy and is absolutely right regarding the long-term benefit, and in terms of tackling the health problems that people have at the moment and for the foreseeable future, which is a real and present problem.

We have found that it is very difficult to track what money is spent on tackling those problems out of the nearly £12 billion that is spent on the health service as a whole. That is true once we get to the level of an individual health board or council as it is very hard to tell who is using health and social care services, which communities they come from, and how much deprivation they face. It is also hard to tell what is happening with primary care services. We have done what we can to draw that out for you in the report, but the finding is really that it is not clear how the resource is being targeted.

Targeting is critical to tackling inequality. We know that, if more is spent overall, what tends to happen is that the more affluent people are better able to access services and get more benefit from them, which means that although there is an overall gain in health there is probably an increase in inequality at the same time.

The Convener: If my question was, "Over time—whether 10 or 15 years or a longer period—have successive Administrations skewed spend to target it to address these health inequalities?" your answer would be, "We can't tell." Is that fair?

Caroline Gardner: That is the closest that we can get. We have given you the information that we have been able to pull together, both on special initiatives, which you see in exhibits 10 and 11, and on the allocation of mainstream health services. It is not possible to see what the long-term shift is, although there has been a significant investment by successive Governments since the Parliament was established.

The Convener: Thank you.

10:15

Mary Scanlon (Highlands and Islands) (Con): I want to get to the heart of the matter because this is nothing new. Since 1999, I have been on the Health and Sport Committee or its equivalent for eight years in total. Health inequalities have been at the centre of the agenda for all the time that I have been on that committee and, I am quite sure, for those times that I have not been on it. I am looking at the figures now and they are no better, despite everything and all the good intentions.

I would like to run through one or two points regarding the comparison between the most and least deprived. In comparison with the least deprived areas, in the most deprived areas there are more than twice as many GP consultations for anxiety—which worries me—four times higher smoking rates, eight times more alcohol-related hospital admissions and five times more teenage pregnancies. The average gap in life expectancy of 11 years is the same as it was in 1999, and in the most deprived areas obesity and dental health are poorer, alcoholic liver disease has increased fivefold, alcohol deaths have trebled, and the rate of drug-related hospital discharges is 16 times greater.

I am quite sure that the Arbuthnot formula and the NRAC—NHS Scotland resource allocation committee—formulas have all taken account of deprivation. There are about 40 per cent more GPs in deprived areas and about twice as many dentists, who receive the additional payment allowance of £9,000. There are more than twice as many pharmacies and higher QOF—quality and outcomes framework—payments for long-term conditions in deprived areas. Some £170 million was spent last year and yet we do not know where the money is going, how it is being spent, or whether it is being targeted to those in greatest need.

I quote from the report:

"policies and strategies ... to ... reduce health inequalities have so far shown limited evidence of impact."

After 13 years of this Parliament and a shared intention across all parties, where have we been going wrong?

Caroline Gardner: There are a couple of important points to make on the range of issues that you raised. The first is that we know that inequalities in health are not the responsibility of only the health service; they are affected by a range of other things, including deprivation and poverty, as we say in the report. The wider economic and social context in which we are working will have had an impact on some of the health problems that you ran through in your list of indicators.

When the health service and other public services focus on those problems, one of the real challenges is that, unless they are very careful to target their interventions and the money that they are spending on the people who are most in need, the effect tends to be that everybody moves up a little but people who are more affluent gain more benefit, so the gap actually increases rather than closes. That is why health inequality is such a tricky problem to tackle.

A targeted approach to tackling health inequality from both the health service and the wider public services is very important. As we say in the report, one of the challenges is that we do not know to what extent most of the £11.7 billion that was spent on the NHS last year and social care spending by councils is targeted on the people who have the most significant needs and biggest health problems. We recommend that that should change and that there should be more tracking of who is using health services and a better understanding of the barriers to the use of services.

At the moment we do not have that. We just know that, for example, although life expectancy is increasing for all of us, the gap is still increasing, as you can see in the charts in the report.

Mary Scanlon: Humza Yousaf and I visited the Drumchapel centre, which I found very interesting. Of all the people who we spoke to and all the people who gave evidence, no one said that they needed more doctors, but they did say that they needed a better understanding of housing, deprivation and poverty. They said that they had so many worries and concerns that they could not concentrate on trying to look for a healthy lifestyle.

The rate of GP consultations for anxiety is almost twice as high in the more deprived areas. Is that not a call for help, and is that being listened to? I do not want to stray from the audit discussion but, to me, that is the core figure.

In your opening statement and in paragraph 49 of the report you mentioned that patients from deprived areas receive

"over 20 per cent fewer cardiology treatments than expected while those from the least deprived areas received over 60 per cent more treatments than expected. People from more deprived areas may have lower rates of treatment because they are less likely to reach hospital alive following a heart attack."

Something is going far wrong there. We took evidence on the issue in Glasgow. It almost seems to be a matter of blaming people in deprived areas and saying "It's all your fault—you're not getting to the hospital quick enough and you're not recognising when you're having a heart attack." That cannot be the way forward, surely.

Caroline Gardner: Absolutely—and it is certainly not our intention to blame poor people for that.

Mary Scanlon: I appreciate that.

Caroline Gardner: We are saying that health inequalities are a big problem that is not the responsibility of only the health service. All public services, the third sector and people themselves have a role to play in tackling inequalities and addressing that big problem, but we are saying that the health service—particularly primary care—must be at the heart of doing some of that. GPs are often the first port of call for people.

You are right that things such as consultations for anxiety and depression can often be a signal that there are wider problems that need to be addressed. There has been a lot of investment in, for example, the keep well programme and the deep-end GP practices in particular. Talking to GPs in deprived areas, we heard that they often feel that they do not have enough time to spend with patients to properly understand what is going on and that they do not have the networks into other public services that would help them to start to tackle some of the problems.

That is an important starting point. There have been good investments and good work has gone on, but there is certainly room to take it further and ensure that it is targeted at the most difficult problems.

Does Claire Sweeney want to pick up on that issue?

Claire Sweeney (Audit Scotland): There are a couple of points to make. When we carried out the field work for the audit, we found very good examples of local working, which we wanted to highlight in the report. We saw good examples of partners coming together in the widest sense. People from housing, the police, the NHS and local authorities have sat down together and worked out who the people are in the local community to whom they really need to provide more support on a collective basis. That is very encouraging.

The other thing that came through quite strongly was the disconnect between some of that good practice and encouraging work at the local level for communities, and the funding and planning for services. There was sometimes evidence that things were making a difference, but does that relate strongly to where the funding goes? If people put in bids for resources for the local area, are they listened to? Do people take the bid on board as a priority? There is an important point there.

The other issue to mention is the important role of the community planning partnerships, which we drew out in the report. They have a lead role in the agenda, and it is important that they have a clear idea of priorities in developing their approach to health inequalities collectively, and that they have clear measures in place to check that they are making a difference and that the investments that they make in an area lead to improvements for local people. That came through strongly from our local work.

Mary Scanlon: To be fair, we have had evidence of good practice for 13 years. Many of the programmes are pilot programmes. People tick the box and say, "Haven't you done well? Your three-year funding is finished; we'll now go back to where we were."

I must be honest. I find it really disappointing that, as the report says,

"There is no evidence to date that targeted national programmes have helped to reduce health inequalities".

That includes the equally well initiative. I also refer to appendix 3, which states that there has been no impact or improvement.

I will give one small example, which is not rocket science. Deprived areas have more than twice as many pharmacies, which can at least help the four times as many people who smoke in those areas, but there is no join-up between the pharmacy and the GP. We are told in the box next to paragraph 62:

"A pharmacist who is undertaking health checks as part of community-based intervention is not able to email any information to the client's GP. The information has to be printed off and taken to the GP surgery because there is no secure email. This creates more work for the pharmacist and gives them little incentive to continue to carry out health checks".

There are twice as many pharmacists in deprived areas, but there is no point in their doing anything because, in this century, they are not even connected to the GP. We cannot even ensure that; instead, pharmacists have to get out on their bike, go round the corner and hand information into the GP. All that we are seeing are barriers and barriers and barriers.

We have heard for 13 years that there should be better partnership working, and we are hearing today what we heard in 1999 about the lack of partnership working. That is not the result of a lack of political will from any party, so what needs to be done? There seems to be a pharmacist on every street corner, so it is a nonsense that there is no incentive for pharmacists to carry out health checks because they cannot even have access to secure email.

Caroline Gardner: I agree that that is a great example of the targeted changes that are needed if partnership working is to become a reality.

There is no doubt about the commitment of successive Governments to tackling health inequalities; there has been significant investment. What we are saying is that it is important to target that investment in the communities in which it is most needed at a very local level—we gave the example of an area in Shettleston ward, in Glasgow, to show how localised problems can be. As Claire Sweeney said, it is necessary to focus effort in the area by working with the GP practice and the community health partnership to agree on how the barriers that you described can be taken away.

Secure email is important—none of us wants our personal healthcare information to be handled insecurely—but the problem should be straightforward to fix if attention is focused on it.

Mary Scanlon: As the convener said when he quoted from your report, it is estimated that the economic cost of health inequalities is £26 billion to £30 billion, and yet we have not got the money or the will to connect pharmacists to GPs. That is not good.

The Convener: That was a statement, not a question.

Mary Scanlon: It was, sorry, but I thought that it was worth considering the opportunity cost of not successfully intervening.

Sandra White (Glasgow Kelvin) (SNP): I thank Audit Scotland for its excellent report. At our most recent committee meeting, I said that I had been shocked to learn that 86 of the 100 deep-end GP practices are in Glasgow. That is worrying. Deprivation is key, as the Auditor General said in her opening remarks, and people need to work together.

I must say to Mary Scanlon that the policies that are coming from the Conservative Westminster Government are certainly not going to make things any—

Mary Scanlon: That has nothing to do with it.

Sandra White: It has a lot to do with it, Mary.

Mary Scanlon: It has nothing to do with the report.

Sandra White: At a time when housing and other welfare benefits are being cut, the people who live in the most deprived areas are going to have an even more shocking time. I wanted to put that on the record.

As the Auditor General said, there has been some improvement to people's health, which is welcome. However, there is a lot of work to be done, particularly in deprived areas.

I was interested in exhibit 11 on page 19, and I want to pick up on the figures, which the convener referred to, for the money that has been allocated to addressing health inequalities. In 2008-09 the total funding was £586.05 million; in 2009-10 it was £595.95 million; and in 2010-11 it was £607.30 million. The money has gone up, so is the approach not working because of the lack of partnership working, particularly on the part of CHPs?

I take Mary Scanlon's point about pharmacies. In my area, Kelvin, a number of pharmacies work closely with doctors and hospitals, but because of the NHS board's data protection arrangements they are not allowed to email information, although they would love to do that. We should look at that. Is partnership working not reaching the deep-end practices?

Caroline Gardner: There was a great comment in Professor Graham Watt's letter to *The Herald* last week, after the report was published. He said that we need the NHS to be at its best where the need is greatest. One of the challenges is that, in areas such as the ones that the deep-end practices cover, not just health need but every other type of need is greatest. Housing, education and so on are difficult issues for people who live in such communities, for reasons that we all understand.

I will ask Claire Sweeney to talk about some of the specific things that we have seen that could improve the situation, but let me stress again—because it is so important—that a critical part of reducing inequalities is to target a local area, look at what the specific problems are, and build ways of working that improve the situation. There are some practices where secure email is in place and where community pharmacists can, with consent, access patient's records, and they can take on a lot of the work that can be done in a community setting close to people's homes. In other places, establishing secure email is still a barrier. We need to understand better what is needed to shift those barriers—and the equivalent barriers in other places, which will be different.

10:30

Claire Sweeney: When we talk about partnership working in that or any context, we are not talking about the big, general concept of something that is just a good thing to do. It is a matter of being clear about why the partnership is coming together. For some things, the partnership might need to agree that it would be just as good for the police or housing services to deliver something on their own. The important point is to agree, as a partnership, which bits can be achieved only by working together and then to focus on those bits, because working together is time consuming and takes a lot of effort.

One big thing from the report is about the need for performance measures, so that an assessment can be made of what is making a difference and the difference that any investment makes can be tracked. When we talked to people in front-line services, we were told that it is very difficult to measure performance. We accept that to a certain extent, and they are working hard to improve measurement at a very local level.

People told us the reason why things could not be monitored or measured but, as auditors, we often saw that they were describing tangible things that could be monitored. The changes that need to be made are short, medium and long-term changes, but it is possible to see them happen and demonstrate that some things are making a difference. For us, it is a matter of people having a much keener eye about how performance measures need to be developed at a local level.

There is something quite interesting about the message on partnership working and people's intent and commitment. We saw a real commitment from people at a very high level that partnership working is important for Scotland—they signed up to it and the need to improve it—but we also saw people working at the front line, day in and day out, struggling to take it forward. There is something interesting in how the process is connected: what is preventing partnership working from happening? Is there something in the middle that means that it is not delivered as effectively as it could be? It will always be hard, but we saw that there are definitely cases where things could be improved.

Sandra White: Thank you very much. I take on board the comments about pharmacy working because certain pharmacists, such as Reach pharmacy and others in my Glasgow Kelvin constituency, work closely with doctors and they seem to have their act together.

I want to pick up on what is said in the report about tracking what happens and outputs. On page 19, paragraph 36 states:

"GP practices in Scotland received around £134 million in QOF payments ... There is evidence that it has helped to reduce the gap between the most and the least deprived areas in the management of chronic disease".

It then says:

"it is too early to say whether these improvements in management practices have led to reductions in health inequalities."

Is that because those improvements have just been made and we need to look at the position in the long term? Are there other areas where such changes have been made previously and have not been tracked?

Caroline Gardner: That is a good example of what Claire Sweeney was just talking about. We all hope that that investment will help to improve the health of the poorest people and those who are most deprived in the long term, but it is too soon to see that because of how long it takes. What we can see is that the investment is improving the targeting of the management of people with some chronic diseases. That is a good interim measure that you would expect to lead to a narrowing of the gap in the long term, but that narrowing of the gap is too long term to be seen.

Claire Sweeney: That is right. Some of the GP practice initiatives when the new general medical services contract was introduced were about getting lists and registers set up so that people could see what they were dealing with. It is a case of moving on from that now. We know some of the things that can make a difference and we now have a better feel for the populations that we are dealing with, so what do we next? It is almost a step-by-step process in relation to the GP contract.

Mark Griffin (Central Scotland) (Lab): Caroline Gardner stated that QOF payments have the potential to reduce health inequalities but they are not designed explicitly to do that. Would it be an appropriate recommendation in the report to ask that one of the QOF outcomes should be to specifically address health inequalities?

Caroline Gardner: I think that that is happening, but you may want to pick that up with the next panel of witnesses, from the Scottish Government. We know, for example, that there was an agreement in recent GP contract negotiations to make some shifts to the indicators that can be used to target inequalities further. That is something that I know is very much in the mind of Government in negotiating the contract and the quality and outcomes framework with GPs in Scotland.

The Convener: It is Christmas and I am instinctively generous, but colleagues need to try to keep the balance of their contributions towards questions, or we will miss Christmas lunch, which I believe the canteen is offering today.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I am curious about the expected savings from improving life expectancy. For some reason, I had it in the back of my mind that, if we take into account the totality of pension liabilities and so on, it costs more money if people live longer. I take on board the information that the witnesses gave, but does the calculation take into account pension liabilities, for example? I am not saying that that is a reason not to improve life expectancy; I am just curious to see the figures behind the calculation.

Phil Grigor: It is based on the cost benefit analysis of introducing a public policy. It will

obviously cost money to pay out more in pensions, as you say, but there is also an economic benefit to people living longer in that they will spend more. The figure is based on the net benefit of people living longer.

Colin Beattie: I am encouraged to hear that.

At the previous meeting, I asked about GPs in deprived areas. The report makes it clear that, although other facilities such as pharmacies are in deprived areas in larger numbers, GPs are not. We have had explanations from the Government as to how it calculates such figures but, unless I am mistaken, in absolute terms, there are fewer GPs in deprived areas. Does that affect the outcomes in those areas?

Caroline Gardner: GPs are an important part of tackling health inequalities because they are the first port of call for most people with a health problem and because they are able to look right across the person's life—at their circumstances and their family—and think through what the real problem might be, given the time and other support services that are needed to do that.

The challenge for the Government is that GPs are independent contractors so they cannot be directed to particular places in Scotland. However, we have seen that incentives can work. For example, specific incentives were introduced to encourage dentists and pharmacists to set up in more deprived areas. You can see from the two graphs on page 23 that the association between the distribution of dentists or pharmacies and deprivation is much clearer than that for the distribution of GPs.

That is why we think that there is room to go further, in line with Mr Griffin's question, to put incentives into the GP contract to encourage the same sort of pattern.

Perhaps Phil Grigor would like to add to that.

Phil Grigor: That is a fair point. We have shown that the deprivation allowance for dentists that was introduced in 2007 has had an effect. Obviously, GPs are independent contractors and we cannot force them to go anywhere particular, but exhibit 16 shows clearly the impact of introducing the deprived areas allowance for dentists. If that was introduced for GPs, it might go some way to closing the gap.

Colin Beattie: I am also interested in a theme that goes through the report, which is that there does not seem to be clear measurement of outcomes. In the past, the committee has discussed the lack of statistics to back something up, but we have some good statistics in the report and it seems curious that, although we have all these facts and statistics, we do not have outcomes. Why might that be? Looking through the report, I do not get a feel for whether what we are doing is right. Mary Scanlon touched on the fact that, over 13 years, successive Administrations have thought that they were doing the right thing by putting the money into this, that and the other, but there seems to be no proof that that is so.

Caroline Gardner: In the long term, the statistics that we have in the report are the outcomes. The problem is that they are long term; it can take a generation to demonstrate whether our current approach to targeting services is affecting people's healthy life expectancy or particular diseases. We suggest that there is a need to build in more evaluation at the beginning of significant investments such as the keep well programme and some of the other investments that have been made to tackle health inequalities. In particular, there is a need for more short and medium-term process measures and impact measures to show whether things are moving in the right direction.

A good start would be knowing whether hospital services, for example, are reaching people in more deprived communities at the rate that we would expect; the evidence in our cardiology report earlier this year suggested that they are not. We need to understand better why that is and what barriers to that we can get out of the way.

Colin Beattie: Although we cannot measure such outcomes yet, will we be able to do so in time? The measures are in place; seeing whether we are on the right track is just a question of time.

Caroline Gardner: It is a question of time and of being explicit about what we are trying to measure. If we do not have a proper framework for evaluating the effectiveness and cost effectiveness of what we are doing, we will not know whether the continuing change in life expectancy is a result of the money that we are investing.

The broader point is about building in evaluation at the beginning of a policy, so that its impact in the medium term as well as the long term can be tracked. Claire Sweeney might have examples to bring that to life for us.

Claire Sweeney: Exhibit 21 looks at CPPs and single outcome agreements. That gives a bit of a picture of what we mean by a lack of a clear focus on what we are trying to achieve, particularly at a local level.

We have picked up challenges in how single outcome agreements describe progress and what is intended, and we have picked up variation. When we have big problems that are consistent across many areas, we would expect the picture to be much more coherent and consistent. Exhibit 21 provides a nice example of where we see scope to

do more and to be more focused and defined about what people are trying to do with their resources.

The Convener: I gave Mr Scott's apologies but, like Marley's ghost, he is here.

Tavish Scott (Shetland Islands) (LD): Yes—rumours of my demise have been greatly exaggerated.

I apologise for missing the early part of the evidence. The Auditor General said that the state is providing, or should provide, more incentives in the GP contract. Why should the state put any more money into GPs' pockets?

Caroline Gardner: I do not think that I suggested that more money should be put into the contract. My understanding of the agreement that the Scottish Government and the British Medical Association in Scotland recently reached is that it is about reallocating money within the current total that is spent on the contract. The question is probably better directed to the next panel of witnesses.

Tavish Scott: Sure, but do you think that, by any stretch of the imagination, the GP contract is working to deliver what successive Administrations have sought to achieve in tackling health inequalities?

Caroline Gardner: That is still a work in progress. The report does not evaluate the GP contract, but we have done work on that in the past.

As Claire Sweeney said in answering a question from Mr Beattie, in the contract's early years, a lot of the focus was on getting infrastructure in place, such as disease registers and processes for calling people back for testing and screening that we know will make a difference. That infrastructure now needs to be used to direct what GPs and primary care teams do to tackle health inequalities.

More can be done. There is some evidence that the contract is making a difference—we refer in the report to improvements in chronic disease management—but, in relation to inequalities, more can certainly be done in terms of what primary care teams do and where GPs are located.

Tavish Scott: The Government of which I was part signed a GP contract that was a shockingly bad deal for the taxpayer. I am worried that you might be suggesting that we should augment that by giving GPs more incentives to do what they should be doing anyway.

Caroline Gardner: My focus is on using the incentives that are built into the existing contract more effectively in relation to health inequalities. Claire Sweeney was involved in the previous work that we did to evaluate the GP contract, so I ask her to pick up any points to which I have not responded.

Claire Sweeney: We looked at how the contract was implemented and the early stage of introducing it. A few years back, we did quite a lot of work on looking at the transition to the new contract. I think that we produced the report on that in 2008.

The direction of travel is about trying to make more use of things that will make a bigger impact through the GP contract. Caroline Gardner mentioned the more recent changes from negotiations in Scotland and the pattern that they have taken. The shift away from rewards for changing lists and rewards in relation to administrative organisational approaches through the contract to a focus on improving health locally is encouraging. That is definitely the direction of travel.

10:45

Tavish Scott: Do you not think that we are just playing at this? As colleagues have said, we have been at this for 13 years and, frankly, nothing much has got any better. We will be here in another 13 years and again not much will have got better.

Is the GP contract not at the heart of this? We have a relationship in which GPs are private contractors. NHS boards have no ability to control that. GPs can listen to all this guidance, but they do what they wish. It is clearly not working, is it?

Caroline Gardner: GPs are key to getting this right, as is secondary healthcare. My sense is that we do not have enough detailed information about where the £11.7 billion that was spent on the health service is being spent specifically to tackle inequalities. We are not saying that it is easy—clearly it is not. Scotland has been dealing with this problem for a long time, as have other parts of the world. However, targeting is critical—understanding where the need is greatest and ensuring that the resources are focused on tackling inequality.

Tavish Scott: Would it therefore be completely unfair to conclude that we should—if we were being radical—abolish the way in which we currently pay GPs and move to a salary system that the NHS could control effectively, which would allow us to put taxpayers' money into exactly what we are trying to achieve?

Caroline Gardner: I will have to start with my usual caveat about policy. However, in this report we have not found that the existing GP contract could not be used to greater effect to tackle health inequalities. That is the direction of travel and

there is an opportunity to take it further, to make sure that we are getting to people with the interventions that we know make a difference.

Tavish Scott: Is the Audit Scotland argument therefore that there should be much more prescription around what Government gets from the GP contract?

Caroline Gardner: I am not sure that "prescription" is the right word. It is about making sure that incentives are aligned with what we know works in tackling health inequalities and with the communities that we know have the biggest problems. Targeting in both those ways could be done through the existing contract and is done, to some extent. There is a lot of mileage left in dealing with this problem by taking that targeting further and matching it with a wider understanding of how health service and public services resources are being used.

Tavish Scott: It could go a lot further than it is at the moment.

Caroline Gardner: It could certainly be used more effectively and, as I said, that is the direction of travel.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I have a brief supplementary to that, regarding the approach that was taken to incentivise the dental practice system in 2006-07. Is there an evidence base that shows that there have been public health benefits from that incentive scheme?

Caroline Gardner: That is a very good question and I will ask Phil Grigor whether we have any information about the next step. That was one of the interim measures to get dentists in the right place and I do not know whether we have evidence of impact yet.

Phil Grigor: Information on oral health is pretty poor. Exhibit 6 includes evidence on improvements in child dental health, which has improved across deprivation levels but is still markedly poor among the most deprived children in Scotland. In the supplement that we published on the website, there is a detailed breakdown of which children at ages five and 11 have met the national standard. The national standard was met across the country and those in the most affluent areas met it quite comfortably, but those in the most deprived areas did not meet it.

The measure to which you refer may have had some impact in improving overall dental health, but those in the most deprived areas are still much worse off.

Willie Coffey: It is probably a question for the next panel, convener. That measure has been in place for some six years.

We are indebted to Audit Scotland for the depth and rigour of this study, which is one of the most detailed studies that I have seen in years. It is very hard hitting, of course, and it provides members with the opportunity to see the big picture of Scotland's health or pick out individual points and score whatever points we want to score.

I was particularly pleased with the way that you introduced the report, convener, in that you looked back over generations and said clearly that Scotland's health inequalities are a generational issue that successive Governments have tried to address with some valiant attempts. You also said that there are significant opportunities to gain financially—you mentioned a figure of £20 billion or so.

I see from the report that a simple reduction of 1 per cent in smoking would save 540 or so lives. Without getting into the alcohol debate, I think that we could say the same for alcohol—if we could tackle the consumption of alcohol, we would save thousands of lives and millions of pounds.

The Scottish Government's interventions show that there has been a change in policy in recent years to intervene at an earlier stage. It is probably too early to assess the efficacy of that work but, nevertheless, we have to try. The question that I have for the Auditor General, therefore, is this: where are the opportunities in the system for the greatest gain? I know that that is a big, broad-brush question, but I would like to put your response to the next panel.

Caroline Gardner: You are right about the ambitious public health policies that Government has introduced. That has been a priority for successive Governments but, in the report, we note in particular the impact of the smoking ban and the early indications of the changes that that is bringing. We recognise absolutely the commitment of successive Governments to that issue.

My sense is that we are now getting to the point at which the big initiatives, such as the smoking ban and minimum pricing for alcohol, and the big programmes, such as keep well, are probably going to be less effective than understanding which communities are the most challenged, what barriers they face, how the health service can help to remove those barriers and provide better support, and how the health service can work with partners in the community planning partnership to work more widely on housing, the environment, economic development and all the other things that have an impact on the wider determinants of ill health. Those factors are extremely local and circumstances differ greatly between areas, so it is important to shift the lens and focus on the areas that we know, based on good information, are the ones with the biggest challenges.

I ask you to turn to exhibits 4 and 5 on page 10. People talk about Glasgow as having health challenges. That is true, in overall terms. However, if you look at the breakdown by ward—as shown in exhibit 4—you can see that there is a wide spread between the least deprived and the most deprived communities in terms of the hospital admissions for alcohol and drug misuse. Exhibit 5 breaks down one ward—Shettleston—by enumeration districts, and you can see that the spread is wider. That shows that we are talking about an extremely localised problem. Understanding where the problems are and what their characteristics are in each area is the key. We have some of the infrastructure to do that, but we need to be targeting particular areas.

The Convener: Not to decry for a moment the public health initiatives on smoking or alcohol—although we can argue about what they should be—would you say that they fall into the category of health inputs that lead to a generalised improvement in health but do not necessarily address inequality?

Caroline Gardner: I do not have the detailed evidence at my fingertips, but I would be very surprised if that were not the case. We know that smoking has reduced overall since the smoking ban came in, but we also know that it has reduced more quickly among more affluent groups than among more deprived groups.

Willie Coffey: One of the clear messages in the report is that we need to be better at tracking the effect of our various interventions. It has been said that we could spend the same amount of money again and still be no wiser about whether this intervention caused that outcome. I think that we probably need to do more work on that, and I would be obliged if the next panel could give us an indication of how we can track the money that we are spending to try to reduce health inequalities, so that we can see whether that is being effective.

James Dornan (Glasgow Cathcart) (SNP): I acknowledge the point that you make about localisation—my constituency contains certain areas that clearly have poorer levels of health than others. Would you say that the CPP has a central role to play in this issue, with regard to pulling together all the partners?

I see that there will be a new single outcome agreement that will bring in health inequalities. Will that play an important role in marrying the services together to bring about a better outcome?

Caroline Gardner: If the community planning partnerships are going to fulfil their potential, they must understand all the challenges that their areas face and they must marshal the contribution that each of the partners can make—the council, the health board, the other statutory partners, the voluntary sector, and communities themselves. My sense is that that needs to start with a clear and detailed picture of the challenges in each area and a concrete plan of action for the money that can be contributed, what the services can bring to bear and how things need to shift to tackle individual problems.

Claire Sweeney can talk about this in a bit more detail because she has recently looked at some CPPs in relation to health inequalities.

Claire Sweeney: When we talk to people in a local area and try to get a feel for how the partnerships are working and coming together to do some of the things that Caroline Gardner has just mentioned, it is interesting to note that it starts off with a bit of mistrust in some areas. Housing, for example, might ask what it can gain from the partnership. It is almost a case of learning to understand each other's business, seeing where the focus needs to be, and seeing the potential improvements for the people who are receiving services as well as for those who are delivering the services.

We brought a report on community health partnerships to the committee a little while ago. What came through that report was the importance of partners working together to understand what they are trying to do. We found that some big partnerships often missed taking that important step right at the start of the process, which meant that any efforts that they made were almost ill focused because they did not really understand what they were trying to do collectively. That came through strongly in this piece of work, especially when we spoke to people at a local level. There is a bit of a silo mentality, for want of a better way of putting it, and people are not really seeing the benefits of working together more coherently. That is not to say that they should be working together just for the sake of doing it; they should be focused on and committed to what they are trying to achieve. They should put in resources and staffing and keep updating and checking that it is making a difference. I cannot emphasise enough that that was often lacking in some of the local areas that we spoke to.

James Dornan: I recognise that situation because I went to a few CPPs when I was a councillor. One of the concerns for me was the silo mentality, which meant that some organisations were looking after themselves rather than looking at the big picture. I hope that that will change with the proposed community empowerment bill. Do you also accept that, as well as CPPs looking for their vision, that vision must be driven by the people who live in the area? There is no point in the organisations telling the public what is good for it. It has got to be a case of saying, "This is what we need. How can you help us to get it?"

Claire Sweeney: That is right. The other important thing that I should have mentioned is that, as well as the partners understanding their business and what they are about, they need to engage with the local people. It takes effort and time to convince people that they can do things that will make a difference and that they can trust the partnerships to do things that will support them and lead to improvements. We cannot overstate the importance of engagement, and that is what the good partnerships that we saw had tried to do. They saw engagement as being important very early on, and there is evidence that it is leading to change. The partners need to see that engagement is starting to deliver so that they stay committed.

The point that was made earlier about the short-term focus and budgets being in one minute and out the next is also a big feature. We are talking about long-term investment.

Colin Keir (Edinburgh Western) (SNP): My question has been answered for the most part. It was basically about the silo mentality and the culture, among the health boards in particular, of protecting what they have and not being willing to impart information easily. I say that because I have some experience in local authorities. Are there any particular problems in any particular area that highlight a lack of communication? The first quote on page 29 says:

"Some practitioners and even managers don't know what the CPP is".

Obviously, there is an issue with the information that comes from health boards and local authorities, and there can be a silo mentality. Is there any particular area that appears to be worse than others, or is it just a general culture that is embedded in the system?

Caroline Gardner: It is generally a difficult problem. Claire Sweeney talked earlier about the gap that we often see between the CPP across an area and what is happening in a particular GP practice when patients are turning up every day with a range of problems. It is not easy to fill that space in the middle in the right way.

At the moment, there is a real opportunity to move forward because of the statement of ambition for community planning that has just been published and the more recent guidance, which helps to set clear expectations about what all 32 partnerships should be doing. We would love to see some of the very detailed information about what is happening in the local areas and a dialogue with the people who are providing services locally to decide what is needed in a particular area to help close the gap for the particular problems that they are trying to tackle.

Colin Keir: Is the problem national? Is no one place worse than any other?

Caroline Gardner: We are not able to answer that from this piece of work. Through Audit Scotland, the Accounts Commission and I are jointly carrying out some work to look at the effectiveness of CPPs, and we will brief the committee on that work in the new year. We might be able to give the committee more of a picture of the effectiveness of partnership working at that time. There is wide variation across the country but, as Claire Sweeney said, we are not sure that it is a case of one particular place getting it right and one being the problem.

The Convener: The issue of partnerships and how we audit and hold them to account is a recurring theme for the committee.

I thank the Auditor General and her colleagues. We will now change panels. We are running a bit late, but we should still take a five-minute comfort break.

11:01

Meeting suspended.

11:05

On resuming—

The Convener: I welcome our second panel of witnesses on the report "Health inequalities in Scotland", who are from the Scottish Government. We have Derek Feeley, director general for health and social care and chief executive of the national health service in Scotland; Sir Harry Burns, the chief medical officer for Scotland; and Donald Henderson, who heads up the public health division. Mr Feeley, would you like to make some introductory remarks?

Derek Feeley (Scottish Government): Yes—briefly. We are grateful to the Auditor General and her staff for their helpful analysis of the issue.

The Audit Scotland report begins by stating:

"Tackling health inequalities is challenging."

I think that that underestimates the task. It is probably the most complex problem that we face, and there is no simple solution. Audit Scotland recognises that, overall, health is improving, although I fully accept that inequalities remain a significant and long-standing problem for us.

I agree with the picture that Audit Scotland presents and I welcome its recognition of the scale and scope of the challenge. However, I regret that the report is relatively narrowly focused thereafter, when it does the analysis of the issue. Paragraph 9 of the report sets out the focus. The Scottish Government and, I think, other stakeholders made

representations at a number of stages during the preliminary work about the importance of the wider determinants of health.

It would be helpful if the chief medical officer had an opportunity at some point to cover those issues. He can also comment on some of the economic benefit issues that were raised in the earlier evidence session, if that is acceptable to you, convener.

The Convener: I am happy for Sir Harry Burns to add to your remarks, if he wants to.

Derek Feeley: I will finish my points and then Harry Burns can perhaps add something. I suspect that the committee will find that I will defer to him—again, with your permission, convener—more often than I would on almost any other subject that the committee might ask about: he is the recognised expert in the field, so there is no point in my trying to second-guess what he might say.

I have a few initial comments on the report's specific recommendations for the Scottish Government. A range of indicators already exists to monitor progress on reducing health inequalities. The most recent publication of those is in a document called "Long-term monitoring of health inequalities", which was published in October 2012. That is an annual report that goes back, I think, to 2009. I am keen to get the committee's view on the adequacy of the indicators: whether there are things that we might do to refine and review them and whether they properly give the committee the picture that members need. However, the indicators exist.

I know that the committee is interested in the distribution of primary care. On that, our priority to date has been not so much to dictate where practices should be located, but to work with GPs to ensure that the allocation formula and the contractual measures give sufficient priority to deprivation. We are very willing to do more on that. We are well engaged with the deep-end practices and we are keen to continue that dialogue with them. I accept that the contract could offer more, which is one reason why we have recently worked hard with the BMA to try to agree with it a more Scottish contract.

We have work under way with the Convention of Scottish Local Authorities to try to enhance community planning. As the committee knows, the Auditor General referred to the statement of ambition and the new guidance that was issued on 4 December, which identifies health inequalities as a clear key priority for single outcome agreements.

We are about to start a significant piece of collaborative working around early years right across the public sector, based in community planning partnerships. We might want to spend some time exploring that. The committee may have heard people talk about the early years collaborative, which is aimed at reducing infant mortality and improving attachment and readiness to learn. That is an important piece of work that has the potential to make a considerable contribution in this area.

The final thing to flag up for the committee is that we have reconstituted the ministerial task force on health inequalities. It will consider Audit Scotland's report and the committee's deliberations on that report and its recommendations. The task force plans to issue a report in summer 2013.

Sir Harry Burns (Scottish Government): I, too, welcome anything that shines more light on health inequalities. For me, health inequalities are the biggest issue facing Scotland. They are not only a problem but a manifestation of the social inequalities, social complexity and social disintegration that drive criminality, poor educational attainment and a whole range of things that we would want to be different in Scotland. The more attention that is paid to those drivers, the better.

The unfortunate thing about the report is that if it had come out 20-odd years ago, it would have been really helpful. It does not pay much attention to the complex science that we now understand underlies the problem of health inequalities. Twenty-five years ago, I was a surgeon in the Royal infirmary in Glasgow. We had to deal with ill health of huge depth and scale, and it was blindingly obvious to me that we would not fix that problem through paying attention to conventional risk factors such as smoking because, as the report mentions, smoking cessation projects widen health inequalities; nor were we going to solve the problem through the NHS. Instead of trying to persuade people to stop smoking and to take exercise and so on, the deep, underlying social issues had to be dealt with.

At the time, the next layer of complexity was all about locus of control—those were the buzzwords. Affluent people thought that their health decisions were in their own hands—that is internal locus of control.

I would tell patients in the Royal infirmary that they really needed to give up the booze or the fags, but I would get the reply, "Och, if you're gonna die, you're gonna die. Let's just carry on. We need to enjoy the time we've got." That represents external locus of control.

We began to ask ourselves what the psychological drivers of that are. Is it poverty? Is it hopelessness? Is it lack of opportunity? Work that I started when I was at the Royal began to show that cancer patients responded to their diseases

very differently depending on whether they were from affluent or deprived parts of Glasgow. There were biochemical differences in the way in which they responded. That brought in the whole issue of stress responses, inflammatory responses and biochemical drivers. We wondered what was going on, as things were just getting more and more complex.

We began to understand that what happened to people early on in life was behind some of that. I think that we will come back to the notion of the early years collaborative as a major step change in the way in which we are tackling the issue.

I was interested in the convener's comments about the intergenerational aspects of the issue. You are closer to the science than I expect you are aware, convener. We now know that, astonishingly, it is possible for the experiences of a grandfather to imprint his genes in ways that are transmittable to his sons and grandsons; in other words, the adverse experiences that a grandfather had 50 years ago could still be operative, despite the fact that his sons and grandsons are not exposed to those adverse experiences. That is the science of epigenetics, which I can explain in a bit more detail if the committee wants.

The problem is astonishingly complex. All these issues are interrelated and we will not solve them by trying to persuade people to change their behaviours. We need to get to the root of all of this, and the answers are probably multifactorial.

11:15

The other point that the convener made was about the scale of the cost of health inequalities. In fairness, Audit Scotland took the processes that were used by the Marmot group a few years ago and prorated them to Scotland. However, I think that the Marmot group's calculations were wrong. A few years ago, I looked at the economic impact of abolishing inequality in mortality from heart disease and cancer—the two biggest killers in Scotland—but I could not get the figures to stack up anything like the Marmot group did. The Marmot group based its calculations on work that was done at the University of Chicago by an economist who eventually won the Nobel prize for that work. In fact, if we abolish health inequalities in heart disease and cancer, we increase life expectancy from about 68 to 72 in deprived areas. People aged 68 are not usually economically active, particularly in those areas, so the economic benefits that are claimed in the University of Chicago's work do not exist. I would argue that the benefits are very much less than the Marmot group suggested.

Health inequalities are an issue of social justice and I think that we should deal with them because that is the right thing to do, not because of any economic benefit. Nevertheless, there are issues to which I would like to return to do with the way in which the calculations have been done regarding the benefits of some of the interventions.

The Convener: Okay. Thank you very much. You are tempting me to go down the road of discussing biology that sounded a bit Lamarckian. It did not work for Stalin—[*Laughter*.] We are the Public Audit Committee.

The ministerial task force was initially established and then reconvened, as Mr Feeley said, to address health inequalities. Exhibit 11 in the report elaborates Scottish Government spend that is specifically directed at reducing health inequalities covering a three-year period. To my eye, at best that expenditure is static; perhaps, in real terms, it even falls over the three years. If the ministerial task force has been reconvened to address health inequalities, if this is the Government's own identified funding for addressing these challenging and complex problems and if the figures include spending on the early years and young people—which increases over the three years, reflecting, to some extent, the increase in preventative early intervention work—my question is pretty straightforward. Given the report that we have in front of us and the fact that the task force has been reconvened, are the figures going to increase in next year's budget?

Derek Feeley: I do not have next year's budget figures in front of me, but we could certainly do an analysis.

The Convener: You must have some sense of where the budget in the health service, at least, is going.

Derek Feeley: The overall health service budget is going to increase.

One of the issues with exhibit 10 and exhibit 11, which shows our own figures, is what is included and what is excluded. For example, exhibit 10 is largely Scottish Government spending on health improvement and the public health domain—it does not include things such as the family nurse partnership initiative, which is very much aimed at addressing health inequalities, or the QOF payments, which are, in some respects, also aimed at addressing health inequalities. There is always an issue about what to include and what to exclude.

None of those numbers reflects the fact that much of our health spending is made according to need and, as we heard clearly from the Auditor General, Mary Scanlon and others, need is significantly greater in deprived areas. Therefore, a significant proportion of the overall health budget will be allocated to deprived communities. We

could carry out the comparative analysis, look at what is in those allocations and extrapolate from there, but I am not sure that that would give us a strong signal about whether we would be likely to improve health inequalities.

The Convener: It might not, but surely the evidence in the report shows that although some central allocations are made with an element of consideration of need it is not possible to demonstrate how that translates into distribution on the ground. If the Scottish Government is making allocations centrally with that in mind, what do you intend to do to ensure that at health board and CHP level—and perhaps more locally than that—funds follow need, which is surely the intention of central Government when it makes the allocations in the first place?

Derek Feeley: Although some of the money, particularly the £167 million shown in exhibit 10, is ring fenced for particular purposes, the totality is much less so. It is for local boards to determine local priorities.

We are increasingly tracking outcomes, which allows us to judge whether the money is being deployed for maximum impact. For example, we have recently tried to ensure that our health improvement, efficiency, access to services and treatment—or HEAT—targets have a clearer focus on making a proportional investment in areas of deprivation. We have introduced into our smoking cessation target, our healthy weight target and so on specific deprived community-related elements. As a result, you would expect benefits to flow through in the longer-term indicators.

Harry Burns may wish to comment.

Sir Harry Burns: On Derek Feeley's point about money flowing to need, when I was lead clinician for cancer in Scotland 10 years ago, I was very much concerned about the fact that deprived women were more likely to die of breast cancer than affluent women, which we thought might represent a failure in the health service to distribute treatment equitably. In fact, when we examined the matter, we found that more deprived women were dying because they were getting more aggressive cancers. They were actually getting more treatment than affluent women. I am sorry to tempt you back to biology, convener, but it all comes back to the fact that those women had a different pattern of cancer and, 10 years on, I think that we are beginning to get close to an understanding of that. As I looked at different outcomes from care, I could not find any evidence that distribution of NHS resource across cancers was not appropriate.

The Convener: I am sorry, but I am struggling slightly with this. The Scottish Government seems to be presenting two completely contradictory arguments to the committee. The first is that funds are already pursuing need and are being disproportionately spent in areas of greater need in order to drive outcomes; however, the second is that such measures will have no impact whatever on health inequalities because they are driven by far more profound and biological measures. I do not know which argument the Scottish Government is presenting to the committee and I would be grateful if the position could be clarified.

Sir Harry Burns: I am very clear that we will not narrow health inequalities through actions taken by the NHS on its own. We need a pan-societal response. The NHS can be a catalyst, but we will not cure health inequalities in that way. We will make some steps in some areas—we might well come back to the area of heart disease, where we are beginning to see the impact of the keep well programme—but we need to tackle the fundamental drivers, which lie outside the healthcare system.

Derek Feeley: That is what we are saying. The health service can and should make a contribution, but it will not in and of itself completely remove health inequalities.

I commend to the committee Dame Sally Macintyre's report "Inequalities in health in Scotland: what are they and what can we do about them?", which was published by the Medical Research Council social and public health sciences unit at the University of Glasgow. Although it came out in 2007, I think that it remains valid.

Sally identified in the report eight or so characteristics of policies that are likely to be effective in reducing health inequalities: changing the environment; bringing in legislative and regulatory controls, such as smoking bans; implementing fiscal policies, such as increasing the price of alcohol and tobacco; dealing with income support issues; reducing price barriers, such as with free prescriptions and school meals; improving the accessibility of services, which I think is the real focus of the Audit Scotland report and what we have been talking about; prioritising disadvantaged groups; offering intensive support; and starting young, as with the early years collaborative and family nurse partnerships.

Our contention is that we need to do all of those.

The Convener: Good.

Mary Scanlon: I have a supplementary question. From exhibit 11, I note that there has been a small increase in funding for

"Harms to health and well-being: alcohol, drugs, violence",

and for

"Early years and young people".

However, the exhibit shows that the budget for

"Health and well-being ... diet and physical activity, health checks"

and

"smoking"

has been cut. It also shows that the budget for physical environments and transport—the area that Mr Feeley just mentioned—has been cut by £6 million, and that the budget for poverty and employment has been cut by £5 million. If Sally Macintyre identified those issues in a report five years ago, why are you cutting the specific budgets for them?

Derek Feeley: I cannot speak to all those budget lines as I am not the accountable officer for them all and I certainly do not have all the detail. However, if it would help the committee, we can do the forward comparison of what is in them.

Mary Scanlon: I seek some clarity on another issue. I have been off the Health and Sport Committee for a while, so I went to Google to find out what had been done on health inequalities recently. I found a press release of 29 November that stated, as Mr Feeley mentioned, that the ministerial task force met for the first time that day. However, it also stated that the work of the task force

"will build on the Equally Well report of the last Ministerial taskforce in 2008."

I appreciate that the task force will report in 2013 and I welcome very much the work in that regard by Paul Wheelhouse, Angela Constance, Derek Mackay and Michael Matheson. However, has the task force continued to meet since 2008, or was it abandoned in 2008 after the "Equally Well" report was produced, meeting again last week—four years later—for the first time since then? Is my reading of the press release wrong?

Derek Feeley: Harry Burns is a member of the task force, so I will let him answer.

Sir Harry Burns: Ms Scanlon is absolutely right. The original ministerial task force set up a series of interventions with the purpose of learning what worked and sharing that learning. It is now a new task force that is reconvening to see what has been learned in the past four years.

Mary Scanlon: So there has not been a task force since "Equally Well" was produced in 2008.

Sir Harry Burns: That is right.

Mary Scanlon: There has been no cross-working ministerial task force for four years.

Donald Henderson (Scottish Government): Sorry, can I come in? This was before my time in my current job, but there was a reconvening in 2010, which I understand was less fundamental than the original 2008 inquiry. However, broadly every two years, ministers have wanted to look at this area. In fact, if it had not been for the Audit Scotland inquiry, I think that we would have kick started this work probably a bit before the summer rather than a bit after the summer, but we wanted to see where the Audit Scotland work was taking us.

Mary Scanlon: So since 2008 there has been one meeting of a ministerial task force—in 2010.

Donald Henderson: No, there was a reconvening of the process in 2010.

Mary Scanlon: Okay.

Donald Henderson: We can write to you with the details of that.

Mary Scanlon: I was just a bit surprised that the press release said that the task force met on 29 November for the first time since the report was published in 2008. I thought that I must be reading that wrongly.

Sir Harry Burns: The 2010 reconvening was about ensuring that we were pulling together the information and lessons from the 2008 process.

Mary Scanlon: I had it in my mind that there was a Government target in 2007—I do not know whether it was a HEAT target—to reduce inequalities. Did that target exist, or did I imagine it?

Derek Feeley: I do not recall, to be honest.

11:30

Sir Harry Burns: We continue to monitor things such as inequalities in mortality from heart disease. We measure absolute and relative inequalities. For many of the major killers, mortality has been coming down, but it has been coming down at equal rates in affluent and deprived areas. Inequality has not widened in absolute terms, but because the denominator gets smaller, it widens in relative terms. This is all arithmetical, really, but our aim is to narrow measures in relation to mortality.

In my annual report last year, I called attention to the fact that most of the measures have not narrowed in absolute terms. I identified two exceptions. First, there was a narrowing in relation to low birth weight rates between rich and poor, which I think is quite important. I can come back to that. The other exception, intriguingly, was a narrowing in the rates of first admission for heart disease. That is turning into a narrowing in the rates of death from heart disease this year.

We are beginning to see some signs that the keep well programme, which started in 2006 following the Kerr report, is having an effect. We

predicted that it would take five to 10 years to see anything happening. We have some evidence that some practices are doing the keep well intervention much more effectively than others, and it may well be that we are beginning to see the scale of that work coming to a point at which, statistically, it is having an effect. However, it is rather early to say that.

Mary Scanlon: Right. I go back to Mr Feeley's comment that there is a range of indicators. I have read the report from cover to cover, particularly appendix 3, which looks at all the strategies that have aimed to improve health since 2008, so we are talking about a period of four to five years. The report states:

"Single Outcome Agreements do not provide robust evidence of progress in ... health inequalities".

Exhibit 21 states that community planning partnerships' annual reports

"do not provide consistent or robust evidence".

Appendix 3 states that the first annual report on the child poverty strategy contained

"no evidence of impact to date."

Those are all Government programmes. The report also states:

"NHS Health Scotland has not yet determined how to evaluate the long-term impact and cost effectiveness of Keep Well."

On the equally well test sites, the report states that there is

"no evidence that they have helped to reduce ... inequalities".

I spent a fair bit of time reading the report, and I have quoted those comments from it, yet Mr Feeley comes along saying, "Well, there's a range of indicators." The Audit Scotland report covers the range of interventions. Why do we not have the benefit of Mr Feeley's range of indicators? Audit Scotland could not find them.

Derek Feeley: I think that there is a footnote on some page of the report that mentions the long-term indicators.

Mary Scanlon: Really?

Derek Feeley: As I say, the indicators were published in October 2012. Do you want me to list what they cover?

Mary Scanlon: Well, do they cover everything that I have just listed, where there is no information?

Derek Feeley: They cover healthy life expectancy at birth, premature mortality, mental wellbeing, low birth weight, hospital admissions, coronary heart disease deaths, cancer incidence, cancer deaths, alcohol consumption and alcohol deaths.

Mary Scanlon: Appendix 3 of the Audit Scotland report covers Government interventions, which I think all members of this Parliament supported: equally well, the child poverty strategy, "The Road to Recovery: A new approach to tackling Scotland's drug problem", "Achieving Our Potential" and so on. I presume that you carry out research and think, "This will target inequalities and deprivation. It will be of benefit, so we'll come up with an action plan and a strategy." The intervention then comes to the Parliament and lots of money goes into it, yet what we have today is little or no evidence of impact.

I could go through all the interventions. For example, on the preventing obesity route map, the report states:

"There is no evidence of impact to date."

"The Road to Recovery" was published in 2008, so it is almost five years since it came out, yet the report states that the progress report

"did not include any information about impact."

As I mentioned earlier, the report states:

"the rate of drug-related ... discharges was ... 16 times higher among people in the most deprived areas."

What I cannot understand is that you come up with action plans and strategies and allocate the money, and we all support them—we all want them to work—yet we have no evidence of impact.

Sir Harry Burns: You put your finger on the key point earlier—the history of the effort to narrow health inequalities is full of three-year projects and projects that are done piecemeal in different parts of Scotland. At the end of the three years the projects are evaluated, people say, "Oh, there is no difference," and we take the money away.

The tale has been 50 years in the making, and it is not going to change overnight. The Scottish statistics are certainly not going to change when different things are being done in different parts of Scotland. I would have been astonished if, after three years, equally well had made any difference to the Scottish statistics.

However, the seven or eight equally well test sites have come up with some real learning that, when done at scale across the whole of Scotland, will make a difference. My question for you is whether there is any political will to do that. Can we begin to say across the whole of Scottish society—at Government, MSP and local authority level, at health board chair and chief executive level and all the way down to the front line—that we are all going to do what we know has worked in Shettleston, Kirkcaldy, East Lothian and so on, and do it at scale, consistently, 24/7? That is what

it will take. It will also take stickability—it will take doing it for five to 10 years. Then we will see a difference—I guarantee that.

Mary Scanlon: I do not want to go back, but certainly for 13 years, public health has not been a matter for criticism in this Parliament. I have one simple question that I asked earlier about something that may not be one of the major strategies, but is important nonetheless. What can you do about getting a joined-up information technology system between a pharmacist and a GP?

In this age—in this century—given the technology that we have, why does a pharmacist have to print off information, get on his bike and take the information to a GP because there is no secure email and no incentive to carry out health checks? Can that barrier be overcome?

Derek Feeley: I am sure that it can be overcome. We have made considerable progress over recent years in the electronic transmission of prescriptions, for example. Most of that now is done electronically. I do not know where the example comes from but I will investigate the matter, which I am sure can be fixed.

James Dornan: I was interested to hear Sir Harry talking about poverty and hopelessness. Everybody knows that poverty is a driver in this. I have been making that point about hopelessness for some time. You see it with people whom you live beside and people who come in to see you. They think, “Och, well, it's just one of those things, this is what happens when you live in this area,” whatever area it is.

As a grandfather, I am a wee bit concerned that the sins of my youth may well be paid for by my granddaughter and grandson. I am really pleased about the early years collaborative; it is a fantastic idea and it will have a long-term benefit. Is anything already in place that means that my grandchildren do not pay the price for my sins?

Sir Harry Burns: The science around this particular epigenetics thing that we are beginning to investigate is by no means clear. However, the evidence is that, with anything like that, we are likely to find some way of reversing it if it proves to be an issue. We have already seen some signs in some very localised situations that it has been operative.

Your granddaughter will not pay the price for your sins because it is inherited down father, son, grandson and mother, daughter, granddaughter lines. The evidence on it is very much sex-segregrated. I am sure that you led a blameless life anyway.

Our best bet is to focus on one of the key drivers of the epigenetic change—lack of nurturing. There is some powerful experimental evidence that shows that failure to nurture offspring leads to changes in how brain chemicals are produced, particularly brain chemicals associated with positive mood, such as serotonin and so on. Those chemicals are not produced in such great quantities in offspring who are not nurtured effectively.

One of the key aims of the early years collaborative is to support young parents who do not have a clue about how to handle screaming kids, and to show them how to nurture and relate to their children consistently. The experimental evidence is very strong: by doing that, you will reduce things such as attention deficit at school and improve school attainment and health, and you will deal with a lot of the societal problems.

One of my aspirations for the early years collaborative is that it will eventually lead to the closure of Polmont young offenders institution, because there will be fewer young people having to cope with not having learned how to cope, as it were. The early years collaborative may well break that cycle if we do it properly, but that will only happen if we do it at scale across the whole of Scotland. Consistency is really important if we are to prove that the approach works.

I believe that the time for wee projects is long past. The scientific evidence is quite powerful in a number of areas, so we should apply it. Critically, to come back to the point about measurement, we need to measure that it is being delivered, not with a report two years later but on a day-to-day basis. For example, we can say that we did a particular thing today to those 10 mums to be, and we did something else yesterday to those 15 mums to be, and measure the interventions that are being delivered.

That is what will turn things around. The early years collaborative is the single most important thing that we can do. Again, however, I would caution people against thinking of it as a magic bullet. There is no one thing that will make a difference; it is important that we do it all.

James Dornan: Thank you for that. The nurture response encouraged me greatly.

As you say, the approach is not a silver bullet, which takes me back to the point that I raised earlier about the CPPs and the single outcome agreements, and the importance of the community being at the centre of the CPPs. Do you agree that that could play quite an important role in ensuring that life gets better?

Sir Harry Burns: Absolutely. As you will know, a review of community planning is under way and I have had the opportunity to be at the first two meetings. I said to the review—the minutes are on the website—that we should get in behind action

to improve early years from minus nine months to five years old, and even before minus nine months, as we need to be thinking a lot about the health of young girls who may well become pregnant.

I would implement a set of actions that are aimed at reducing offending and reoffending, and at giving young men who live chaotic lives the opportunity to gain control over their lives and make judgments about their future. We should introduce active labour market programmes. I had the opportunity to chair a European-funded Europe-wide project on worklessness and health, and I know that active labour market programmes of that sort, which do not just get people out of unemployment but teach them life skills too, seem to be very effective. We had a really interesting meeting in which we looked at interventions that were being used in the Roma community in eastern Europe. That is a very problematic group, but things are being turned around very successfully.

Finally, I would improve physical activity across the age range. People who take two-and-a-half hours of some type of exercise a week are much more likely to remain fit and independent into old age, and are much less likely to lose their memory and fall down and break their hips, and so on.

There is a range of interventions that we could implement at scale across Scotland that would change the life course, and they would narrow health inequalities as long as they were done in a sensitive way in deprived areas. James Dornan's earlier point about doing things with rather than to the community and helping it to be in control is critical in that regard.

Community planning is at the heart of the approach, but it needs to co-produce outcomes with the community rather than telling the community what to do. We are here to help the community to design its own appropriate interventions, which is one of the big lessons from the equally well initiative.

Tavish Scott: I am finding this session utterly compelling, so please forgive me for asking a couple of what I hope are not completely stupid questions. Is tackling health inequalities the number 1 NHS and Government priority?

Sir Harry Burns: It is for me.

Tavish Scott: I think that I have gathered that.

11:45

Derek Feeley: Is it the number 1 Government priority? It runs like a thread through the Government portfolios. That is why it is one of the priorities that we have identified for the community planning review and why it is on health's list of priorities. Over the past few years, we have all shared a sense of frustration that we have not been able to make the progress that we have wanted to make. Tackling health inequalities is right up there.

Tavish Scott: I will ask the question the other way round. Forgive me for asking this, but is there anything that is more important at the moment? Is there any issue that drives your inbox every day more than health inequalities?

Derek Feeley: My inbox is driven partly by what is really important and partly by what is really urgent.

Tavish Scott: I understand that.

Derek Feeley: The more we can get the health service to deliver what it needs to deliver in terms of quality of care for its patients—we are making progress on that—the more we can focus on the more significant, longer-term generational issues, but we need to do both.

Tavish Scott: Indeed.

On the principle that the convener and other colleagues pursued, I accept your case that it must be a long-term approach and that politics does not help, because politicians are all interested in the short term, but are there examples of programmes to tackle health inequalities that were introduced in 2000 or at some other time during the first session of the Parliament that are still running and still effective? Are there any programmes that have survived the churn of politics?

Sir Harry Burns: The example that I am most familiar with is that of the 2006 keep well programme. It was not about health checks, because the evidence around the cost-effectiveness of health checks is very poor. It is necessary to see a great number of people to deal with one problem. The aim of the keep well programme was to use postcode—which is a marker of socioeconomic deprivation—to target and enhance the pattern of intervention.

Glasgow has had one of the biggest programmes involving the most participants, so it has gathered the most data. What we have seen in Glasgow is a variation in impact depending on the way in which the GPs have implemented the programme. The impact has been greater when the GPs have not just implemented the health check, but have surrounded it with, for example, assistance with literacy. To give an example, 20 per cent of the patients who attended my clinic at the royal infirmary could not read the instructions on the drugs that they were given. Providing that level of support alongside the intervention has been much more effective than just saying, "Right, you need a drug to lower your cholesterol. Away

you go." The effectiveness depends on the way in which we do things. That comes back to the point that, as a society, we need to co-produce the outcomes with the individuals concerned. We should do things with them rather than doing things to them. Helping people to take control of their lives in that way is a hallmark of the successful keep well practices.

We must learn where the good outcomes are and ensure that that practice gets spread. That is what the patient safety programme has been spectacularly successful in doing. It is a question of using that improvement methodology across the spectrum. It is critical that we involve local authorities and the broad system in that process.

Tavish Scott: I completely accept that, but is it the case that we still have too much initiative-itis, as it were? Are there too many things that flow at you from Government? This is genuinely not a political point. It must happen under all Governments that Government ministers want to take a new approach to an issue. Is the result of that that you have not been able to have a series of programmes that have allowed the NHS to drive progress on health inequalities during the 13-year period of devolution?

Sir Harry Burns: Derek Feeley will want to answer that, but I have worked in some detail with every health minister since Sam Galbraith and I can honestly say that they have all wanted to do the right thing, irrespective of politics. They might have varied slightly in how they have wanted to do things, but the reality is—I am not trying to butter folk up—that politicians want to do the right thing. I have not experienced initiatives being stopped or started willy-nilly. If the evidence is there that things are moving in the right direction and there is an expectation that they will move in the right direction, people want to get in behind that. I am not too negative about the issue.

Tavish Scott: That is reassuring, but when will we be able to know that there has been success—"success" is probably the wrong word; perhaps I should say "progress"? Are we talking about 10 years again?

Sir Harry Burns: That is a question that I have had to answer. I think that the early years collaborative will show a number of changes. The first thing that you will see will be a reduction in low birth-weight babies. Then you might see a reduction in the stillbirth rate and perhaps an improvement in the infant mortality rate. You should see that a year from the start of the project, or as soon as it is scaled up enough to be able to have a statistically significant impact.

You will then begin to see infant mortality fall a bit—I would not predict a huge fall in infant mortality. At the two-year health visitor check, you should see a reduction in developmental delay. There are intermediate markers, so a reduction in developmental delay at the 24-month health visitor assessment is predictive of better educational attainment in five years' time. There are markers on the road that will enable us to be confident that that will happen.

Let me reinforce the point that we will see that only when the number of people involved in the intervention is a big enough proportion of Scotland's population to get statistical significance. Projectitis, whereby we do a wee bit here and a wee bit there, will lead to failure, because folk will say that the approach is not working—it will not be working because there will not be enough people in the system to enable us to show the statistical benefit.

Derek Feeley: We need to do a lot of stuff if we are going to make progress. We will have to be able to manage a range of connected programmes across the whole of Government and the whole of Scottish civic society.

The early years collaborative gives us the opportunity to apply a common method to that big challenge across public services. The method that we have chosen to use is the one that we have been using on patient safety, which is about getting the reliable application of quite common things—it is about doing the common things uncommonly well. There is quite a lot of evidence about what we should do; the challenge is getting that to happen at scale, reliably. That is what we are trying to do in the early years. We will need to stick at it, because the work takes a while to stick.

The good thing about it is that we are counting every day, as we go along. We start with one family. If what we do works with that family, we will do it with five more families; if it works with five families, we will do it with 25. We are counting all the time, and the power of the data is as much in how regularly we count it as it is in the sample size. We will start to get a different kind of data, which we will be able to use to gauge our progress as we go along.

Mary Scanlon: Tavish Scott asked about initiatives that start and stop. Until recently, there was no health check between the measles, mumps and rubella jab and starting school—at 15 months, three and three-quarter years and five years, there is nothing. The 24-month health check has only just been reintroduced. Maybe we are paying the price of stopping and starting. There has been an impact on the health visitor profession. Has that been damaging, in the context of the early years?

Sir Harry Burns: It is really important that we have started to do those checks again. We have started to do them again specifically because they

are a step on the road to narrowing health inequalities.

I love health visitors. They are wonderful. They are a hugely important workforce and they do really important things. The critical thing is to ensure that they are organised in a way that gives maximum impact. At the end of the day, it is for health boards to take that on.

Mary Scanlon: The health checks should never have stopped.

Sir Harry Burns: I would not disagree with that.

Mark Griffin: The previous panel talked about the negotiations with the BMA on the GP contract. I want to give Mr Feeley the opportunity to talk about that and about whether the QOF could be targeted at tackling inequalities.

Derek Feeley: I think that there is an opportunity. With the deal that we struck only in the past week or so, we have started to move towards a more Scottish contract in which particular Scottish issues are picked up. There are already things in the new deal that will help us in the agenda. There is, for example, a stronger focus on polypharmacy. That tends to go with multimorbidity, which we see in deprived communities. There is an attempt to increase activity around anticipatory care. A key issue in tackling deprivation-related health inequalities is the ability to anticipate issues.

We have tried to get it over to the committee that GPs have an important part to play. No one is denying that, but they are not the magic bullet either. However, as we move forward in the negotiations, we will try to ensure that we continue to emphasise bending the contract in whatever way we can to support our work on inequalities. We have made a start.

Mark Griffin: The report documents the effect of the additional payment to dentists on the provision of dentists in the most deprived areas. We can see that that provision has almost doubled since 2006. Do you foresee a similar outcome for GP provision in the most deprived areas as a result of any changes to the contract?

Derek Feeley: We had a particular issue in dentistry that needed to be fixed. I am not sure that we have quite the same issue with GPs.

I was interested in the commentary on GP numbers, and I am trying to find the chart that shows them. It is not as though there is no correlation between GP numbers and deprivation—it is important to recognise that. I have not done the sums, but it looks to me that there are around 25 to 30 per cent more GPs in the most deprived areas than in the least deprived areas. In total, there are more GPs per head of population in Scotland than in any other bit of the United Kingdom. If we looked at the distribution of GPs in other bits of the UK, we would not see even that level of correlation between deprivation and numbers of GPs.

There are a limited number of things that we can do to require GPs to set up in particular locations. We have done some things and we are continuing to do them. An example is the resourcing of new premises. There is a big investment coming up in a new health centre in Possilpark, which ought to make it a more attractive place for GPs to do their business.

We definitely can and should do more in the contract, which we have just discussed, to try to make those places more attractive. We have had some success with that. Exhibit 12 in the Audit Scotland report shows that the deep-end practices tend to do relatively well. We can and should continue that, because that is definitely part of the solution.

GPs have an important part to play, and we should continue the conversations that we have had with the deep-end practices. We are working with them on initiatives on consultation lengths to see whether those can make a difference to the quality of the interaction in deprived communities. We are doing stuff around the detect cancer early programme to try to understand better why people in deprived areas do not respond to the bowel screening programme, for example, as often and as regularly as people in less deprived communities do.

There is a lot of work to do, and we will keep doing it.

Sir Harry Burns: The effectiveness of the intervention is not necessarily driven by the number of GPs; it is driven by the number of people in the extended primary care team. The evidence from things such as the keep well and equally well programmes suggests that the signposting of individuals is important. A GP will not necessarily see someone through a bit of rehabilitation for an alcohol problem. The folk who will manage the programme do not have to include the GP. My preference would be to ask what broad range of skills is needed in the community and to invest in that. I think that we are likely to see that.

12:00

The Convener: I will perhaps follow up on that point later, but I have a question for Mr Feeley. In the commentary on the distribution of GPs, the report makes the point that there are no whole-time equivalent figures broken down by deprivation. Is there any possibility of that level of information becoming available?

Derek Feeley: We can have a look at that. If we can construct even some kind of estimate for the committee, we will do that.

I see that Harry Burns wants to say something—I think that he is going to make a point about people travelling out of area.

Sir Harry Burns: Yes, I am. When I worked in Glasgow, we looked at that issue and found that the people in Easterhouse, for example, might be signed up with up to 100 practices spread throughout Glasgow, depending on where their families came from historically. Therefore, the number of GPs in an area does not necessarily tell us about the number of GPs who are actually seeing patients, if you get my drift.

The Convener: I do, but we have to work with the data that we have, and the better quality it is, the better we will do, otherwise we are in the dark and not looking for the light.

Sir Harry Burns: I accept that, but you need to be aware that it might not be completely accurate.

Sandra White: I could not agree more with what Harry Burns has been saying. There is not a great deal of difference between what he has said and what the Auditor General said. Audit Scotland's report is about health and the money that has been spent, but the issue is more complex than that—deprivation is the key. We are looking at figures and other aspects. Earlier, I said roughly what Harry Burns said—that we have to look at the issue holistically—although I perhaps put it a bit more strongly.

I am interested in the GP contracts. Obviously, those are negotiated on a UK-wide basis. Will we have particular difficulties because the contracts are negotiated on that basis and not just in Scotland? Paragraph 38, on page 20, states:

"Changes to the ... Contract are negotiated at a UK level".

I just wonder how far down that road we have got and whether there are any difficulties.

Derek Feeley: This year, a deal could not be struck at UK level, so we entered into negotiations with the BMA in Scotland and reached an agreement with it. The opportunity has always existed for us to do slightly different things and to flex our approach within the UK contract. For example, the enhanced services in England are different from those in Scotland. However, in the latest negotiations, we took quite a big step towards something that is more appropriate to Scotland, but still within a broad UK framework. We have maximised our flexibility and we will continue to do that.

Sandra White: I just wanted to clarify that in my mind.

I talked about a more holistic approach involving CPPs and partnership working. Everybody has mentioned that. In my Glasgow Kelvin constituency, there is a great deal of working between local pharmacies, hospitals and doctors, so that is an example that could perhaps be considered. I am interested in localisation and things such as healthy living centres, which should flow down from the health service and CPPs. Obviously, Glasgow has a particular problem with that. While we have Government spokespersons—or whatever they may be—here, I would like to ask whether there is an opportunity for the Government to consider more legislation to ensure that health boards, councils and CPPs work together more holistically.

Derek Feeley: Legislation will take us only so far on that. The forthcoming community empowerment bill will help to set the right kind of environment. However, as Sandra White rightly says, part of the issue comes down to the way in which local people interact. Most of the evidence on what makes good partnership working is about people showing leadership locally.

Government should set the right kind of environment for that to happen. However, as Harry Burns said earlier, in some instances, the right solution is not to do things to people, but to enable and empower local people to do things for themselves. From examining what works in some of the equally well pilot sites, we have found that the local application of simpler rules makes a big difference in such programmes.

Is that fair enough, Harry?

Sir Harry Burns: Absolutely. In local application, people find innovative solutions. I need to be careful about what I say here but, when we stand back, we might not immediately think that those are the right solutions. However, in that situation, local people find a way to deal with previously intractable problems by coming up with solutions that we would never have anticipated. That is the power of co-production.

Our role—by that, I mean the role of officials and politicians—is to allow an environment that enables people to co-produce better outcomes. They have part of the solution and, by coming together, they can create a different dynamic across the community. Too often, we get in the way with legislation, rules and regulations. I recently had the experience of a community that wanted to take over a disused building, but the local council said, "Naw, you cannae do that. It's not zoned for that." My response to that would be that the council should change the zoning.

Too often, we get in the way. Our prime role should be to ask what we can do to help connectedness in communities. If what we are

doing gets in the way of that, we should stop doing it.

Sandra White: I will leave it there, although I could go on for ever.

The Convener: Surely. Best not to, though.

Mr Coffey, could you go on for ever?

Willie Coffey: I certainly will not, convener.

I echo Tavish Scott's comments about how fascinating the discussion is. It is certainly lifting my gaze above and beyond the raw statistics that appear in the report. Those statistics are helpful, but the discussion is making me think about other issues. I am grateful to Sir Harry Burns and his colleagues for that.

I sometimes have to remind myself that we are the Public Audit Committee, not the Health and Sport Committee. I asked the Auditor General and her team whether there was evidence to show that the investment that has been made in dental practices since 2007—in particular, the incentive scheme—had resulted in better outcomes for public health. I ask the witnesses to indicate whether that is the case.

Derek Feeley: There are better outcomes, but they are spread throughout the deprivation deciles, because a number of things that we have been doing, such as fluoride varnishing, have made a big difference, but they have made a big difference for everybody.

The best thing to do is to offer to write to the committee with whatever evidence exists about what that additional investment has bought. It has been part of a broader programme to improve dental outcomes in Scotland, so I fear that it would be difficult to identify cause and effect in relation to the investment.

Sir Harry Burns: There is a problem with getting the data that would show better dental health in adults, although dental inspections in schools will tell us the number of decayed, missing and filled teeth that children have.

The fluoride varnishing has been significant. Previously, dentists were not paid to use fluoride varnish, but that has changed and, together with measures such as breakfast clubs, which help kids to have better dental hygiene, that has had an impact in the most deprived areas.

Paradoxically, the biggest impact of adult dental health would probably be on heart disease. There is powerful evidence that shows that the chronic inflammation that gets set up by poor dental health has an impact on the arteries. That brings us back to the complexity of the issue. The incidence of heart disease is falling dramatically. I would be the last person to suggest that that was because of better dental health, but it might well have made a contribution. We can never unravel the matter. That brings us back to the really complex nature of the drivers of health inequalities.

Willie Coffey: I am even more fascinated by that subject than I was before. Thank you for your response. If there is any evidence or any report on the impact that that work has had, I would appreciate seeing it, as would the committee, I am sure.

Another point that you made that gave me concern was about the incidences of breast cancer in deprived and more affluent areas. You say that there are more aggressive cancers in deprived communities. I am no expert, so I am keen to hear from you what kind of interventions society can make to try to turn round that statistic.

Sir Harry Burns: That is all down to oestrogen-receptor-positive and oestrogen-receptor-negative cancers. We found that oestrogen-receptor-negative cancers were more common in women from deprived areas, which meant that they were more likely to have chemotherapy and radiotherapy; whereas, for oestrogen-receptor-positive tumours, the women could use a particular medication with fewer side effects. We puzzled about that, but the Glasgow Centre for Population Health has published a couple of studies in the past year that show that DNA methylation is different in affluent and deprived Glaswegians. I am sorry for getting very technical and biological, but methylation is a measure of how much damage has been done to DNA—how much someone's DNA has been influenced by adverse environments—and the evidence suggests that there is more likelihood of mutation in people who have experienced more DNA damage. We have evidence that there are different levels of DNA demethylation across the social spectrum.

I am happy to come back and give you a talk about that issue if you are really interested. It shows the biology of deprivation and demonstrates that deprivation goes right to the centre of the cell and affects it. That brings us back to the fact that simple solutions will not work. We need to do everything that we know will help, at scale.

Willie Coffey: I have a final, more general point. I sensed your frustration when you talked about consistency and stickability. Is the big message that you would give the committee and policy makers that, from this point on, regardless of the messages in the Audit Scotland report, we must ensure that, as you have said several times, whatever measures appear to work are applied across the board and stuck to? That has not been the case in the past, but should it be the policy in the future?

Sir Harry Burns: The approach has been too piecemeal. Across society, we need to recognise the scale of the problem and do things that our best evidence shows work. We need to build the will to do that across the whole of society and we need to prove that we are doing it. As Derek Feeley says, we must get the day-to-day process measures that show that it is happening out there at the front line, not for the purposes of judgment, but to support the front-line staff to continually improve what they are doing and to learn and develop. We must build the will—those are the words that I would use.

The Convener: Thanks very much. I want to follow up on one thing before we finish, to inform the discussion that we will have later about how to progress, bearing in mind that, as Mr Coffey said, we are the Public Audit Committee, not the Health and Sport Committee.

In previous work, we have engaged with deep-end GPs on the Audit Scotland report on cardiology services. Mr Coffey and I met some deep-end colleagues and were struck by the evidence that we heard from them. Many of the messages that they gave us reflected things that Sir Harry has talked about today. They told us about fatalism in their patients, who say, "This is what happens: we smoke, we drink, we die early—that is how life is." They also talked about co-morbidity and the difficulty of getting to the heart of a particular problem; about the importance of non-health interventions to do with housing, income and welfare; and about the importance not only of GPs, but of the wider team, which might be anyone from health visitors to welfare rights advisers.

Is it not the case that, for most people, the GP still acts as the gateway or door to accessing all those wider things? I think that the GPs' argument was that they need more resources and time to undertake some of the work that, as I think you have implied, is of central importance. Is that a reasonable suggestion?

Sir Harry Burns: It is not unreasonable, but I must come back to health visitor and nurse support. When I carried out a lot of breast cancer surgery, I learned that, when the women had a problem, they would turn to the breast cancer nurse specialist rather than me—and I would like to think that I was pretty approachable. Given that the people whom individuals in crisis relate to differ very much, we should have a properly staffed team.

The commitment of some of the deep-end GPs to this agenda is humbling, and I am in regular contact with some of them about issues that they are dealing with. However, we need a diversified economy of people who will help. It comes back to the question of who can best signpost; sometimes it will be welfare rights advisers, but people often see nurses as the least threatening.

The Convener: A number of colleagues have commented on the compelling nature of this evidence session and, with the witnesses' forbearance, I have allowed it to run over a bit. I thank Mr Feeley, Mr Henderson and Sir Harry Burns for their attendance.

I suspend briefly to allow the witnesses to leave.

12:16

Meeting suspended.

12:18

On resuming—

"NHS financial performance 2011/12"

The Convener: Our next item is consideration of correspondence from the Scottish Government in response to my letter following our discussion of the section 23 report "NHS financial performance 2011/12". A paper has been circulated to colleagues.

As we are running over time, let me make a suggestion. Although the correspondence goes some way towards answering some of our questions, it queries some of Audit Scotland's views on the transparency of the NHS accounts. As I think that it would be reasonable to give Audit Scotland the opportunity to respond in turn to those comments, I suggest, for the sake of speed, that we write to Audit Scotland and seek its remarks in writing. Is that agreed?

Members *indicated agreement.*

Mary Scanlon: I have a question, convener.

The Convener: Sorry, Mary. Go ahead.

Mary Scanlon: The figure of £1 billion of backlog maintenance is being used in debates—[*Interruption*.]

The Convener: I am sorry, Mr Dornan. I did not realise that you were not here when I reconvened the meeting.

Mary Scanlon: The Scottish Government has supplied figures for backlog maintenance that is medium, significant and high risk, but we need to know the definition of "high risk". For example, does property in that category meet health and safety standards?

I believe that Willie Coffey mentioned this at the previous meeting, but we also need to know what surplus assets are included in the figures for backlog maintenance. Given that such assets are included, the £1 billion figure is not an accurate account of the situation. After all, if a building is

surplus to requirements and about to be sold, it should not be included under that heading.

As the Public Audit Committee, we require a definition of high, significant and medium risk. My understanding is that the definition of "high risk" might not meet health and safety requirements, so we need more clarity from Mr Feeley on that point.

The Convener: I suggest that we write to the Auditor General, seeking her comments on the correspondence. Mary Scanlon has suggested that we write to the Scottish Government to ask for its definition of high, medium and low risk in capital programmes.

Mary Scanlon: I also want us to ask about the figure for backlog maintenance when the surplus assets have been taken out. In my opinion, those assets should not be included in the figures and I hope that, when they are removed, we will get a more realistic figure.

The Convener: Do members agree to ask those questions of those two bodies?

Members *indicated agreement.*

The Convener: Thank you very much. As we will now move into private session, I ask members of the public and the media to leave.

12:22

Meeting continued in private until 12:42.

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