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Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 5 February 2013

Session 4

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HEALTH AND SPORT COMMITTEE
4th Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Mark McDonald (North East Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)
David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

David Liddell (Poverty Alliance)
Professor Sally Macintyre (University of Glasgow)
Dr Gerry McCartney (NHS Health Scotland)
Professor Carol Tannahill (Glasgow Centre for Population Health)
Professor Graham Watt (University of Glasgow)
Erica Wimbush (NHS Health Scotland)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Tuesday 5 February 2013

[The Convener *opened the meeting at 09:57*]

Health Inequalities

The Convener (Duncan McNeil): Good morning and welcome to the fourth meeting of the Health and Sport Committee in 2013. As usual, I remind anyone who has a BlackBerry or other mobile device to turn it off, please, because they can interfere with our sound system.

Agenda item 1 is a round-table evidence session as part of a scoping exercise to help us develop a remit for the committee's inquiry into health inequalities. When we do a round-table session, everyone usually introduces themselves, which is helpful—and then we have a quick quiz to see how many names we can remember.

I am the MSP for Greenock and Inverclyde, and I am convener of the committee.

Professor Carol Tannahill (Glasgow Centre for Population Health): I am director of the Glasgow Centre for Population Health, which is a research and development centre that is focused on developing evidence on and providing leadership for action to tackle health inequalities.

Bob Doris (Glasgow) (SNP): I am an MSP for Glasgow and deputy convener of the Health and Sport Committee.

Professor Graham Watt (University of Glasgow): I am professor of general practice at the University of Glasgow.

Drew Smith (Glasgow) (Lab): I am an MSP for Glasgow.

Professor Sally Macintyre (University of Glasgow): I am director of the institute of health and wellbeing at the University of Glasgow.

Mark McDonald (North East Scotland) (SNP): I am an MSP for North East Scotland.

David Liddell (Poverty Alliance): I am here as a board member of the Poverty Alliance.

Gil Paterson (Clydebank and Milngavie) (SNP): I am the MSP for Clydebank and Milngavie.

Erica Wimbush (NHS Health Scotland): I am head of evaluation at NHS Health Scotland.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am an MSP for Mid Scotland and Fife.

Dr Gerry McCartney (NHS Health Scotland): I am a consultant on public health and head of the public health observatory team at NHS Health Scotland, which is part of the Scottish public health observatory.

Aileen McLeod (South Scotland) (SNP): I am an MSP for South Scotland.

The Convener: Thanks, everyone. Would any of the committee members like to ask the first question to open up the discussion?

10:00

Aileen McLeod: I thank everybody for coming to give evidence.

A few weeks ago—on 22 January—we heard from Sir Harry Burns, the chief medical officer for Scotland, who said:

> "Inequalities in health are just a manifestation of inequality across the whole of society. To target inequalities in health without trying to understand what the drivers are for adverse outcomes across all those domains is to miss the point."

He went on to say:

> "It would be a mistake for any part of society to think that inequalities in health are just an issue for the health service. They are an issue for the whole of society, just as inequalities in relation to offending, work and so on are issues for the whole of society. Unless we understand that, we will carry on experiencing problems."—[*Official Report, Health and Sport Committee*, 22 January 2013; c 3151-52.]

In the paper that we received from Gerry McCartney, he said:

> "Given that income, wealth and power inequalities are the key determinants of health inequalities, it is unlikely that health inequalities will decline if substantial progress on reducing these economic and democratic inequalities is not achieved."

My first general question is: what, in your opinion, would make the biggest difference to or have the most positive impact on health inequalities?

Dr McCartney: What you have described would do exactly that. Any set of policies or actions that can narrow inequalities in income, power and wealth in society will be most likely to make that difference. We have good evidence to suggest that that is the case. On inequalities and time trends across the world, there are a couple of good studies from the United Kingdom and the United States of America that track inequalities in health from 1920 to the present day. We can see that inequalities dramatically reduce between 1920 and the mid-1970s, during a time when income inequalities, wealth inequalities and inequalities in power, as measured by the rise of the welfare state in those countries, declined. Then, in both countries, there was a reverse, as income inequalities and wealth inequalities rose. We have fairly good evidence that income, power and wealth inequalities drive health inequalities.

Professor Macintyre: The three key issues are employment, income and education. It is important to note that policies in those areas would help to reduce social inequalities in relation to health and other things. Those are three key domains.

Professor Watt: Harry Burns is saying that the issue will not be addressed satisfactorily if it is seen as a job for the national health service. I would like to twist that slightly. The issue of health inequalities has been professionalised and has become one in which rather a small number of people are involved at the policy level and at the delivery level. That is a recipe for failure. Either it is an issue that is addressed by everyone in the main stream, or it will be marginalised and work to address it will be ineffective. That is one reason why it has not been effectively addressed.

I would find it helpful to consider two questions. The first is: what are the origins of inequalities and what, therefore, are the policies to address them—by that, I mean trying to prevent them and to extend healthy life expectancy. The second question is what the health service and other services can do once health inequalities have arisen. That is a very important part of the equation but clearly it will not do anything to address healthy life expectancy. Once healthy life expectancy has ended, however, and people have acquired the conditions—it is usually several conditions—with which they are going to live the rest of their lives, a much clearer set of resources are available to us to influence that situation than are available to us to address the early origins of inequality. We should not put all our eggs in one basket.

Harry Burns cites the negative effect of a chaotic and adverse environment in the early years. By analogy, when we try to engage with the problems of multiple morbidity, we can see that a chaotic and adverse environment is a recipe for widening inequality in later years. We need to look forwards as well as backwards. Looking back, we might ask ourselves how we got into the mess that we are in, but looking forwards to a population that is getting older, acquiring problems of multiple morbidity and trying to live well and independently with its conditions, we need to ensure that public services are not widening inequality.

When the committee last discussed the subject, there was a recognition that many health improvement initiatives can have perverse effects, given where they are taken up and where they are not. One needs to extend that argument and recognise that the health service as a whole has the potential to achieve the same perverse effects unless we make it our business to identify and address them.

The Convener: Does anyone else want to pick up on that? I always give our panel of witnesses the first say, so if anything that Professor Watt has said provokes a comment, please feel free to come in.

Professor Tannahill: I would like to pick up on the theme that Professor Watt introduced of looking forwards as well as looking back. As Gerry McCartney and Sally Macintyre said, the evidence on the determinants of health inequalities is now strong. The challenge for us is to think about what more Scotland can do to address those determinants. It would also be worth while for the committee to consider what the future determinants of health inequalities will be, and to consider some of the trends that are emerging that might cause future health inequalities. I am thinking, for example, about the move towards e-health and the way in which digital exclusion might perpetuate health inequalities.

We should also think about the changing nature of work. The evidence on and around work and health inequalities was developed at a time when employment was very different from what it is today. In thinking about what Scotland can do to help to reduce health inequalities in the future, the committee should be concerned about the changing nature of work and the consequence of people being in and out of poor-quality work on short-term contracts for their health, which seems from some recent evidence to be even more detrimental than long-term unemployment. The country needs to consider those issues now, at an early stage.

Fuel poverty is another example. The rising cost of fuel and the reduced availability of energy will have the worst impact on the poorest people in society. We have a challenge to look forward as well as to address and respond to the evidence from the past.

The Convener: Does anyone else want to comment? Gil, are you anxious to come in?

Gil Paterson: Yes. From what has been said, it sounds to me as if it is almost too late when it comes to health services making a real impact. Have I got that right?

Professor Tannahill: I do not think that that is right. I would broaden the point that Graham Watt made to include not just health services but services more generally, because all services need to have addressing inequalities as a fundamental part of what they are about. Unless they consciously think about that, plan appropriately and deal with evidence in a way that is concerned about differential impacts on different parts of society, they will not be playing their full part.

However, the point is that services are only part of the picture. We cannot see the solution to Scotland's health inequalities as lying simply with the services in society. It also depends on redistributive policies, among other things.

Gil Paterson: Maybe I should articulate my point a bit better. Is the suggestion that the health service manages the inequalities rather than changing them?

Professor Watt: There are two issues, and it is important to keep them separate. The first, which is what we are doing to prevent inequalities in the future, certainly applies across all areas of policy. The other is what we do when inequalities arise. The reason why I particularly welcome the Audit Scotland report that was published just before Christmas is that it highlights that issue much more substantially than any previous Government report has done.

Usually, comments on the national health service's contribution are rather dismissive—in fact, you rather implied that by saying that it is too late. That might well be true for the kinds of initiatives that there have been, which have been well described. Such projects are often short term and lack coverage and continuity, and we certainly do not need more of them.

My major concern is that the health service is not well set up to avoid widening inequality in future, given the mismatch of resource and need. That is partly about manpower; it is also about connectivity and the extent to which we have too many cooks—too many specialist services and not enough integrated care that is set around the individual's experience and life.

The Convener: Does everyone accept that health has a role to play in addressing health inequalities? It used to be said that up to 50 per cent of the health gap could be addressed by health measures. That was the evidence that was given to a previous health committee on which I served. Does anyone disagree?

Professor Watt: As the population gets older, services become more and more important. Over the past 50 years there has been a huge explosion in what organised healthcare can do. I am talking about not just specific evidence-based interventions but well co-ordinated continuity of care. If such care is not at its best where it is needed most, it is axiomatic that the health service will widen inequality.

Dr McCartney: I want to build on Graham Watt's point about the importance of separating the service response from the causes of and potential big solutions to health inequalities. One way of thinking about that might be in terms of mitigation of health inequalities versus their causes and undoing.

When we discuss health inequalities there is always a danger of drifting from a discussion about the importance of poverty and inequality in society to a discussion about society, parenting or individualised interventions and health services. We often call that "the lifestyle drift"—Hilary Graham, who is a professor in England, uses the term. There is also a service drift, whereby we start talking about the societal determinants of health but quickly end up talking about health services.

Duncan McNeil asked about the proportion of health inequalities that health services could deal with. The issue is problematic, from a methodological point of view. The Scottish public health observatory produced the health inequalities tool, which modelled the impact of different causes of health inequalities and the potential impact of interventions. It relies on a number of assumptions, not least that there are not competing causes of health inequalities. However, as Graham Watt said, people in our most deprived communities are not affected by a single condition but have multiple morbidity—they have lots of conditions. If we solve one condition, the other conditions that are just under the surface will manifest themselves.

That is why thinking about the more fundamental causes and societal determinants of health and not just a single pathway is important, because that is what determines all the outcome measures. Imagine that we eradicate smoking in Scotland from tomorrow. We could model that and find a massive impact on life expectancy and health inequalities, but the truth is that other pathways would take the place of smoking-related disease.

If we went back 150 years in Scotland, we might find that the biggest causes of health inequalities were typhoid or tuberculosis. Roll forward 60 years and it was heart disease, cancer and stroke. Currently, alcohol, drugs, suicide and violence are big determinants of health inequalities—and that will change again; in 20 years it might be obesity-related diseases. If we focus on single causes and do not deal with the fundamental determinants of health inequalities in Scotland, we run the risk that other causes will fill the gap.

Health inequalities are not inevitable. Inequalities have narrowed in the past and internationally.

The Convener: I think that we realise that there is a debate. At our meeting two weeks ago, Gil Paterson asked Harry Burns about the poverty argument, and he responded:

> "It would be a mistake to assume that poverty is the cause."—[*Official Report*, *Health and Sport Committee*, 22 January 2013; c 3152.]

He went on to ask why some people succeed and others fail. There is always pressure on politicians to act, but we are getting different messages from people.

10:15

Professor Macintyre: I will make a couple of points. First, Gil Paterson implied that it was too late for the health service to do anything. I would say that it is not, because universal health services have a fantastic preventative and inclusive effect. Antenatal care, health visiting, free obstetric care, vaccination programmes for kids and school health services are all available to everybody in this country. There may be slightly different levels of uptake, but they are really important for preventing inequalities. It is not the case that the health service is just mopping up things in later life.

I highlight Harry Burns's reply to Gil Paterson at the committee's meeting on 22 January somewhat with horror. When we talk about social inequalities, we are talking about socially structured inequalities that mean that, on average, people from poorer backgrounds have poorer outcomes across many domains of life, such as health or crime.

Harry Burns is keen on parenting. We all know that good parents can help to ameliorate problems and provide more resilience, but health inequalities are not about parenting; they are about the socially structured issues that cause those inequalities, such as poverty, unemployment and living in terrible places.

When we talk about social inequalities, we are not talking about random variation—why some people do better than others in health—but about broad generalisations that life expectancy and healthy life expectancy are systematically different between social groups. The problem with Harry Burns's reply is that he implied that, if you have good parents, it is fine, but if you have bad parents, it is bad.

I could go on about that. Can I make a couple of points about it?

The Convener: Yes, certainly.

Professor Macintyre: It is really about evidence. I am a researcher, not a policy maker or practitioner but, in a report that I wrote in 2007 for the ministerial task force, I pointed out that we can think of policies to reduce inequalities at three levels. The biggest level might be regulation or legislation, followed by local structural levels and then individual approaches.

For education or the best start in life, you can regulate standards in education. You might want to lower the minimum age of education. You can do local things such as improve schools in certain areas or improve pre-school provision, or you can focus on parenting and try to make individually focused interventions.

What has perhaps been neglected in Harry Burns's view about what to do in education in the zero to three-year-old age group or from three up is structural approaches such as better pre-school education. I would be concerned if a focus on picking out potentially bad parents and giving them intensive support took away from the fundamental importance, if we want to reduce inequalities, of progressive universalism in services such as pre-school education—that is, everybody has access to the service but we perhaps invest in poor areas and groups that could benefit more.

Professor Watt: To illustrate the point, most people who smoke do not get lung cancer. We could do a lot of research to try to work out which individuals get lung cancer and target them so that smoking would be okay except for the high-risk group. However, we do not do that. We recognise that smoking is a social hazard and have policies to control it without knowing who will benefit and who will not.

We need to avoid going down to the level of individual explanations because that will not guide policy helpfully.

David Liddell: The Poverty Alliance viewpoint is that poverty and inequality are at the heart of the issue. Poverty is the killer. Although the relationship between deprivation and health is complex, the links between the two are clear. We take the strong view that, as many of the witnesses have said, we need to examine the fundamentals. As Sally Macintyre said, employment, income and education are the areas on which we should focus heavily.

It is right to separate the role of health in reducing inequalities. The committee should consider the issues of power, resources and inequality and how best to deal with them. It is interesting that, at the committee's meeting two weeks ago, employment was not mentioned as an important issue. However, it is an important issue to consider. We should consider measures such as community benefit clauses. I guess that the fundamental point is that we need more state intervention to reduce inequality.

I suppose that another linked issue, which we might come on to later, is to do with welfare reform and people being inappropriately pushed into employment. That is different from the bigger point about looking at employment as a key factor. At present, the unemployment rate among young people is, I think, 21 per cent. Gerry McCartney described different manifestations of the problems. We need only look back to the 1980s to see the consequences of mass youth unemployment. Those are the big issues that we should explore.

The Convener: Maybe part of the problem is that health departments under various Governments have accepted that health inequality is their issue and not a shared issue. In the economy and education portfolios, inequalities will not be at the top of the agenda. Is it a failure that, although we have health inequalities as a priority, inequalities do not feature as a priority in all portfolios? Is that what you are suggesting?

Professor Macintyre: There are inequalities in a range of outcomes. The education department should be concerned about inequalities of educational outcome, and other departments should be concerned about deprived communities, for example. Part of the issue is that health issues and the gap in life expectancy are so obvious and we can say that inequalities are killing people, which is a strong statement. Some other inequalities do not have that sort of resonance, so people do not say, “Wow, we are killing people—we need to do something about it.” However, if we are to influence health inequalities, we have to target those other sectors, too. I do not know about the politics or whether those other sectors are not concerned with inequality.

Dr McCartney: I back up Sally Macintyre’s point and your point, convener, that, if we are to narrow health inequalities, we need all the departments in the Scottish Government, and arguably also the UK Government, to make whatever difference they can to narrow the societal inequalities that drive health inequalities.

Health inequalities are special for the reasons that Sally Macintyre outlined. I stay a mile from Ferguslie Park in Paisley. When we did a community profile of that area, we found that a 15-year-old boy would have a 50:50 chance of making it to the age of 65. That is a profound injustice. It is unfair and it is not the right thing in a civilised society. Because that is a mortal injustice, it should drive and spur action by the Scottish Government and Parliament. Although health inequalities are a manifestation of the economic and other inequalities that are in the remit of various departments, that outcome in itself—that, by accident of birth, some people have a really high chance of dying prematurely—should give us all a sense of horror and should drive change.

Professor Watt: I am particularly interested in the inverse care law, which is that the availability of good healthcare is related inversely to need. The same observation applies to education. I have heard general practitioner colleagues in a deprived part of Glasgow talking about the proportion of teachers in their local secondary school who have been there for any length of time. There is a manpower issue in delivering education. We shared that point with a journalist, who wanted to speak to the headteacher, but of course the headteacher could not speak without jeopardising his or her position. One advantage of general practice is that it is independent, so people who are involved in it can speak independently about policies and their consequences. Health services are therefore very much better described, analysed and commented on than other services.

Professor Tannahill: I want to encourage some thought about whether the issue is about policy or implementation or, indeed, the relationship between the two. In Scotland, we could look at early years policy such as getting it right for every child—which, as it says, is about getting it right for every child and is therefore concerned about differences by social structure, ethnicity and so on—the solidarity target in the poverty strategy and other such aspects. I do some work on regeneration, and there is a clear commitment to address the quality of environments in Scotland and to improve our poorer environments and thereby improve the quality of life.

We could look across the various policy areas, find out how the different parts of Government see their role in supporting a more equal Scotland and review those policies to see whether they go far enough. However, we also need to look at the resource flows from those policy aspirations. Are those aspirations realistic or just hugely ambitious, given the resource flows that come from them? What do they mean on the ground in different communities across Scotland? For example, some school premises are available out of school hours for the community to use for a range of activities, but others are not. I find that incomprehensible and do not quite understand why that should be happening. If schools are a community resource that can be used to give people opportunities in life, they should be open everywhere.

Another example that I know the Health and Sport Committee will be interested in relates to the great Scottish run or the women’s 10K. Although these opportunities for people to be active have been hailed as big successes in Scotland, with thousands of people taking part in them, the gap between the people in our better-off and our poorer communities who take part is about 6:1 and there would be scope for schools in poorer communities to foster people who might want to take part in, say, the junior Scottish run.

Although such policy aspirations exist, they are not tracking through to realities on the ground because of resource allocation, leadership and the perception of the job on the ground and we need to change the dialogue about the sort of society we want and what success might look like.

Professor Watt: It is a question of dose. Quite often, we get the diagnosis and the treatment right and the dose wrong. We simply do not prescribe enough of what is good. We might have got rid of homoeopathic medicine, but we still have homoeopathic policy.

Let me give the example of the millennium development goals, which were set worldwide in 2000. In the decades preceding 2000, there had been a progressive slowing of reductions in infant and general mortality. However, since 2000, international aid for health has quadrupled and a variety of child health, maternal mortality, TB, HIV and malaria programmes have been put in place. Although many criticisms can be made of those programmes, they have made a real difference to child health, maternal mortality and the prevalence of these big infectious diseases. Being big and bold is part of the solution.

Erica Wimbush: Picking up on some of the points made by Professors Watt and Tannahill about big and bold initiatives and the importance of bringing some of what we learn from implementation back into our thinking about where we should focus our health inequalities policy, I should tell the committee that we have offered the ministerial task force that is trying to bring together action across the many Government portfolios our services in reviewing the current evidence and the learning from initiatives on the ground to tackle health inequalities and feeding that back into policy. I believe that we have circulated a paper about that review to the committee; indeed, two of the panel members—Carol Tannahill and Sally Macintyre, who is chairing it—are here this morning. I think that it is worth while spending some time on what we have learned from the past before we go too much further in thinking about where we should focus our policies.

The review that we are doing will report in May. I recommend that to the committee. I do not know whether Sally Macintyre would like to say anything more about the review at the moment, but I am sure that the committee would be interested in it.

10:30

The Convener: It sounds as if Sally Macintyre has been volunteered.

Professor Macintyre: As Erica Wimbush says, we are hoping not only to learn from Scotland but to consider the best available evidence from around the world with regard to what might be effective and cost effective in reducing inequalities in health. I mention cost effectiveness because there has been a problem in Scotland, and probably in the UK, of thinking only about what policies are effective in improving health, but that is not necessarily the same as thinking about what policies are effective in reducing health inequalities, and, often, cost effectiveness is left out. We will be reviewing the evidence on the best experiences elsewhere with regard to reducing health inequalities, as well as learning from the local picture.

It is a shame about the timing of the review. In terms of the ministerial task force and the work of this committee, it would have been better if we could have presented the report to you at your first meeting and to the task force as early as possible. I hope that the review will not be too late to be of use to you.

Professor Watt: On the question of research, as an academic, I am all in favour of evidence. However, evidence itself is socially structured and patterned and is least likely to come from the kinds of areas that we are talking about. Only 12 per cent of encounters with patients involve a condition that comes under the quality and outcomes framework, which is the evidence-based incentive system for general practice. The other 88 per cent involve other conditions, usually several other conditions. We are only just waking up to the need to have an evidence base that represents the experience of the majority of patients, which is that they have more than one condition. The Scottish research system is substantially structured towards the investigation of single issues. That is too fragmented for the experience of patients. One of the things that would be helpful to come out of your review is the extent to which the research system is asking the questions that this committee wants answers to.

The Convener: Last week, a question was asked about the health inequalities task force. I will give you the opportunity to decide whether we should take anything from it.

The last time there was an intensive discussion about this subject in the Scottish Parliament was during the period from 2006 to 2008. The health inequalities task force met about nine times in that period but, since then, it has met four times in total. Does that indicate that we have a renewed interest now? Does it indicate that there is an inconsistency in this area?

Professor Tannahill: I have the privilege of being a member of the health inequalities task force. After it was established, it met monthly until it produced its first report. It was agreed that it should reconvene two years later to review progress, which it did. Then it reconvened two and a half years after that to review progress again and come out with a further set of recommendations. The periodicity that you describe reflects the fact that the task force was not established to be an on-going body; it was always meant to be a short-term task force that would come up with some recommendations and review progress periodically.

Given what we know about the entrenched nature of health inequalities, we have to be realistic about the timescales over which we will see progress, and we have to be careful about what we should be looking for over a timescale such as two years.

The Convener: Does everyone agree that the number of times that the task force meets is not that important and that it should just meet when its members decide that it should?

As no one wants to pick up on the issue of the task force, I will let Bob Doris ask his question.

Bob Doris: I have to say that I have no set view on how often the task force should meet.

In the two round-table evidence-taking sessions that we have had, the themes of economic inequality and welfare reform were mentioned and it was suggested that, where we can, we should try to mitigate the worst effects of those factors through social policy, including health policy. Again, I need to put it on the record that, because the Scottish Parliament does not have all the levers of power, we will mitigate rather than remedy. However, because we cannot do as much as we would like, my question is about what we can do.

I am keen to know what is happening on the ground. With regard to the talk about health inequalities, I have written down “positive life experience”. If we give people a better, positive life experience, they are less likely to suffer from ill health, so I am interested in knowing how we can do that on the ground in the most deprived communities. Graham Watt spoke to the Public Audit Committee about whether we have got the balance right on time spent with doctors in their surgeries in the most deprived areas and whether doctors there are just firefighting serious medical conditions, whereas in other parts of the country positive health messages can be given.

I am keen to know what works well on the ground in our deprived areas in terms of the NHS—be it in general practice or elsewhere—not just telling people how to be healthy but asking them what they would like to do to be more healthy. I am talking about the idea of social prescribing rather than the idea of doctor knows best. Are there examples of activity co-ordinators at health centres who can suggest other things for people to do in their lives? Do you have examples of signposting towards the local skills agency, where people can pick up training and apprenticeship opportunities? Are there positive relationships with housing associations? With the move towards integration, I am keen to see a model on the ground that is not about the doctor spending 10 minutes with someone and saying, “We’ve spent nine and a half minutes making sure that we know what the latest bad thing that is happening to your health is, and there are 30 seconds left to ask you how you are in yourself more generally.”

What is happening well on the ground to give the time for doctors or other professionals to have a positive engagement with people who are most at risk of health inequalities?

Professor Watt: The first thing to say is that the health service is most equitable in dealing with emergencies in hospitals. However, in Glasgow we are building the biggest acute hospital in Europe to deal with the consequences of not preventing things. Where the health service is inequitable is partly in access to specialist services, which is a whole separate area, but also in what Bob Doris is talking about, which is the quality and quantity of care that is provided at ground level.

Bob Doris asked for a model. I would say that it would have several components. One is that it would be unconditional; it must be dependent not on what people can provide but on the problems that people present with, particularly the combinations. The intervention should not be a single or one-off intervention but should be a serial encounter. The key or silver bullet is the relationship between patients and an individual or small team whom they come to know and trust. The fact that it is a serial encounter will mean that there are opportunities for false starts and starting again.

Clearly, general practice is by no means the panacea, but it does have continuity, coverage, contact and relationships for most people. That is a huge structural resource around which to organise things. People need to have more time, because we know that, in the absence of time relative to need, patients are less likely to report being empowered by seeing a professional, especially if they have a mental health problem, which is the commonest co-morbidity in deprived areas. At the same time, the practitioners describe being very stressed because after each consultation there is another long one to come. The pressure needs to be taken off that for both patients and practitioners in order to change the adverse, chaotic, episodic nature of what goes on.

Serial contact, with relationships, provides the opportunity to link into all the things that Bob Doris described. There are huge resources in communities in that regard, such as the third sector and area-based health services. We do not lack resource; what we lack is the social capital that allows us to make best use of the resource, which is, in essence, a plethora of relationships. In some ways, the relationships between practitioners and patients are the healthiest, while the most dysfunctional relationships are those between professionals, services, managements and practitioners.

My model would be that we need a service that is unconditional; sufficient time to get to the bottom of problems, which means that flexibility needs to be available when required; a focus on the serial encounter rather than just on the beginning of things; shared learning, so that we do not have a thousand ships passing in the night; much more support from central organisations—the main NHS support organisations are notable by their absence or low profile in deprived areas, so that is another area that this committee could usefully ask some important questions on; investment in leadership at ground level for the building of social capital; and investment in better relationships between leadership at ground level and leadership at area level, which is often the most dysfunctional in terms of lacking understanding, mutuality and respect.

What links all those things together is investing in human relationships. That is the one resource that we are not short of, but we tend not to invest in and manage it.

David Liddell: On the issue of local resources, there are many valuable community and bottom-up initiatives that tackle health issues, but they are often funded on a shoestring or for only a short term so they come and go. The Castlemilk stress centre is a good example of that. It would be useful for the committee to explore that issue in more detail to examine the problems of evaluating such initiatives. Providing proper resourcing to fund such initiatives over the longer term is important, as they can add to what the health service does directly.

On the distribution of GPs, there are models in other countries, where additional GP resources have been provided in more deprived communities. For example, in Australia state funding is provided for the training of general practitioners on the condition that they agree to work in the most deprived communities for five or 10 years after qualifying. The committee could look at other models, which might be cheaper than some of the existing approaches to delivering health and combating inequalities in our more deprived communities.

The Convener: I think that Richard Simpson has a supplementary on that.

Dr Simpson: My question follows on from that, but it is on a slightly different issue.

Bob Doris: I think that Professor Tannahill also wanted to respond.

Professor Tannahill: I agree with both the previous points that have been made, but incorporating that attention to social relationships, or a relational way of working, into mainstream approaches presents a challenge that cannot be addressed simply through a number of projects. We have lots of good examples of the sorts of approach that have been described, but they tend to be short-term funded and have insufficient reach to have an impact at a population level. Unless we move to a situation in which concern about the issues that Graham Watt has described is part of the day-to-day job of people who work in mainstream services, we will not improve the situation from where we are.

Bob Doris: On that, I mentioned GPs, but I am also interested to hear whether other health professionals might have a role. For example, every year I attend the launch of the Maryhill activity directory, which brings together hundreds of different local clubs, which are not always very well attended but do a fantastic job in providing huge opportunities. I can appreciate that a GP may not have time to chat about such local opportunities in a 10-minute slot, but perhaps that could be done by community pharmacists, dentists, physiotherapists and a variety of others. Should other professionals have a front-line role in tackling health inequality? Are they doing that currently, or is there scope for them to do more of it? Does everyone have a responsibility, so it is not just down to that 10-minute slot with the GP?

Professor Watt: The practice team information data—the PTI data come from 60 Scottish general practices and inform a lot of primary care policy—show that, in any year, about 20 per cent of people do not go to see their GP, probably because they do not need to do so, and about 70 per cent of people go for a consultation perhaps twice or three times a year because, like most people around this table, they are generally healthy people who might need the doctor occasionally. However, about a sixth of people account for half of all the consultations in general practice.

We therefore need a plurality of services. Not everyone needs a relationship with a generalist, although some do. Some people might not need help from health services at all throughout their long lives, and other people might well get what they require from pharmacists or other services.

10:45

The problem with plurality—and this is always one of the problems with the market—is that we do not know what is going on or who is getting left out. The advantage of the NHS in Scotland is that the GP list system gives us a denominator that allows us to measure what is not happening. That is key to addressing inequalities. We should not just be measuring activity; we should be measuring what we are not doing. When services are diffuse and pluralistic, it is difficult to get a handle on who is not getting what they should be getting. There is a problem for the health service in that that denominator is based on GP lists and is not an area-based denominator. So much of our research is based on geography, whereas the community that the NHS deals with through its point of contact with primary care is a community of interest, and it is not always geographical. There is a mishmash there that is quite challenging to address.

I have one other point on what we are actually trying to achieve. The unit of currency is the patient's story and their experience. The job of services is to improve the knowledge, experience and confidence of people who are living with conditions and making use of the resources that are available. That is the story that we are trying to create. The sum of what we produce is the compendium of stories, so we do not necessarily need to re-evaluate a stroke, hypertension or keep well programme; it is about the compendium of stories that exists at a local level. The conjecture is that if we are investing in people's knowledge, experience and confidence while they are living with their conditions and accessing the resources that are available, they will live longer and more successfully in the community without the chaotic use of, for example, emergency services. That is the road that we need to go down.

Dr McCartney: I just want to reflect on the past 10 or 15 minutes. Bob Doris's original question was about how we can promote positive life experiences in deprived communities. I was expecting people to talk about gaining employment, having enough income to live, and having an equal community with good housing, and what have you. However, we have just experienced the lifestyle drift. We very quickly started to talk about individual-level experiences. We have talked about directing people to sports clubs and, although that is a legitimate conversation and there is no doubt that we need to do that better, there is a danger of focusing overwhelmingly on individuals rather than taking the population-level view, which we know is what drives health inequalities. I am just reminding the committee that such lifestyle drift happens all the time and in every conversation we have about health inequalities. Every time we set out to make a policy or recommendations, we end up drifting down to discuss individual-level interventions and factors.

Dr Simpson: I fully understand what Dr McCartney is saying. We can go back to the big policy issues and say that we want to eliminate child poverty and have full employment, which are the two big policy issues that came in with the Labour Government in 1997. We moved to reducing child poverty by a third and increased employment to the highest it had been since the 1960s. We should be seeing a benefit from all that. It is primary prevention—that is what Dr McCartney is talking about—and, of course, Governments have to look at that because if they do not, they will never solve the problems. That does not alter the fact that a whole generation suffered the initial years of poor education and child poverty, and we have to deal with them as well. As Gil Paterson said, we cannot write them off, although it might be too late.

Are any of the things that we have been doing, such as the Arbuthnott formula and the NHS Scotland resource allocation committee, coming good on the ground, through allocation of resources to deal with deprivation? We are supposed to have a national allocation system that takes deprivation into account. Do we have that? The Audit Scotland report seems to indicate that we do not. What practical steps can we take? No one has succeeded in dealing with the problem.

The UK Public Accounts Committee report is one of the most damning reports that I have read. The failure of policy that it describes was at UK level, and it was really blistering in its attack on delivery of the policy. It was really bad. We have the equally well and keep well initiatives, but it seems to me that such work is largely divorced from general practice—which is where it should be done, in my view.

I do not understand, do not see and am not hearing from the witnesses what practical steps we can take, other than to play around with more tiny policy initiatives and test things out. Are there significant things we could do to focus on multimorbidity—social and health related—in deprived communities, by focusing on practices? The deep-end group is one thing that has emerged. Should we focus on that and put in place policies that give people the resource allocation that they do not have at present either as GPs or as allied health professionals, including nurses and health visitors?

Would a radical change in policy work, such as putting in substantially more funds and offering a change in contract that would, rather than the QOF addressing just 12 per cent of conditions, address all the issues? Should we tell health boards that they must apply the NRAC deprivation funds to communities? They appear not to have done that. Have they?

I am sorry—there is a question in there somewhere. That was more an expression of the frustration that I feel after 12 years of being associated with the Parliament side of things.

Professor Watt: There are two issues. One is resource allocation and the other is what is done with it. The Arbuthnott and NRAC formulas were well intentioned; they had the best data, the best methods and the best statisticians, but nevertheless failed to address a particular problem. When needs are converted into use of the health service, particularly through emergencies, they can be counted. The strength of both approaches was that they could assess need for hospital care and produce a formula that reallocated resources on that basis, but they could not redistribute resources in general practice because of the lack of data on unmet need.

Here we come to the point about numbers. There was some misinformation in the evidence to the committee two weeks ago about GP numbers, because the Audit Scotland report, while quoting recent Information Services Division data, produced some rather misleading information on GP manpower. The most recent data based on whole-time equivalents are 10 years old, because the Government stopped collecting the data with the new GP contract. Those data show a flat distribution of GP manpower. It is not the case that there are 25 to 30 per cent more GPs in deprived areas, as I think the committee was told two weeks ago. That is based on a misinterpretation of inaccurate data in the Audit Scotland report, which is largely due to the undercounting of GPs in the most affluent areas. The lack of manpower is a real constraint.

In answer to Richard Simpson, I say that the deep-end group has a set of proposals that are almost at the point of being completed and shared. It is not, by any stretch of the imagination, a simple business of plonking GPs in deprived areas, as was described two weeks ago. There needs to be additional capacity, either through using vacant slots in surgeries so that there is always the ability to spend longer with a patient, given that GPs do not know who will turn up, or—based on the CARE Plus study—through investing extra time in needy patients. Probably, both approaches are needed.

There are a variety of ways in which that additional capacity could be woven into the existing strengths of local teams; we are not talking about new build or new teams. Allied to that, there needs to be investment in attached workers. Nanette Milne talked two weeks ago about the model in which the attached health visitor and social work know each other and work together coherently. That coherence in local teams needs to be regained. Attached workers are, to an extent, anathema to area-based addiction and mental health services, which see such workers as being inefficient. However, when we are dealing with high-volume case loads, there is a case for attached workers.

We need link workers to link primary care teams' cumulative knowledge about their patients with the resources in communities, and there are lots of such projects on the go. They involve a whole lot of things; it is not just an informational issue that can be solved by a website such as that which is used in the ALISS—access to local information to support self-management—project, important though that is. Relationships must be built so that the resources can be used. There is also the infrastructure issue of the training, fellowships, information and research that make a coherent and shared learning experience.

When we produce our proposals in two or three weeks, we will not be prescribing with the i's dotted and the t's crossed; we will be suggesting a direction of travel that needs to involve lots of people. The big challenge is not about resources, which could easily be worked out—almost on the back of an envelope. The real difficulty is, rather, in getting services to work coherently together, because underpinning the process is—inevitably—a transfer of power, responsibility and accountability from areas to ground level. I do not for a minute underestimate the challenge of doing that.

Knowing what we know about the epidemiology of multimorbidity and demography, the question is how the health service will use the resources that are available to it—principally, that means manpower—to avoid inequity in what it achieves. That requires something of a new direction or, if you like, a new partnership.

People ask whether the approach will work. Probably the best evidence is that unco-ordinated, partial and incomplete care, in which the left hand does not know what the right hand is doing and in which there are people who do not know what happened previously and have no commitment to what will happen next, is a recipe for premature use of emergency services. That seems to me to stand to reason. The question is not whether, but how we try to do things differently.

The Convener: I do not know whether anybody else wants to comment on that. I suppose that it takes us to some of the measures that have been put in place supposedly to address the situation. In April 2006, we discussed the issue with the chief medical officer and he agreed that we had to enhance the primary care service and match increased performance with an increased number of GPs.

We have had community health and care partnerships and community health partnerships. Bob Doris and I endured four years on the previous Health and Sport Committee when we tried to get single outcome agreements to include poverty in their indexes. We are not quite sure what happened to those individual single outcome agreements over time.

Many things have been tried to bring about co-ordination. A couple of weeks ago, we heard from

Derek Feeley that the Government is now talking to the Convention of Scottish Local Authorities on some of the issues. We talk about this quite a lot.

Professor Watt: We submitted evidence to the consultation on integrated care, but we ignored the first 15 questions, because they were all about managers meeting at area or locality level. That is an important issue that has not yet been cracked and that might or might not be cracked in the future, but much more important is the issue of which wheels need to be oiled for integrated care to work around the patients' needs. That is much more to do with professional relationships than with relationships between services.

It is important to get people sitting round the table in localities to agree to work together. Resource distribution does not happen unless that is the case but, at the end of the day, the patient experience depends on how a small number of people work well together in providing care. It is that and not managerial relationships that needs to be at the heart of integrated care.

11:00

Erica Wimbush: Richard Simpson raised the issue of what happens to all the resources that we put in, given that we do not seem to be achieving any effect in respect of high-level outcomes. There are difficulties in tracking through a very convoluted system how resources are deployed in services and in partnership working. We need to get better at setting much shorter-term outcomes to assess our progress in reaching the higher-level outcomes, which are about reducing health inequalities.

You heard from Harry Burns and Derek Feeley, who, in relation to early years, advocated shorter-term outcome measures on the pathway to reducing health inequalities—I think that they were talking about delayed development—so that it becomes easier to see whether investments translate into outcomes that are relevant to particular services. If we get a bit cleverer at identifying those shorter-term outcomes, we will probably get better at tracking progress along the path.

The Convener: Bob—do you want to come back on that?

Bob Doris: I do not want to come back on that specific point; my question was more about following the money through. We heard about NRAC, which I think Richard Simpson asked about.

Dr McCartney: I will build on the point that Erica Wimbush made about some of the difficulties that we have in learning from initiatives. Keep well is as good an example as any, and Erica and I are involved in the latest round of evaluations of that intervention. The way it has been implemented has meant that it has been incredibly difficult to get any evidence on its effectiveness. I know that the committee has heard anecdotal evidence that it is making a difference, but we really do not know.

There are always dangers with introducing services—especially services that have a screening orientation. Members might be aware of the controversy around breast cancer screening, which did not set out to be a bad intervention; it is just that when you find cases in the community and start treating them there is a danger of over-treatment. With keep well, there is the danger of treatment-related conditions developing in cases that would not necessarily have presented to services without the intervention. It is really important that we evaluate these things properly.

We are continuing to put in place interventions without putting in place counterfactual groups, control groups or comparison groups to allow us to see the effects and whether there are any adverse consequences, and without being able to understand the short-term, medium and long-term outcomes and then to transfer that learning. We are in a cycle of consistently bringing in new health improvement interventions, often with the aim of reducing health inequalities, without really knowing very much about what worked in the previous cycle.

There are people sitting around the table who can probably remember further back than I can to previous interventions such as have a heart Paisley. What did we learn from those? What learning did we apply subsequently? Do we know whether they worked? What were the adverse consequences? Did they narrow health inequalities? We probably do not know the answers to many such questions and yet we continue to devise and to promote more health improvement interventions. We have heard suggestions from around the table about more things that we could do, but have we learnt from what we have done already and will we make the same mistakes again? Interventions are often individually oriented, rather than dealing with matters at a population level.

Professor Watt: I would argue against there being more health improvement interventions. They usually follow a screening mode; they generally lack coverage and talk about people being hard to reach, which is really a function of the screening process; and they lack continuity when the funding runs out. They are all front-ended; they are the start of a process. The question is, though, "What happens next?" Keep well has processed huge numbers of people very usefully by assessing their risk, but what happens after that?

It is important to remember that there is only one general public, which should be our focus, but there is a public as seen by keep well, as seen by mental health services, as seen by addiction services, and as seen by this group and that group. If, as I have done, you have sat in a meeting of professional groups that are involved in child healthcare, you would sometimes think that the number of children around must be very much bigger than it actually is, because there are so many services looking at different aspects of children. There is only one public, and that should be the unit of our evaluation, whatever services they are getting.

To go back to Gerry McCartney's previous point, there are public health policies that do not require contact with the public, and they are probably the most important ones in relation to the issues that we are discussing. It is the job of public health to address those kinds of policies.

Other policies do require contact with the public, and we probably have too many of them. Primary care involves contact with the public—it has coverage and it has continuity—but what it lacks is the resource to harness those. We do not need to reinvent the ways of contacting the public; we need to make better use of the contact that we have—uniquely, in Britain—because of the NHS.

The Convener: Does anyone else wish to comment on that? I think that this was discussed when Harry Burns was with us. In previous evidence sessions we have had a debate about outcomes, monitoring and so on, and the message that seemed to come across was that we really need to get on with it. We are doing a lot of small projects, but we need to be doing bigger ones, and we need to stick to them—we need to push them on. What do you think we mean by all of that?

Professor Tannahill: I am a bit more optimistic than Dr McCartney is about this. We are learning, and I have no doubt that it is a long-term challenge that we are facing. I agree with Erica Wimbush that we need to find ways to learn more effectively as we go.

I will pick up on one methodological aspect, and I will then recap on some of the things that I think we have learned. The methodological thing is about cost effectiveness, which was highlighted in the Audit Scotland report. Cost effectiveness simply takes into account the cost of doing something and the effectiveness of that intervention in achieving the desired outcome.

It is an issue, however, that cost effectiveness varies according to the population group to which the intervention is being delivered. Smoking cessation services are more cost effective in affluent communities than in poorer communities. People talk about smoking cessation as being a cost-effective initiative. On one level, however, that does not make any sense—it depends how it is being delivered and to whom it is being delivered.

As a society, we need to think about the value that we place on people going through such services. Is it worth just as much to Scotland to improve the life expectancy of someone in a poor area by one year as it is to improve the life expectancy of someone in a more affluent area by one year? I hope that it is and that we value all those lives the same. It will cost us a lot more to do that in poorer areas, however.

If we are driven purely by cost effectiveness, without some sort of value metric being placed alongside that, we are not going to shift our system towards interventions in poor areas or address greater need. I hope that I have explained that well enough—it is a caution about being driven purely by cost effectiveness. There is a risk, at a time of austerity, that cost effectiveness becomes the primary focus, and that some of our other values become secondary to that.

When it comes to learning, we indeed need to learn from interventions, but we also need to come back to where we started today. Globally, if we can work towards establishing a more equal society, there will be benefits to everyone in that society—not only to the poorest. Our health outcomes will be greater and the effect on our health inequalities will be greater.

Redistribution should cut across all aspects of society and all the services that are provided in society. I think that it was Sally Macintyre who used the term “proportionate universalism”. In Scotland we have not had enough clarity on what that means, how it can be delivered across all aspects of public service and what level of proportionateness is necessary to reduce health inequalities in Scotland. That would definitely be worth further consideration by the committee.

That picks up on Dr Simpson’s question about NRAC and how that tracks down. Does NRAC give us an adequate amount of proportionate universalism at national level? How is that being translated across all aspects of society? I urge the committee to consider not only health services but the range of public services, which all have a role in reducing health inequalities.

Professor Watt: Carol Tannahill’s point about proportionate universalism is one of the most important points of the morning, in terms of its being a yardstick against which policies should be developed and evaluated. From a deep-end point of view, we are trying to make proposals to be applied pro rata, and not just to a target group.

The early detection programme for bowel cancer was introduced on the basis of evidence of its cost effectiveness, but that was on the basis of a response rate of about 60 per cent, I think, which largely excluded deprived areas. The cost-effectiveness data were very context specific.

The issue needs to be set in context: each local health system is a microeconomy in which there are lots of currencies being juggled, the main one being time, and in which lots of incentives and disincentives are being managed. Simply to set up a scheme and to put it into a context without considering the wider microeconomy is a problem. That is why the early detection programme for bowel cancer may well be one of the initiatives that has a perverse effect regarding inequality.

I am going to try and ration my contributions, as I feel that I am speaking too much, but my parting shot relates to the Public Audit Committee's highlighting of the inverse care law as an important social determinant of health. That committee is perhaps the first to do that. Many of the reports on the social determinants of health have not really grasped the extent to which public health services, by inequitable distribution, can be a social determinant of health and therefore of health inequalities. We hope that this is the beginning of a new look at the issue.

The Convener: I do not want to decry your self-discipline, but I need to ask you something further. The issue of the inverse care law and the gap that has widened was raised at our meeting on 22 January. Harry Burns said that the gap has widened despite the things that we have done—not necessarily because of them.

Professor Watt: I am not aware of any serious attempt to address the inverse care law in Scotland in so far as it involves general practice.

The Convener: You suggested that some schemes—including the bowel cancer early detection programme—are widening the gap. The argument was made two weeks ago. How do we know what would be the case if we had not introduced them?

Professor Watt: We had a meeting with the team that runs the national programme, who wanted to talk to representatives of deep-end practices. They provided the locum fees that allowed us to have a round-table discussion. One of the main issues is that the delivery of that programme in deprived areas would be much better if there was a sitting down between the people who are involved with the national plan and those in the local practices to work out how to work together.

If, for instance, there was a focus on the campaign for one month a year, when the practice and the national campaign were working together to use all opportunities to involve patients, there would be a greater likelihood of engagement than there would be simply through writing to people from Dundee with an envelope and asking them to collect stools. That would be unlikely to happen in a practice in a deprived area. What has been missed is the principle of co-design, whereby delivery at a local level is discussed first with the people who know the local situation.

11:15

Dr McCartney: I want to follow on briefly from Graham Watt's point. My paper was, I think, circulated in advance of the meeting and draws on Sally Macintyre's paper to the health inequalities task force in 2007 or 2008. In my paper, a couple of tables outline the interventions that are more or less likely to exacerbate or to narrow health inequalities. Interventions that rely on individual agency—people opting in—such as bowel cancer screening programmes, are much more likely to exacerbate health inequalities, whereas things that people cannot get out of—housing interventions, legislation on making places smoke free and minimum unit pricing for alcohol—are most likely to narrow health inequalities. Sally Macintyre perhaps wants to go into that in more detail.

Professor Macintyre: I want to pick up a point that Carol Tannahill made about values. If bowel cancer screening has differential uptake by social class—say 60 per cent among higher social groups and 30 per cent among lower social groups—you might be increasing inequalities, but should you abolish the policy if both groups are still benefiting? There is an issue about saying that widening inequalities is always bad, because if the poorer groups are still benefiting, you might consider how to get them to benefit more—that is about proportionate universalism and what resources are needed. It is important to note that although a programme might have widened inequalities, everybody might still have benefited, albeit differentially.

When you said previously to Harry Burns that some programmes had widened inequalities, he replied that they had not and that the gap had widened in spite of the programmes. In my paper from 2007 I pointed out that although inequalities seem to have widened since the second world war, that is not a reason to abolish the NHS, free education and universal services. Some people have argued that with the NHS, free antenatal care, immunisation and free education—all the welfare reforms post the second world war—inequalities have widened, so we should abolish them all. I do not agree and I wonder whether that is the point that Harry Burns was responding to by suggesting that if we had not had those things, inequalities might have widened more.

David Liddell: The economic situation and the impact of welfare reform on health inequalities is an important area for the committee to look at. The Poverty Alliance has recently undertaken research on use and availability of food banks, which is an important aspect that is not fully understood and requires further investigation. Evidence from research in Fife shows clearly that women in the study regularly skipped meals in order that their children did not go without. Obviously, the physical health impacts of such behaviour over the long term are a cause for real concern. Everybody benefits from the general health service, but the exact opposite is the case with welfare reform and the current economic situation.

Drew Smith: Where should accountability for all this lie? Professor Watt said earlier that a professional community is involved in tackling inequalities at a policy level, but there is not necessarily the required manpower across the national health service and all the other associated organisations that need to be involved in tackling inequalities. Inequalities policy is something that happens at a high level and we all say that we know that everyone else needs to be involved, but where is the evidence that they are? If such evidence is not there, how do you create a meaningful target at the top level of Government that says what progress we want to make and what we will measure it against, and how do you work that down through the system at every level? If that does not happen, we just end up with periodic committee inquiries every four or five years during which people say, “It’s hugely complicated and everyone has to be involved and everyone is responsible, therefore no one is responsible.”

Dr McCartney: The Scottish Government does publish annually a long-term monitoring framework on health inequalities, which includes a basket of outcome measures on health inequalities. Although it is imperfect, as all measures are, it is the best available data that we have. It includes things such as indices of inequality for all-cause mortality and admissions to hospital for heart disease, down to the differential across society in low birth-weight babies. That is a good basket of measures. I do not think that there is a specific target for that at present. The question is whether you would need a target for each of those outcome measures or whether you would pick perhaps all-cause mortality or the like. There are certainly means by which to monitor progress.

Erica Wimbush: That is an extremely good question. It is one of the big challenges to community planning partnerships. Health inequality has been identified as one of the CPPs’ main priorities over the coming years and they are accountable for outcomes. What outcome exactly will there be in relation to health inequalities? How will CPPs be held to account? That is one of the things that the national community planning review has been considering.

Mutual, joint accountability across partners is difficult to implement, and I am not sure what joint accountability will look like. Will the partners have shared systems for monitoring outcomes? Sharing information across a partnership presents one of the key intractable problems that we have had with partnership working.

You have hit the nail on the head regarding how to hold people to account. I do not think that we have found a solution for how to do that, and it is one of the things that we will need to address if we are going to make any progress in addressing health inequalities through community planning partnerships.

Professor Watt: The thing that brings it down to ground is the experience of patients. Whatever people say they are trying to do, it is the experience of patients that counts. A lot of the documentation that is produced around inequalities is simply the advertising of good intentions and activity, but we do not know what that achieves. I am not sure that I am suggesting something that exists already—it might need to be imagined and invented. I cannot think of anything that would bring the thing down to ground other than something based on patient experience.

Increasingly, patients will determine their own goals. A colleague, Jan De Maeseneer from Ghent in Belgium, was talking to us about the typically multimorbid elderly patient with many problems failing to get what she needed from fragmented services. The thing that turned the corner was asking the patient what she wanted. Increasingly, the goals were functional and social. They were to do with going shopping, playing cards and that sort of thing, and the diabetes was secondary. A hundred years ago, people said that we should listen to the patient, who was telling us the diagnosis. Nowadays, we need to listen to the patient as she is telling us what her treatment goals are. That is the currency with which we should be evaluating services.

The Convener: Sally, do you wish to respond in any respect? The objectives of your paper were to measure and understand the problem. Do you feel that, since you wrote that paper, there is now a measurement and, crucially, an understanding of the problem?

Professor Macintyre: Regarding the issue of accountability, or more generally?

The Convener: Yes, and regarding the responses that we have heard.

Professor Macintyre: No, I do not wish to comment.

Drew Smith: I return to the challenge in what Professor Watt has been saying. You talked about asking people about their experience, understanding it and then trying to shape policy on the back of that experience, but those are exactly the same people who, the professionals will tell us, are hard to reach. That goes back to the big conundrum. Dr McCartney was talking about lifestyle drift and the danger of making policy around trying to change people's behaviour, whereas Professor Watt is kind of saying the opposite—not in disagreement, but with a different way of using the idea—which is that, rather than trying to make policy around changing people's behaviour, we should be making policy around learning from people's experience. We are talking about individuals, but in two different ways. Is there any more that I can tease out regarding that?

Dr McCartney: There are a couple of different things that might be getting confused here. Broadly, there are two types of research regarding learning—qualitative and quantitative. Someone asking why or how questions will want to gather qualitative evidence to help them understand the process. Someone asking a what question wants numbers—quantitative evidence that tells them how much of something there is or what the difference in something is across a population group.

That is about learning, but there is a difference regarding outcomes. The outcomes that I described, which the Scottish Government is currently using, are hard quantitative outcomes—counting how many people end up in hospital or how many people die from particular conditions. We could easily add other measures to that—indeed, there is one measure regarding mental wellbeing and inequalities in mental wellbeing across society that is used as part of the current basket.

The kinds of measures that Graham Watt mentioned, such as social capital or functioning, are partly included in healthy life expectancy, which looks at how functional people are in their own context, so it is encapsulated in one measure that the Scottish Government uses, but other measures could be added, depending on what is important. I suppose that Graham Watt is proposing that we could do more research to find out what is most important for patients and then add in those outcomes. That is not unreasonable.

Of course, the advantage of those harder outcomes is that they have no survey bias. If people die, they are counted in the numbers. Therefore, people in more deprived areas do not disappear from the numbers, whereas in some of the survey estimates, such as the Scottish health survey, the response rate hovers at just under 60 per cent. No matter how much additional weight is given to responses from deprived areas, respondents are different from non-respondents, so any kind of survey measure always has that kind of danger. I know that lots of work is going on to try to minimise those biases, but at least with the harder outcomes there is not that danger.

Dr Simpson: I want to tease out what Dr McCartney said. The one area in which there has been a narrowing of inequality is in the cardiovascular field—the narrowing is not massive, but the inequality has not broadened. If, for example, smoking was the big factor there, we would have expected inequality to broaden because more than 40 per cent of people in socially deprived areas still smoke, whereas only 10 per cent of those in socioeconomic category 1 do so. We have not succeeded in narrowing the difference in smoking rates, yet inequality for cardiovascular disease has reduced. As I understand it, part of that is due to improved technology, but part of it is due to lifestyles. Can we tease out why, even if the narrowing has not been great, the cardiovascular field has not gone the way of other areas and had a broadening of inequalities? Why have outcomes in that field improved for all?

Dr McCartney: That relates to my earlier point about looking back over history to the different causes of mortality. You are right that, on most measures, cardiovascular disease inequalities have declined, but in their place we have seen a rise in inequalities in things such as alcohol-related mortality, drugs-related mortality and mortality due to violence and suicide. Where the gaps have been left, if you like, other causes have taken their place. All causes of inequalities in mortality have pretty much stayed static, while inequalities in cardiovascular disease have come down. That is the danger of focusing on individual causes. Things such as the provision of smoking cessation services, better housing and better income will have had an impact on cardiovascular disease mortality and inequalities, but without focus on the fundamental causes, other cause-specific mortalities will intervene and we will end up with the same gap in all cause mortality that we had before.

Dr Simpson: That does not really answer the question. I accept your point that we need to tackle at a global level issues such as education, child poverty and housing—all big issues that our committee is not really focused on, although they should obviously be included in our report, as you keep stressing. What did we do right in cardiovascular? Not only has mortality come down by 40 per cent generally, but that is the one area where the inequalities gap has narrowed. Were we doing anything, or do we just say, “Well, that is just due to chance and we do not know what happened"? Has anyone worked out why there has been a narrowing in that area? If there is a reason, we might be able to start applying the lesson to other disease-specific inequalities, which we need to tackle alongside the major issues.

Dr McCartney: I am afraid that I do not have a good answer to that. The best that I can think of is some work that was done by Simon Capewell and colleagues at the University of Liverpool. They looked at the range of factors that influenced the decline in cardiovascular disease overall rather than inequalities in cardiovascular disease. They attributed a large proportion of that to improvements in treatment. If that is true, one could imagine that perhaps we have managed to make access to treatment more equitable, but I do not know whether that is true in the Scottish context.

Dr Simpson: The evidence is that the opposite has happened. As I understand it, people from poorer communities access treatment much later. As I understand the existing evidence, once those people get into the process, they get treated as well as anyone else, but they do not get into the process quickly enough. Therefore, that does not answer the question at all.

The Convener: We are not going to resolve that issue today.

11:30

Professor Macintyre: We could look at that specific issue as part of the policy review and update of the evidence. We can consider why that has occurred. We can ascertain whether there is any evidence to show why there is a diminishing gap in deaths from cardiovascular disease. That is an interesting point that we will take up.

The Convener: Good

Mark McDonald: This might be a little bit of a brain dump, so we will see how it goes. Bob Doris's earlier point about mitigation ties in quite well with Mr Liddell's point about welfare reform. Only last week we saw figures from the Department for Work and Pensions that showed that there will be a huge increase in the number of children in poverty simply as a consequence of welfare reform.

I will move on to a few different issues.

We have spoken about proportionate universalism. Dr McCartney's paper refers to the dangers of reducing some universal provisions that are available. I guess we could have the debate about universality and its benefits, but the theme that I am picking up is that there is a bedrock of things that we apply on a universal basis that we should build on, then on top of that we need to build a targeted approach that means that we do more in some communities beyond the bedrock of universalism. I therefore do not think that there is the clash between universalism and targeting that one might assume would arise.

I always feel that there is a cycle of self-perpetuation when we talk about deprived communities. I know that that sounds a bit fluffy, but we always label some communities as deprived or hard to reach. I remember when I was the vice-convener of housing in Aberdeen City Council the horror that I felt at the fact that we labelled areas as less desirable for getting a council house in—imagine the stigma attached to that. I think that that has a detrimental impact on individuals' feelings of self-worth. Perhaps that contributes in some small way to inequalities; that is, simply the sort of mental degradation that can come to individuals who feel "I live in a deprived area," or "I live in an area that nobody wants to live in."

Another point is about the resource transfer that will be needed and how we message that. As I said at a previous committee meeting, we politicians are spectacularly bad, and always have been, at doing the long term well. If we tell people that we are going to shift money now, but that they will have to wait to see the benefits of that, it is a hard sell. It is also a hard sell to those communities or groups that we are taking the money from to do the targeting. I remember speaking to a senior police officer who said that he goes to meetings of a community council and is asked for an hour about crime, although it is a community with one of the lowest levels of crime in Scotland. On the other hand, there are communities out there where he really needs to target his resources. I guess that the same would be true across all sectors.

The question is how we get across the message that we need to be much more intelligent in how we target, when it is likely that people who are not targeted will have a bit of a kick back at that. Any helpful advice from the professionals in that regard would be appreciated.

Dr McCartney: Mark McDonald makes a number of good points. I will touch on the universalism point first. The dangers of undermining universal public services are multiple. If we have services that are not seen to be for everyone, people start to ask questions about why they should pay their tax towards them and they become poor services for poor people and are stigmatised. However, Mark McDonald is correct that just a flat level of service can often exacerbate inequalities, as we have said here. We therefore have to provide equitable services for everybody, but do so according to need, which is a real challenge.

One way in which we can sell that, in a sense, goes back to a point that Professor Tannahill made. She talked about the evidence that emerged from Richard Wilkinson and Kate Pickett's work in "The Spirit Level", which showed that more equitable societies do better on a range of outcomes, irrespective of their mean income level. For example, Japan and the Scandinavian countries are more equal on most measures, and their outcomes on crime, health and housing and even their environmental performance are all much better than those in more inequitable countries, such as the UK and the USA. We can sell to all people in Scotland the idea that, if we had a more equal society, not only the poorest groups but the more affluent groups would do better.

I will raise another aspect that we could reflect on—it is a trap that I, too, have fallen into. I produced a railway map that showed the difference in life expectancy across Glasgow and showed that Bridgeton, in the east end of Glasgow, has a particularly low life expectancy. What happened was that journalists immediately got on a train to Bridgeton to ask people, "How does it feel to live in this really rotten area?" We were all tearing our hair out, because that is exactly the stigmatisation that we did not want to happen. However, we cannot sit in silence when such inequality exists.

We have a juggling act to do in deciding whether to highlight problems, given the danger of stigmatising people. One way round that is to talk not about "deprived communities" or "the poor" but about the gradient across all society. It is not the case that everybody is doing fine except some sub-group of the population. As we progress across any ranking of the population, people do progressively better or worse—that depends on how we look at that. Inequalities affect everybody, not just the people at the very bottom. A more equitable society benefits everybody.

Professor Watt: This is a job for politicians. Dealing with inequalities is not a task for technocrats or for people to manage on society's behalf through services that are in addition to the main stream. The main stream is the message. We are talking about social solidarity, which must be reinvented, because it is disappearing right, left and centre. England provides a good example not to copy; the current politics in Scotland might allow us to reinvent solidarity.

A key message is that the system is not a free good—everyone needs to be involved and there is a subscription for everybody. People have lost the idea that they are subscribing to a universal system to which they might put in more than they get out. The challenge is to sell a feeling of satisfaction and relief for people in putting in more than they get out. If we take a consumerist view, in which people are concerned only with what they get out of services, that will be dangerous and will mean the end of universal approaches.

My conclusion is that there is a task for politicians in selling universality as something that involves everybody. A subscription fee goes with that, and people cannot talk about the issue unless they pay the subscription.

Professor Tannahill: The only thing that I can add is the concept of co-production. It is interesting to comment at this stage; I agree completely about the issues of labelling and the language that we use.

There is no doubt that one of the lived experiences of inequality is that people feel that they are objectified rather than treated as people. The language that is used about them is not human language, and they do not have a say in decisions that are made about them. In everything that we do, we need to get much better at hearing people's voices and involving people who are at the lower end of the socioeconomic spectrum and who are experiencing the worst health—we do not do that well enough in Scotland.

Professor Watt: We do not allow sufficient time for co-production to happen. The original paper on co-production in a health context—there were previous papers about it in another context—came from a seminar with Julian Tudor Hart in our department in Glasgow in 1994. His key phrase was "initially face to face, eventually side by side". That is quite a journey. A lot of the self-management and self-help initiatives assume that people can jump to it. In deprived areas, the journey is long and needs to be invested in, but co-production is very much the destination.

Mark McDonald: A previous comment that I made in a committee was taken wildly out of context, so I want to make it clear that I am not suggesting that, if we stop talking about "deprived communities", everything will suddenly get better. I am simply making the point that, if we label areas as less desirable places to live, that builds an impression among the people who live there.

Graham Watt makes another interesting point about messaging, which is that the welfare reform agenda and other pan-UK reforms are having an impact through messaging. He talked about the break-up of social solidarity and the notion that more people might think, "Why should I pay my taxes to sustain people who are on benefits or to deliver a better service to a certain section of the community?" We run that risk, and Graham Watt is absolutely right that the onus is on us as politicians to try to counter those arguments and to develop a counter-narrative. He has thrown that challenge our way, and I guess that we will have to ensure that we are up to the task.

Gil Paterson: Dave Liddell touched on welfare reform. The committee was informed by a senior Westminster civil servant that the intention is to take £2.6 billion out of the Scottish economy through welfare reform. That will touch on housing and particularly on poor people, including the working poor. What is the panel's view on that reform and how it will impact on services? More aptly, given the resources that the Parliament and Government have available, are we up to the job? Can we possibly mitigate that attack on the welfare state in Scotland?

Professor Watt: Last week, we had a meeting involving 30 deep-end GPs and civil servants from the DWP in London to discuss the employment and support allowance reforms and the imminent personal independence payment reforms. That built on a report that we produced last year that reflected on one week's experience of patients and practitioners of the fallout from the ESA assessments.

That fallout is enormous. A GP in Parkhead said that he now spends 20 per cent of his time dealing with the follow-on from the initial assessments. There are problems with the dysfunctional nature of the new system and the lack of understanding of the initial assessment and the appeal process. That often works to a patient's disadvantage. However, even when those issues are ironed out—they inevitably will be as people accommodate the new system—there is a brutality about the forms, in that they are essentially technocratic and try to impose a supposedly objective assessment of capability to work, irrespective of the consequences.

It came across clearly in the meeting with the 30 GPs from different practices that they are as concerned about the consequences of the decision that is made as they are about the decision. There is a huge mental health burden on individuals who are already trying to cope with various conditions. Destitution is a real prospect as a consequence of this supposedly objective measure. The GPs are against the system because of what it is trying to do to their patients—and, ultimately, they are advocates for their patients.

We have received advice, which I am sure the committee has had, too, that, as night follows day, fewer people will receive the PIP than get DLA, and the amount that others get will reduce, while a minority will get more. That will have huge consequences.

Our impression is that the attempt to reset the parameters for who gets benefit and who does not has been done in a rather crude way and with screening that has resulted in a lot of inaccurate and unjustifiable judgments that can be redeemed by appeal. However, the appeal process is lengthy and requires personal resources that many people do not have. I have been helping my daughter to appeal against an ESA decision, and that makes me wonder what it must be like for someone who does not have professional help to negotiate the system.

11:45

That takes us back to the issues of solidarity, universal support and what people are prepared to pay for. The system crudely puts the ball into the patient's court and says, "Appeal, and if you merit the benefit, you will get it." However, that is a costly approach, given the implications for the mental health of the patients and for the services that have to gather the information for appeals. There is a crudity about it that is actually quite unpleasant. If the system was unearthing lots of people who were getting benefits that they did not deserve, perhaps that would be a justification, but the experience is that examples of that, which are celebrated in certain types of media, are actually uncommon. We will never iron that out entirely. If we are to have a universal system, we have to tolerate a bit of inaccuracy in assessment to avoid the harm that is done by trying to objectify assessments of individual cases.

I am sorry for going on a bit, convener, but although on the face of it the tick-box approach, which I have seen in operation, looks thorough and conscientious and very polite, at the end of the day it fails to understand the complexity of disability at the individual level. One good thing about the PIP developments that are coming is that the assessments will be done not by doctors, but by occupational therapists and physiotherapists, who can make much better assessments of people's ability to live independently.

I am sorry for going on too long, convener.

Dr McCartney: Gil Paterson asks an important question. It is clear that people in our world who have responsibility for public health are worried about the impact of the so-called welfare reforms on the health of the Scottish population. If Gil Paterson's figure of £2.6 billion is correct, that will clearly have a massive impact on income inequalities and on living standards in our poorest communities.

I want to raise two points. First, the aim of welfare reform was to move more people into employment, but if we consider job availability in Scotland and where people are looking for work, we find that there are nowhere near enough jobs to go round. The areas where there are the greatest number of unemployed people are also the areas with the fewest jobs. In the next couple of months, we will publish a report that will show that situation and the trends. In truth, in the past three or four years, we have not had a time when there have been enough jobs to go round. Therefore, it is unlikely that the welfare reforms will move people into work, because there simply is not work available for them to go to, even if they are fit and able to do so.

Secondly, it is difficult for us to evaluate the independent impact of the welfare changes on health. The principal reason for that is that we have been unable to get hold of DWP data to facilitate that evaluation. Scottish researchers in particular face a number of barriers to getting individualised records and linking them to health records. Therefore, it is difficult for us to say anything conclusive about the impact of the welfare changes on health outcomes. We will produce a baseline report for the May meeting of the health inequalities task force, which will outline in high-level and broad terms what the impact might be. However, the report will be restricted, because we have the impacts of recession coinciding with the impacts of welfare change, and we have no individual-level data to allow us to explore the changes.

The work that Graham Watt described, which is more qualitative in nature, makes the point well that the feeling that we are getting from services is that the impacts on health are fairly profound and negative.

Gil Paterson: Would the Poverty Alliance like to make a contribution?

David Liddell: I will not repeat what others have said, but it is clear that the impact is already devastating. The figure that Gil Paterson gave for the amount of money that will come out of people’s pockets shows that the process will be hugely more damaging than it has already been across a range of measures, including health measures, particularly, but not exclusively, mental health.

As was said, trying to mitigate that will be extremely difficult. Payment in arrears is another big issue, not just because of the reduced income. Being paid in that way was supposed to normalise people’s situation with that of people in employment but it will have hugely negative effects. I am aware that credit unions and others are trying to mitigate those effects, but the potential to do that is very limited.

Gil Paterson: Dr McCartney talked about difficulties with the DWP. Does that include the Scottish Government? Has that route been taken to ascertain the information? I would have thought that it would have been automatic and that you would not have to ask.

Dr McCartney: I do not know whether Sally Macintyre wants to comment on this. I previously worked at the Medical Research Council unit of which Sally is the director. We spent a long time engaging with the DWP to try to gain access to its data to allow follow-up and to measure the impact of welfare changes on health. It has a preferred researcher mechanism whereby it asks the research questions and commissions people to do the research. It does not release its data beyond that.

As I understand it, the Scottish Government has been trying hard to gain access to individual-level data to facilitate that work. You can get the aggregate data so you can find out how many people get jobseekers allowance and ESA and suchlike, but that is not very helpful if you are trying to look at individual outcomes. What we would really like to do is to link individual outcomes to health records or at least to have a clear idea about the outcomes for individuals.

Nanette Milne (North East Scotland) (Con): I want briefly to touch on unemployment, which has been mentioned several times. I am from Aberdeen, which is a very prosperous city overall, though it has pockets of poorer, deprived areas. In Aberdeen, we have very low unemployment, which is causing problems. The front page of the local paper today has the issue of people waiting far too long to get care at home because of the difficulty of recruiting home carers because they can get better pay in oil-related industries. Services in Aberdeen are beginning to suffer because of a lack of people to work in them.

Is there any merit in considering incentivising workforce mobility so that people could be encouraged to move from more deprived areas, where there are no jobs, to areas such as Aberdeen—I dare say that there are more—where there are jobs but it is difficult to recruit people to work in them?

Professor Watt: Where would people stay in Aberdeen?

Nanette Milne: That is an issue. I accept that accommodation is probably more expensive in Aberdeen.

Dr McCartney: Perhaps I could offer a general point. There are also spatial inequalities throughout the UK. There are often poles of economic growth and therefore employment. The south-east of England is a classic example of that. Where the income and wealth and employment are not spread across the country, we end up with spatial inequalities as well as inequalities by social class or poverty and so on.

It might be worth reflecting on the way in which development is spread across the country. We know that our most deprived areas are concentrated in the west of Scotland and central Scotland, whereas there are more affluent areas around about. One of the problems of that inequality and affluence throughout Scotland might be the issue that Nanette Milne describes.

Professor Tannahill: I am sure that as Nanette Milne asked the question, we were all sitting here thinking that that would mean people moving their families and so on. Clearly, there are all those issues.

We know that people do move for jobs. The nature of work is changing so much that people recognise that mobility for employment will become much more part and parcel of what people do. At one level, what Nanette Milne is suggesting is not at all against a wider trend.

We know that the young working-age group is the section in society where health inequalities are the widest and where health trends have improved the least, so I welcome the collective focus on that group, which is helpful. The CMO always pushes early years and we support him in that, but the young working-age group is the other group that is really driving Scotland's health trends. That is to do with the quality of work, access to work and all the exclusion issues that we have talked about. It is not simply about poverty; it is about how people treat you when you are in poverty and the things from which you are excluded. Work is such an important route out of that. Although my initial reaction was, "Gosh, there are all sorts of problems with this," we must also recognise the potential of approaches of that sort and of the redistribution of employment and opportunity within Scotland.

The Convener: It is time for a wee plug. I recommend the committee's "Report on Inquiry into the Regulation of Care for Older People", where we look extensively at how we pay and reward the workforce, regulate care, contract and commission services and treat the people who care for our elderly and vulnerable, all of which are big equalities issues. It was pointed out to us that you can get more money handing out leaflets for the Edinburgh festival than you can get working in a care facility looking after old and vulnerable people. Of course, that goes beyond health. The committee's report is a good read.

I think that we have asked all our questions. I thank you all for your attendance and offer you one final opportunity to put on record anything that you feel we did not pick up on or any important messages that you want to leave us with. We would certainly encourage you to follow our inquiry and take not just a passive interest in it. We would welcome your on-going comments on evidence that is presented, which you might strongly agree or disagree with or have minor points to make about. We will discuss all the input that we have had when we write our final report. Does anyone wish to put anything else on the record at this stage?

Professor Macintyre: You asked earlier whether other sectors take notice of inequality. If it is accepted that education, employment and housing influence inequalities in health, does this committee have a role in engaging those other sectors of central and local government? Would that be a topic for your inquiry?

The Convener: We are limited as a committee, but the evidence that we have heard in two sessions so far is likely to lead us to the conclusion that other sectors need to look at this. I cannot pre-empt our report, but the evidence that we have taken so far shows that there is much more involved in this issue than just health. We take your point.

David Liddell: I want to pick up points that Gerry McCartney made. I suggest that you unpick all the issues around asset-based approaches. The risk with individualising health problems is that you avoid a focus on the more fundamental causes of health inequality. We urge the committee to explore that issue in detail.

The notion of moving resources upstream, which is the phrase that is often used in relation to early intervention, was alluded to. Our view is that it is not just about the nought to three age group; results can be achieved across the spectrum of people's whole lives. That is an important point to keep in mind.

There is also the issue of employment and whether there are lessons to be learned—I am sure that there are—from all the regeneration programmes that have delivered to deprived communities over the past 20 or 30 years. I am thinking particularly of the focus on the bricks and mortar rather than the people within communities. That brings me back to my initial point about community benefit clauses and ways in which programmes can have much more bottom-up engagement with the communities that they seek to develop and improve, rather than focusing narrowly on the bricks and mortar.

The Convener: It just remains for me to thank you all once again for your time and your evidence.

12:00

Meeting suspended.

12:07

On resuming—

Petition

Speech and Language Therapy (PE1384)

The Convener: Agenda item 2 is consideration of PE1384. We need to decide whether we will return to the issue or communicate to the Scottish Government further issues that the petitioner has raised.

Do committee members have any comments on the petition?

Mark McDonald: I have a strong personal interest in speech and language therapy. To be honest, I found the COSLA response pretty unhelpful. It reads very much like a sloping-shoulders response.

I wonder whether the committee ought to go to local authority and NHS board level. Perhaps we should cherry pick a couple of NHS boards and local authorities that are attached to them. Perhaps we should consult the petitioner on which areas would be worth exploring.

We need to look into the matter further. The committee's paper 3 recommends that we pick up the matter with the Scottish Government and examine it again during consideration of the proposed integration of adult health and social care bill. That is worth doing, but we need a bit more detail than the COSLA response gave us. The question is the best way to get that detail to inform our work.

Nanette Milne: I agree with Mark McDonald. The need for speech and language therapy is increasing, and it is clearly not available uniformly throughout the country, which it should be. It is important to find out a bit more detail about what is going on where. Therefore, I support what Mark McDonald suggests.

Dr Simpson: Speech and language therapy and occupational therapy are classic examples of professionals bridging two areas. With respect, asking for a report from one of those areas as opposed to a report from the other misses the point. I understand what Mark McDonald says about COSLA not being helpful—I agree with that—but they are joint services and the important thing is to get a report from them jointly. The fact that we cannot get that is a failure of the system.

I do not know whether anyone else on the committee was with me when we visited Glasgow's speech and language therapy service, which has been completely redesigned with a budget of £5.2 million. People are happy with the redesigned joint service: it is working well.

It is a matter of asking the community planning partnerships or community health partnerships. They are the ones that should be able to tell us what is happening on the ground.

Bob Doris: I do not want to be overly negative about COSLA, but there are some issues with its response. I appreciate that it may not want to give an analysis of the impact of cuts to education budgets on speech and language therapy, but it could give us some straightforward raw data about full-time equivalents in each local authority area. I hope that that would be straightforward for each local authority to provide, but it makes much more sense for COSLA as the umbrella organisation to collate that data. We could—hoping against hope—give it one more chance to do that, but I would have no qualms about writing to local authorities.

I have asked previously about access to psychologists for young people in Glasgow. Of course, the local authority employs educational psychologists and the health board employs psychologists. That is a separate issue, but Glasgow City Council had no problem with providing me with information about that, so individual local authorities might not have an issue with providing us with information about speech and language therapists. I am curious about why COSLA is resistant; perhaps it has misunderstood our request. We could go back and ask whether we can get numbers from local authorities for the past five years.

On the recommendations in the committee papers, I would think that we would return to the issue as a matter of course when we consider the integration of health and social care. I support what Mark McDonald said.

Mark McDonald: I take that point on board entirely. I also take on board Richard Simpson's point. We would want to see data not only on the numbers of therapists but the numbers of people who require interventions, how long they have to wait and how that plays out throughout the country.

I am happy to go through community health partnerships if the committee feels that that is the best way to go, but the reason why I suggested local authorities is that, although we will return to the matter when we consider the integration of adult health and social care bill, there is an education input in speech and language therapy.

The one thing that we do not want to do is to leave the educational aspect of speech and language therapy out of the committee's consideration, which we might run the risk of doing when we talk about health and social care integration. I know that this is not the Education and Culture Committee, but speech and language therapy is a health intervention at an educational level. We need to take cognisance of that when we deal with the matter.

The Convener: There is an obvious consensus that we should seek further information.

Mark McDonald: I suggest that we speak to the petitioner. She represents the professional body, which might be best able to indicate from where we would be most likely to get the best response.

The Convener: Thanks very much for that.

Healthcare Improvement Scotland and Scottish Public Services Ombudsman

12:14

The Convener: Agenda item 3 is consideration of how we proceed with the evidence that we received from Healthcare Improvement Scotland and the Scottish Public Services Ombudsman on 15 January this year. Paper 4 contains a summary of the evidence and some options for future work.

I invite comment from committee members to inform our course of action.

Bob Doris: I thank the Scottish Parliament information centre for its summary of key points of evidence and for its hard work on that. However, it is only fair to put on the record that the points do not reflect a prioritisation by the committee of the most relevant points; they are just an attempt by SPICe to capture much of the information.

I will read a couple of the points and provide a couple of additional points for the public record. The SPICe summary states in relation to Health Improvement Scotland:

> "HIS acknowledged a need for two or three more inspectors but highlighted the need to utilise the existing expertise within the NHS".

I am delighted to put on the record that Health Improvement Scotland said during the evidence session that there are current plans to put in place two or three inspectors to support its work. It is therefore not just a case of saying that HIS does not have enough inspectors, because there are plans in that regard. I think that it is important to put that on the record.

Page 3 of the SPICe summary states:

> "When questioned on the current standard of care, HIS responded that 'the baseline in Scotland is reasonably high'".

It did indeed, but just before that comment Dr Coia said:

> "Scotland is a world leader in some aspects of healthcare. In the acute sector in particular, day surgery—to take one example—has mushroomed in Scotland in a way that is a credit to the Scottish health service."—[*Official Report, Health and Sport Committee,* 15 January 2013; c 3109.]

Therefore, HIS did say that the baseline was reasonably high, but it also used the expression "world leader".

I just wanted to put those two points on the record and to stress for anyone who might view the SPICe summary as a committee summary of the evidence session that it is not. However, SPICe has been very helpful in trying to draw together some of the main points that were raised. I hope that what I have said is helpful for the committee.

Mark McDonald: I found the two evidence sessions on 15 January very interesting. I think we should consider repeating the sessions on an annual basis so that we can pick up on some of the points with the witnesses involved.

On the next steps suggested in the options in paper 4, I think that we could write to the Cabinet Secretary for Health and Wellbeing and also pick up some of the issues with him in a general question and answer evidence session at a committee meeting. Therefore, we can write to him in the first instance, await a response, and, if issues arise from that, we can pick them up at the question and answer session.

The Convener: We would need to agree on what points to raise with him in writing. Would it be the cabinet secretary who would deal with the issues raised during the 15 January evidence sessions, or would it be the Minister for Public Health, Michael Matheson? I think that we need to get clarity about where the responsibility lies in that regard, because that might affect our judgment.

Mark McDonald: Given that the committee might have six or seven different opinions about what should go into a letter, perhaps the clerks can liaise with you, convener, and the deputy convener to produce a draft letter that could be presented for approval at the next committee meeting or be circulated by email to members for approval. We could do it that way rather than discuss it here just now, given that we might have several different opinions about what should and should not go in the letter.

The Convener: That may be a solution. However, I am concerned that we would start debating the convener’s or deputy convener’s interpretation or weighting of the evidence taken on 15 January, which Bob Doris alluded to earlier. It is probably simpler to have a discussion with the minister responsible and have them put on the record what they believe are the important aspects of the evidence that we heard. I do not think that a letter would help, because I think that we would end up back here after the letter anyway. What do you think?

Mark McDonald: If the view is that we should just have the cabinet secretary or the minister—if we decide that it is the minister who is more directly responsible for the issue—before the committee for the question and answer session, that is fair enough.

Aileen McLeod: Agreed.

Bob Doris: I would be fine with that as well. The issue is whether we should raise points with the minister or cabinet secretary in correspondence and see whether the response addresses those points suitably before deciding to get them before us, or whether we simply go straight to having them before us. That is just a process point, but I will go with what the committee decides.

The Convener: To try to be helpful, we can send the cabinet secretary or the minister, as appropriate, a copy of the summary of evidence paper and what Bob Doris noted on it so that they can comment on the evidence, with a view to having them before us to discuss it. Would that do it?

Aileen McLeod: Why do we not just send the cabinet secretary or the minister a copy of the *Official Report* of the evidence session?

The Convener: That is publicly available, so I would expect that their officials have read it. The SPICe paper is a summary of the *Official Report* of the evidence session.

Mark McDonald: I acknowledge what members have said, but my take on the clerks’ options—and where I was going with that—is that we would have questions on the SPICe paper as part of a wider Q and A session that we are planning to have with the cabinet secretary. I did not take it to be the case that we would simply pull in the cabinet secretary or the minister on the specific evidence session addressed in the SPICe paper; rather, I thought that we would wrap up some of the points in the paper in the wider discussion that we hope to have at some point in the year.

The paper refers to our having

> “planned ‘ask the Cabinet Secretary’ general evidence sessions.”

The committee has spoken about that. From my recollection of the *Official Report* of the evidence session and from reading SPICe’s summary of the evidence, I do not know whether we have enough information to sustain one single evidence session on this specific topic; rather, it should be part of a wider discussion with the cabinet secretary or the minister.

Bob Doris: In that case, I suspect that the sensible thing to do would be to send the SPICe summary to the minister or the cabinet secretary—whoever the relevant Government person is—and ask for a written response from them. Depending on what is in the written response, we will mop up any additional questions with the cabinet secretary, or we will look to other options, which could be for a minister to come to the committee. By doing that, we would not rule anything out. It seems a straightforward way to progress.

The Convener: Are members okay with that?

Members *indicated agreement.*

The Convener: That concludes the formal part of our meeting. However, I ask members to stay behind for about 10 minutes to discuss the Parliament day and the issues that we were not able to cover in the private pre-meeting briefing.

Meeting closed at 12:23.

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

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