OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 19 September 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 19 September 2023

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
26th Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Carmen Martinez (Scottish Women's Budget Group)
Professor David Ulph (Scottish Fiscal Commission)
Philip Whyte (Institute for Public Policy Research Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 19 September 2023

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 26th meeting in 2023 of the Health, Social Care and Sport Committee. I have received apologies from Stephanie Callaghan and David Torrance, and we are joined by James Dornan.

The first item is a decision on whether to take in private items 4 to 7. Do members agree to take those items in private?

Members *indicated agreement.*

Pre-budget Scrutiny 2024-25

09:15

The Convener: The second item is an evidence session as part of the committee's pre-budget scrutiny ahead of the publication of the Scottish budget for 2024-25. I welcome to the meeting Carmen Martinez, who is the co-ordinator of the Scottish Women's Budget Group; Professor David Ulph, who is a commissioner in the Scottish Fiscal Commission; and Philip Whyte, who is the director of the Institute for Public Policy Research Scotland. We move straight to questions.

Tess White (North East Scotland) (Con): My question is for Professor Ulph. The SFC has projected that health spending will increase from 35 per cent of devolved spending in 2027-28 to 50 per cent in 2072-73. What actions can the Scottish Government take now to prevent that from happening?

Professor David Ulph (Scottish Fiscal Commission): Let me just make two points. It is not our role as a commission to advise the Scottish Government on policy. We simply produce forecasts of what spending and tax revenue is likely to be. Any decisions about policy are for MSPs and the Government to make. It might help if I talk the committee through the drivers behind the projected growth in the share of spending on health.

We are projecting that spending on health will grow faster than other elements of spend over the 50-year period. There are a number of factors behind the projected growth. One factor is that technical progress in the rest of the economy drives up wages, but a lot of the technical progress that takes place in the health sector does not specifically reduce the manpower inputs into work. Some of it does: if you replace normal surgery with keyhole surgery, patients have to be in hospital for less time, which means that there is less cost involved in looking after them.

However, a lot of the progress that takes place in the health sector is about developing new techniques to solve previously untreatable conditions or improving treatments for other conditions. The problem with that is that doctors and high-calibre nurses still have to be paid wages that match those that are paid by the private sector. The costs for hiring labour go up, but you do not get the benefits of reducing the labour inputs into the process. That is one factor that drives the increase in costs.

Another factor is simply that, as you make new discoveries and technical progress, and as you discover new ways of treating people, you will treat conditions that were previously untreated.

For that reason, the amount of treatment that you do will go up. That is another factor that drives up costs.

A third factor is the increase of chronic conditions, such as obesity and diabetes. For example, forecasts that were produced by the Institute for Fiscal Studies said that the growth in the number of people with a chronic condition is 4 per cent, which is higher than population growth as a whole, so a larger fraction of the population suffers from at least one chronic condition. However, the number of people suffering from multiple chronic conditions has been growing by 8 per cent over time. That is another factor driving up the costs of health spending.

A factor that you might think is driving the cost up is demography. In common with many other countries, Scotland has an ageing population but we also have a declining population, which is less common. In the past, the Scottish population grew because the declining birth rate was matched by increases in immigration but now the decline in birth rate has got to a level that is not being matched by immigration, so we project that, over the next 50 years, the population of Scotland will fall.

The way that that pans out in health spending is that the ageing of the population will drive up expenditure on health in the earlier part of that 50-year period but, towards the end of it, the fact that we have a falling population will tend to reduce the rate of growth in health spending. Therefore, demography is playing a small part. It increases the growth in spending early in the period but reduces it later in the period.

I hope that that helps you to understand the forces that are driving spending.

Tess White: It does, thank you. That 4 per cent seems to be an important figure. The SFC's "Fiscal Sustainability Report: March 2023" helped to inform the Scottish Government's decision to apply a higher growth rate of 4 per cent to health and social care expenditure. In your view, given the wide-ranging pressures on the national health service, is that 4 per cent high enough?

Professor Ulph: I repeat that we do not comment on whether a policy is right or wrong. Our role is simply to advise the Government on what the spending and tax consequences of its policies are. I am sorry that I cannot help you further.

Tess White: That is fine.

My final question is for Philip Whyte. Audit Scotland has highlighted many times that the NHS is not being run in a financially or operationally sustainable way. That was the case even before the Covid-19 pandemic. Do existing resources need to be deployed differently or more effectively?

Philip Whyte (Institute for Public Policy Research Scotland): In answering that question, I will come back to your first question to David Ulph as well.

Ultimately, it all comes down to preventative spend. We are more than a decade on from the Christie commission, but the vision that it set out continues to be an ambition rather than something that is being realised. We might come back to prevention at some point.

David Ulph has helped to set out the drivers clearly. We know that the Scottish population is due to decline over the next 20 years but, over that period, we will see a corresponding increase in the annual disease burden. We are getting older as a population, getting sicker and, as a result of getting sicker, getting poorer as a nation. We might come back to some of that. It is ultimately where the driver comes from. We continue to deploy resources to deal with the consequences of preventable and amenable mortality and preventable disease. We are stuck in that situation. We constantly deploy reactive spend to things that could have been proactively addressed much earlier.

On where the resource is right now in the system, the other point that I might come back to is workforce and staffing. We know that a huge proportion of health board budgets and operating costs are taken up with staff costs. Indeed, that is where a huge chunk of the increases over the past couple of years in particular have gone. Staff are our biggest asset and resource, so I do not think that we would say that those resources are not deployed in the right way but, clearly, if we want to continue to grow the workforce, that will add an increased burden and increased pressures to the budget.

I am not sure whether I have given a good answer to your question. That would take us into how hospitals and health boards are deploying resources and it is beyond my area of expertise to comment on how they are deploying every pound and penny. However, the overall summation is that we need to continue to put additional resources into the system because huge pressures have built up in it. Those pressures existed long before Covid, albeit that the pandemic might have exacerbated them, but if we had at some point started to shift our resources into preventative spend, we would have had huge potential to ensure that those pressures did not come to pass.

The Convener: Thank you. I move to Carol Mochan, who joins us remotely.

Carol Mochan (South Scotland) (Lab): Following on from the discussion that you have

just had about preventative spend, one of my questions is whether enough is being done to achieve transformational change in the service, considering the financial instability that the health service is experiencing.

The Convener: Panel members, there is no need to press your button. That will be done by broadcasting.

Carmen Martinez (Scottish Women's Budget Group): Okay, thank you. Good morning, everyone.

The Scottish Women's Budget Group has long called for greater investment in the care sector particularly, and it has called for care to be placed at the core of economic recovery after the pandemic.

Our asks, in a briefing that we published at the beginning of the year, go beyond plans that were established in the National Care Service (Scotland) Bill, because we argue that higher wages and expanding the workforce are key for staff recruitment and retention. We also consider that greater investment in care is crucial to meet current unmet needs, with a focus on quality as well as on prevention. Therefore, when we modelled the cost of care in Scotland, we took into consideration who needs care, the intensity and type of care provision and how much care costs, including care workers' wages. By looking at those areas, we identified a core scenario that we think should be the bare minimum, or a base that we should build from. However, the modelling goes further in presenting a transformative investment scenario, as required to re-envision and reconfigure care in Scotland.

This is where I will address the question. The core scenario focuses on ensuring that current substantial needs are covered by increasing the number of care recipients by about 20 per cent. That would meet current unmet needs and extend free provision to all types of care, including household tasks. The core scenario also aims to increase pay rates to the more competitive wage of £12.50 an hour. The model estimates that that would cost £5,094 million in 2022-23 prices, which is £1,500 million above the current budgeted level of net spending on adult social care.

We said that that would be the minimum that we would like to start with, or the base, but that we should work towards a transformative scenario. The briefing that we published sets out the path to achieve that transformative scenario. It would focus on increasing access to free care for those with moderate needs, as well as increasing care worker qualifications and pay to Nordic levels, with those workers paid an average of £15.21 per hour. That scenario assumes higher take-up rates, which would relieve informal care needs further and eliminate unmet needs. It would require £6,822 million in annual public investment, or 3.7 per cent of gross domestic product, which would be a 1.8 percentage point increase on the current budget and would nearly double public investment in care.

There are different reasons why we think that that investment is important. One of them is that we think that it could lead to greater gender equality outcomes. Eighty-three per cent of the care workforce is female, so higher wages would create more gender equality and help with recruitment and retention within the sector. We also think that higher wages are important to comply with fair work goals.

There was another reason behind this, and I just forgot it, but it will come to me.

Carol Mochan: Do you mind if I come in? I really appreciate the information that you have given us. Given the financial pressures of the post-pandemic backlog, do you think that the potential transformation into a national care service can realistically be done with a single-year settlement, or do we need a multiyear settlement? Are there other things that we need to do to achieve that?

09:30

Carmen Martinez: I have remembered what I wanted to say. Another reason why we should invest more on care is because of the preventative approach. Looking after people before they get very sick should prevent lengthy stays at hospital, which would alleviate pressures on the NHS.

If we look at the costs, our forecast will certainly help, but perhaps we need to ask ourselves whether we can afford not to do something about the situation and whether we can afford not to invest in care.

Carol Mochan: I want to ask one of the other witnesses about how the settlements happen. The boards are telling us that they foresee problems in meeting their current requirements. Would having a different approach be helpful?

Philip Whyte: I will make two points. We know that multiyear budgeting helps a huge range of organisations to plan and figure out where they are spending their money in the long term.

You mentioned the elective backlog. That is a prime example. Obviously, we know what targets the Scottish Government sets. The targets in the NHS recovery plan for in-patient and out-patient activity are not being met. We still have huge amounts of people waiting longer for elective care.

I think that it was Audit Scotland that rightly flagged that there was some concern about the timescales. The situation is partly understandable,

given how the recovery plan was put together and the extent to which boards had a say in how those targets were derived. Equally, those were national targets that were setting out by how much the Government wants capacity and output to increase at a macro level in Scotland by 2026.

However, we know that there are huge variations in waiting lists across the country, health boards and specialties—across everything. Therefore, deriving a national target without knowing how that would be delivered and by whom, where and when at a local level shows a huge disconnect. If you then remove funding from that and there is a disconnect on how much money health boards will have each year, that makes the job even more difficult.

That shows that, rather than having a national-level top-down approach, having a bottom-up approach in which you can start to determine what your capacity and needs are at a local level, and, in turn, what funding is required to deliver that over a much longer period is how you ultimately arrive at being able to meet those kinds of long-term outcomes as opposed to acting on an annual cyclical basis.

Carol Mochan: I have a final question. Professor Ulph mentioned the use of technology.

Something that is repeatedly brought up with the committee is digital—our digital capacity, the ability to speak to each other and the investment that is needed. Is Government doing enough to support health boards with that?

Professor Ulph: Again, that is not something that is in our capacity to talk about. I will just explain what we in the Fiscal Commission do. We produce budget forecasts. Those cover the revenue from devolved taxes, primarily the Scottish income tax—the non-savings and non-dividend income tax. We also forecast spending on social security. We do that for the one-year-ahead forecast for the budget. Also, in May each year, we produce a five-year forecast to look at some of the issues to do with how you plan spending over a five-year period. However, that does not cover health. The only time that we have done any projections on health spending was for the "Fiscal Sustainability Report" that Tess White asked about.

We do not get into any details of modelling and forecasting health spending. Some of the more specific questions about technology that you are asking about are not things that we have knowledge of and expertise in to be able to advise you in any detail, I am afraid.

Carol Mochan: Thank you very much.

Paul Sweeney (Glasgow) (Lab): I thank the witnesses for their contributions so far. We have discussed pay pressures in the NHS and general financial pressures. The Scottish Government agreed a pay increase for 2023-24 of 6.5 per cent for most NHS staff and 12.4 per cent for junior doctors. Nonetheless, payroll pressures continue to persist as a structural challenge for the NHS.

Mr Whyte, you said that wages account for a lot of spend. We need to balance that with recruiting new staff and retaining staff who might otherwise bleed overseas or to external agencies, for example. How do we strike that balance? Do you have any insight into how well boards or national pay bargaining structures are performing in that regard? Structurally, are we potentially adrift from where we need to be?

Philip Whyte: I am afraid that I probably do not have much insight on the substance of your question. I definitely do not want to cut across what I imagine would be the very robust answer that trade union colleagues would give you; I definitely do not want to step on their toes. However, the general point stands. In the hospital sector, just over two thirds of operating costs are taken up by pay. As I said, that is not unexpected. Staff are our biggest resource and our biggest asset, so it is understandable and right that we ensure that pay matches the level that is needed to recruit and retain the best staff.

The question is then about what is left for the wider work that needs to be done. Is the balance right? If we think that it is not, I do not think that the lesson that anyone would take from the past couple of years is that we should restrict staff numbers or reduce pay. At the other end of the scale, non-staff costs need to increase to make up the balance.

Paul Sweeney: That is helpful. Does anyone have any insights on the benchmarks that are used in relation to other healthcare systems in the developed world?

Professor Ulph: I will make a slightly different point in answer to the question about how pay increases will be funded. A lot depends on what happens in the rest of the UK. Health spending is devolved, so a lot will depend on the Barnett consequentials that flow from whatever settlements the UK Government makes. If the UK Government settles at roughly the same level as the Scottish Government has settled, and if it does that by increasing budgets, all the consequentials will flow through to Scotland, so the net impact on the Scottish budget could be quite small. However, if the UK Government settles at a much lower level than the Scottish Government has settled, or if it chooses not to increase funding and to fund pay increases out of existing budgets, there will be very little increase in consequentials, so all the pay increases that have been agreed in Scotland will fall on the Scottish budget.

The impact of pay increases on the Scottish budget will therefore depend to some extent on what happens in the rest of the UK. It will depend on the level at which the UK Government settles and on whether it increases budgets in order to pay for the increase in wages in the rest of the UK. That is something to bear in mind when you are thinking about budgeting for the year ahead.

Paul Sweeney: Ms Martinez, do you have a point to make?

Carmen Martinez: On your question about benchmarking with other countries? No.

Paul Sweeney: Sorry—it looked as though you wanted to comment.

Philip Whyte: I will make a more general point—this is not in response to any particular question—that brings together the discussions that we have had on preventative spend and on staffing. It is about how we balance where we put our resources. On staffing, I note that the NHS Scotland workforce has grown by more than 12 per cent over the past five years. That is understandable and it is to be expected. However, over the past three years—we are talking about different time periods—there has been a 3 per cent decrease in the number of whole-time equivalent general practitioners.

That speaks to a wider point. When we talk about the health service, we are often actually talking about secondary care, which continues to dominate the debate as well as resources and attention. If we want to shift to a preventative model, the biggest returns will be in primary care and community health. I am conscious that there is a GP in the room, so we might come back to the issue at some point.

My general point is that there is a continued domination of secondary care. Again, that is understandable, because that is where some of the most significant pressures are. However, when it comes to staff, funding, resources and everything else, the balance of where we deliver care is still very much stuck in the secondary first model, rather than our starting to look at what we can do to bolster the role of primary care. When we start to think about health inequalities, tackling diseases before they take root and the wider social prescribing and social issues, that is where we see some of the greatest returns.

Paul Sweeney: I have a follow-up question about the potential consequences of capital investment. Do you see an issue with capital investment and productivity enhancement vis-à-vis labour intensity in the system?

Philip Whyte: Again, I am afraid that the area of capital programmes is not within my expertise.

Paul Sweeney: Okay—no problem.

The Convener: Emma Harper has a supplementary question on that issue.

Emma Harper (South Scotland) (SNP): My question is for Philip Whyte. I have some bits of paper in front of me about preventative approaches. Henry Dimbleby has written a lot about ultra-processed foods, and Professor Pekka Puska has done work in Finland on reducing the mortality of people through a whole-system approach by getting restaurants, cafes and supermarkets involved in providing healthier choices that are affordable for people. I am thinking about having preventative spend rather than secondary care constantly fighting fires. Something has to shift in the way that we invest, in order to stop folk getting into the hospital in the first place and to stop people being sick.

I am also looking at our paper on non-communicable disease prevention. My colleagues Gillian Mackay, Carol Mochan, Sandesh Gulhane and Foysol Choudhury and I have been part of a cross-party approach to look at non-communicable diseases, which contributed around 53,000 deaths in 2022 in Scotland. Something needs to be done differently. What do you suggest that we cut in order to move funding to preventative spend? There is only one pot of money, and it is a real challenge to figure out what we need to do differently.

Philip Whyte: To give you some context, I note that we did some analysis earlier this year on the social and economic harms of poverty. We looked at the economic impacts across a number of public services and, just within health board spending—not in the wider health budget—our analysis indicated that around £2.3 billion of health board budget is spent on responding to the consequences of poverty, such as higher avoidable diseases and mortality. Huge amounts are going in every single year.

However, Ms Harper has hit the nail on the head. When we released that report, everyone asked where the money would come from, because it is a seesaw—every pound that you put into preventative spend is a pound that you have to take from somewhere else. It goes back to long-term and multiyear budgeting. We have been having that debate about Christie for more than a decade now. That is more than a decade of time that we have lost in starting to shift that balance. If we had started at that point, you would be seeing huge returns today.

It is really tricky and I do not have an answer to the question about where we start to put that money in, but I always come back to one point. We have a commitment that all health consequentials will be put into front-line health spending, but that amount can vary. In some years, it is hundreds of millions, if not billions of

pounds, but in some years it is only in the low hundreds of millions. If you put a couple of hundred million in health consequentials into the overall health budget, it is a tiny drop in the ocean. If you took that money and instead put it into something like getting every homeless person in Scotland off the streets, which would have a direct impact on people's lives, that could make a huge contribution in starting to tackle the longer-term health inequalities.

I say again that the dominance of secondary care in the debates that we have is understandable given the huge pressures and backlogs that exist in the system. We can direct absolutely every spare penny and pound to fighting the backlogs and bringing them down but, in doing so, we miss the opportunity to start thinking about putting our money into tackling homelessness and into social security and good quality housing, which have long-term, direct impacts on the health inequalities that continue to blight Scotland. We continue to see huge variations between the most and least deprived areas.

It is incredibly difficult, but we need to start at some point. The longer we put it off, the more likely it is that the inequalities will persist and the projections around avoidable mortality and non-communicable diseases will come to pass.

09:45

Emma Harper: We will probably come back to tackling poverty, but I have a question on that issue. Certain things are reserved to the UK Government and some items, such as health, are devolved, but the money is not. What role do food producers and retailers have in engaging with Government to look at how we support diets that are healthier and ensure that people can afford healthier food? Some of the food that is marketed right now, such as processed food, is jam-packed full of calories and does not tell your brain that you are satiated, so you keep eating. There is emerging research on that, which I find pretty fascinating. Is there a role for supermarkets, restaurants and cafes to work with Government to help to deliver a less obesogenic environment?

Philip Whyte: I think that there has to be. The same applies across issues such as poverty. When I talk to the Social Justice and Social Security Committee, the discussion is often centred on what Government can do and the role of social security but, with an issue such as poverty, we need to ask what employers can do on fair work and pay. Exactly the same applies across all areas of public policy. We need to stop viewing things in a very siloed way.

This is not just a health problem; it is a problem where supermarkets, employers, housing associations, landlords and so on all have roles to play. We know that the consequences of poverty are ill health and the health inequalities that we continue to see. That is not something that the health service can solve; it can only deal with the consequences of that until we start shifting the balance of the care that we provide and where we provide it, as well as shifting wider public services.

Emma Harper: Thank you.

Sandesh Gulhane (Glasgow) (Con): Before I ask my question, I declare an interest as a practicing NHS GP.

Professor Ulph, I ask you to clarify briefly what you said to Paul Sweeney about the increase in staff pay. That increase will lead to a cut in other aspects of NHS spend in Scotland.

Professor Ulph: I am sorry, but I did not quite catch your question.

Sandesh Gulhane: From what you said to Paul Sweeney earlier, the increase in staff pay in Scotland is going to lead to a cut in NHS budgets and NHS spend elsewhere. Is that what you said?

Professor Ulph: No. I said something slightly different. In healthcare, a lot of the progress that we make through technological developments tends to come in the form of better treatments for patients and ways to treat conditions that were not previously treatable. It does not come so much in the form of labour-saving progress, whereby you reduce the number of workers that you need to deliver a given level of health. In some areas, there is labour-saving progress. I gave the example of keyhole surgery, where less time is involved in keeping the patient in hospital and less resource is required.

My point was more that you have to keep on recruiting staff who are from other areas of work, and they will benefit from the increases in wages that they get through technical progress, so you have to match wage increases outside the health sector to carry on attracting staff. However, you are not getting corresponding reductions in the number of staff that you need to treat patients, so that drives up the costs of treating patients. That was the point that I was trying to make.

Sandesh Gulhane: Thank you.

Philip, you said twice that staffing is our biggest resource and our biggest cost, which is obviously true. I do not know whether you can answer this, or whether Professor Ulph can answer it, but what is our spend on NHS managers?

Philip Whyte: I do not have that figure to hand. The 12.9 per cent figure is for the overall NHS workforce, which includes administrative and

managerial staff and so on. I started to break the numbers down when I had them to hand yesterday, but I did not get a chance to finish that, so I am not too sure what the spend or the proportion of staffing is in that regard.

I absolutely get where you are coming from. The front-line staff who are delivering care are the most important. Obviously, we need to make sure that the hospitals and everything else are well-run, which requires managerial staff, so I certainly would not make any judgment about the balance or whether the number is too high. However, I do not have those figures to hand.

Sandesh Gulhane: As you were working on them, could you to send them to us?

Philip Whyte: I can indeed.

Sandesh Gulhane: Thank you.

The Convener: Sandesh Gulhane will move us on to our next theme.

Sandesh Gulhane: In response to Tess White, you spoke about preventative medicine and, obviously, as a GP, I will come on to talk about that. We must transform the way in which we think about and deliver healthcare. We cannot keep focusing on health in the way in which we do just now. We cannot treat the NHS as if it were a bike repair shop where people just come in to get repaired. We need to get them better beforehand. Organisations such as the British Society of Lifestyle Medicine are advocating for such a preventative agenda. You mentioned it earlier, but I would like you to expand on what you said and give us some tangible examples of where we could implement preventative spend and the things that we could do within healthcare budgets to achieve that.

Philip Whyte: Emma Harper talked about the public-health-led measures that need to exist outwith the health service. If we look at standards in housing, for example, we know that the housing stock is most likely to be substandard for people who are living in poverty and in more deprived areas. We also know that low standards in housing can give rise to things such as respiratory diseases; I am sure that you have seen that being presented at surgeries. We have not yet tackled the non-health-service bit. We often talk about something as a poverty issue and try to address it as such, but we quite often still do not make the connection and it is not until the health inequality statistics come out every year that we think, “Oh, yeah, there is a big link between health inequalities and deprivation.” We do not think to address those things as health issues; we continue to address them as social issues. We need to be able to do those things outwith the health service.

Within the health system, good innovations have been made in the past couple of years, such as the formation of multidisciplinary teams. There is evidence to suggest that the outcomes are still not fantastic but, at an anecdotal level, although they are not delivering better health outcomes yet, it is really important to be able to bring those professionals together and start to co-ordinate the advice and services that they are providing. That is especially true of the inclusion of mental health professionals, because there has been a huge rise in mental ill-health during the past few years and that has a huge corresponding impact on things such as participation in the labour market and everything else.

Those teams are good examples of how we can start to bring resources together within communities and potentially give rise to the development of more hub-and-spoke models, where there is a really strong central hub within a community that ensures that the GP service is able to provide continuity of care. If we look at experience surveys carried out during the past few years and their implications for resourcing—you might have personal experience of that—we see that one of the first things that can give within primary care, particularly within GP practices, is continuity of care. The same GP is not able to provide care to the same patient every single time because resources are so stretched. The hub-and-spoke model could allow GPs to focus on that much more, while the centre is much stronger.

Any health professionals in those deep-end GP practices that have been at the forefront of the development of community link workers will say that those workers have played a hugely beneficial role by providing more social prescribing and non-health support, which often burdens GPs. although burden is not the right word to use. People often present to GPs with non-health issues and community link workers present a brilliant resource to deal with those. However, in the past few months, we have seen reports about the risk to staffing numbers among the CLWs, particularly in those local authorities where they are needed most, such as Glasgow.

Those are the sort of things that we should look at doing more of. There are probably further innovations that could be made that go beyond my area of expertise. Whatever you call it—whether a multidisciplinary team or a hub-and-spoke model—it all comes down to bringing those wider resources that can tackle the causes of ill-health, and even prevent it, much closer to communities, while also ensuring that we free up GPs so that everyone has access to continuity of care and, although it is such a clichéd way to put it, that “friendly face”, which is important.

Sandesh Gulhane: I could not agree more with what you said about GPs. It is so important that, when I am doing my job as a GP, I am sure that I am helping people's health and not focusing on their social issues, because there are probably other people who are better placed to do that.

You mentioned community link workers. In Glasgow, we are going to see deep cuts made to their numbers. I have received a lot of correspondence from community link workers. I have also spoken to deep-end practices and to GPs—GPs are stopping me in the street to talk about this. The good that community link workers do is huge, and the worry that a lot of them communicate in correspondence is that, if they are cut, they will have to go from working in one practice to working in three practices. They will have maybe a day a week in each practice, which will significantly hinder the work that they will be able to do for the community. What value should we place on community link workers, especially in our most deprived areas?

Philip Whyte: I am very conscious that I do not want to dominate proceedings, so I hope that someone else can come in at some point.

I do not think that we would have the same debate about, or risk to, staffing in any other part of the system that we have in relation to community link workers. Although I understand it—and this is not to say anything about it—attention and focus go on the secondary system, which we continue to prioritise. Primary and community-led care continue to be very much distant runners-up in that debate.

We need to recognise the importance of link workers, multidisciplinary teams and deep-end practices and celebrate much more the role that they play. We are not there yet, because we have not cracked that nut of the recognition of the important role of community-led care. It is not about ensuring that it starts to dominate over secondary care, but that we recognise that the health system is made of at least three or four different bits, each of which needs to be as well resourced, as respected and as part of the solution as any other. We are not there yet. It comes back to the point that we still often do not see social issues as health issues and vice versa—or not to the extent that we should.

Sandesh Gulhane: I am aware that other people want to come in. This is my last question—I am sorry, but I am sticking with Philip Whyte.

About 80 to 90 per cent of all patient contacts happen in primary care; that is where people access healthcare. You are right that we are not quite there when it comes to resourcing, which is dominated by secondary care. We saw a £65 million cut in the primary care budget last year. With that happening, how are we expecting our GPs to provide a service that enables the preventative agenda? How can we give our GPs the time to ask about things such as alcohol or cigarettes or other questions, as opposed to only the thing that brings the patient through the door? Do you have any ways in which we could do that?

Philip Whyte: First, on the funding point, a lot of attention has been placed on the commitment to increase the overall health budget by 20 per cent, originally by the end of this parliamentary session, but it has obviously been met already. There is potentially a question there about whether the commitment was made because there was confidence that it could be met, or whether it was a much-needed increase early in the session, but which needs to go much further than 20 per cent.

What gets forgotten is that, in its first programme for government in this parliamentary session, the Scottish Government also committed to increasing primary care spend by 25 per cent over the session, with at least half of all front-line spend going into community health. The opacity of primary care and community health funding means that I am not sure whether that commitment is being met, what that looks like, or what success looks like.

That is also part of the problem: quite often, in primary care, we do not know where the money is going, because it is not as simple as saying, "Here is a health board and I am going to give you your budget." There are equally big funding commitments in primary care, but I am not sure of the extent to which those are met in the way that the overall health budget is met.

10:00

On the secondary points, again, there is the question of whose role it is. I imagine that you would say that it is not the role of a GP to provide those kinds of services. We need to start thinking about alternative delivery models to free up GPs to provide that continuing care so that they are able to see the same patients and know their histories and needs. Then we need that wider support network within the surgeries. We have things such as the commitment to ensuring that every GP practice has a mental health worker by the end of this parliamentary session. Such commitments are really important and we must ensure that they are met. In that way, people will know where they can go in their communities for that sort of advice, we will have no-wrong-door approaches and holistic services will be provided in one place so that people do not have to go all over the place to find that support. That is incredibly important: it is not necessarily about who provides the support; the most important thing is probably where it is being

provided and the assurance that, if you seek it, you will be able to access it.

Professor Ulph: [*Inaudible*.]

The Convener: Excuse me, but I will move on to questions from another MSP now. Gillian Mackay joins us remotely.

Gillian Mackay (Central Scotland) (Green): Good morning. I will come back to Philip Whyte on something that Emma Harper picked up earlier about preventing people from falling into poverty and ensuring that they have enough money to live on in the first place. With that in mind, what impact does the panel believe that the introduction of a universal basic income or a minimum income guarantee could have on the health and social care system in terms of reducing strain and costs?

Professor Ulph: Again, the Scottish Fiscal Commission cannot comment on new policies; we can comment only on policies that have been produced by the Scottish Government.

However, I will make the point that I was about to make: there is an important interaction between spending on health and spending in other areas of Government. That goes back to the vice versa point. We observe that the increase in waiting lists in the NHS is showing up in spending on social security, particularly disability benefits. It is now the case that 40 per cent of disability benefits payments arise because of mental health issues. Therefore, better delivery of healthcare has important implications for spending on social security. Also, there is now some evidence that that might increase the rates of participation in the economy. Therefore, if you get more people working, you get higher levels of GDP and higher levels of income, which is a point that Carmen Martinez made earlier. Also, tax revenue could rise.

Therefore, it is important that we see the overlap between what is going on in health, in social security and in tax and take that holistic picture of what is happening in government. That goes back to the point about the important interactions between those things. I am sorry that I did not quite answer your question, Gillian.

Carmen Martinez: I will try to contribute. With regard to the minimum income guarantee, socioeconomic factors have implications for health inequalities. We have seen that with austerity over the past 10 to 13 years; there is a wealth of evidence that links austerity and health inequalities. From the survey that we ran at the beginning of the year and other surveys that we have run with civil society organisations, we have seen that, for example, women are already using different strategies to navigate the cost of living crisis. The cost of living crisis will have an impact on poverty, which will have an impact on future spending and pressures on the NHS.

For example, the key findings include the fact that 70 per cent of the 871 women who responded to our survey said that they have not been putting the heating on, in order to reduce costs. Almost 20 per cent of respondents are skipping meals entirely, and that increases to almost 34 per cent for disabled women and 46 per cent for single parents.

Some women have said to us that they have struggled to afford care costs. We also know that provision has not got back to what it was prior to the pandemic. Some women struggle to attend health appointments because of the cost of transport. As long as it is well thought out and it provides the minimum, a minimum income guarantee could help to absorb some of the consequences that the current economic situation is having for people, women in particular.

Gillian Mackay: That is great—thank you.

Paul Sweeney: I thank the members of the panel for their contributions.

The committee recently invited views on winter planning in the NHS. It was suggested in many submissions that the development of a whole-systems approach is hindered by the short-term nature of planning and funding. Do panel members have a view on how we can achieve a whole-systems approach in any practical sense?

Professor Ulph: That is not something that we have covered.

Paul Sweeney: In its recent report, “Tipping the Scales: the Social and Economic Harm of Poverty in Scotland”, IPPR Scotland highlighted the fact that the cycle of reactive spending is avoidable. Do you have a view on how, against a backdrop of such acute pressures on secondary services, we can disrupt that cycle and transition to an increase in preventative spend?

Philip Whyte: I covered a lot of that in response to Emma Harper’s question. It is a delicate balance. David Ulph has highlighted a big problem, which is that I can say, “We need to shift the balance of spend,” but we also need to ensure that we continue to spend on tackling the elective backlog, because we know that the longer people spend on a waiting list, the poorer their health becomes and the greater the likelihood that they will exit the labour market, if they were in it to start with. We have already seen a rise in chronic and long-term conditions, which has resulted in us getting poorer. It is an incredibly difficult seesaw to balance.

I go back to some of the responses that were given earlier. We need to look at the health service and ensure that we are getting the right balance

between the resources that we put into primary care and the resources that we put into secondary care. Primary care will often treat the causes, whereas secondary care will deal with the consequences. We also need to ensure that, in our wider social policy spending, we respond to issues such as housing and social security as health issues, as well as issues of poverty, because health inequalities in particular are a matter of poverty and vice versa. It does not really matter whether we approach such an issue as a health issue or an issue of poverty, but we must recognise that the two are intertwined and start to tackle them as such.

Paul Sweeney: Do you have any examples of service provision in Scotland or other countries where that transition has been managed and is showing promising signs?

Philip Whyte: We looked at that as part of the UK-wide research, but I do not have any examples immediately to hand. We looked at a couple of different models for primary care where a preventative shift had taken place. I would be happy to provide some examples in a follow-up submission.

Emma Harper: I want to come in on the back of other questions that have been asked. In chapter 2 of its "Tipping the Scales" report, IPPR Scotland says:

> "Important action has been taken within devolved powers ... demonstrating what can be achieved with political will and investment."

The report talks about the devolution of new welfare powers and the establishment of Social Security Scotland. More than £1 billion has been spent on 12 new benefits, which include council tax reduction, the Scottish child payment and the best start grant.

A lot of those benefits are outside the health portfolio. Ministers in the Scottish Government such as the Minister for Housing and the Minister for Social Care, Mental Wellbeing and Sport have their own portfolios, but everything crosses over in relation to health improvement, so I am interested in how we consider the budget.

We should value what has been set up by Social Security Scotland—it focuses on fairness, dignity and respect rather than taking the punitive approach that the Department for Work and Pensions takes. Should anything else be picked up in relation to which form of welfare support would help to improve Scotland's safety net?

Professor Ulph: I will say something about social security spending because it is important. The policies that you talk about—the Scottish child payment and the reforms that have been made to how disability benefits are delivered—all have spending consequences. Because of the way that the Scottish budget operates, those are not covered by any block grant adjustment from the UK Government, so they fall entirely on the Scottish budget.

That means that in 2027-28 there will be around £1.2 billion of spending on social care and social security, which is not funded by a block grant adjustment from the rest of the UK. Around half of that arises from spending on Scotland-only policies, such as the Scottish child payment, but half of it comes from the consequences of the way in which we deliver disability benefits, so it is roughly half and half.

By the end of the 50-year period, we project that that figure will grow to £3.2 billion. A large chunk of that—around £2.2 billion—comes from the reforms that have been made to the way in which social security is delivered, particularly through disability benefits, and about £1 billion comes from payments such as the Scottish child payment. Although all those reforms have very good intentions, they have fiscal consequences that fall entirely on the Scottish budget, and will not come through any block grant adjustment from the UK Government. It is important to be aware of the costs that fall on the Scottish budget when you make such reforms.

Emma Harper: I recently read that the Scottish Government is providing £700 million of support to mitigate things such as the bedroom tax. I know that this is straying into politics. The Barnett formula makes adjustments for Scotland, but we are constrained by the way that the budget is delivered in Scotland by another Government. Do we need to be looking at alternatives to how the Scottish Government's block grant is delivered?

Professor Ulph: There are two elements to the block grant: Barnett consequentials, which flow through to things such as health; and block grant adjustments. The adjustments come in two areas, one of which is income tax. The Office for Budget Responsibility will try to forecast what tax revenue Scotland would have raised had it remained part of the UK tax system. Scotland keeps the tax revenue that it raises, which is then subtracted from what the OBR estimates that it would have raised had it remained part of the UK tax system, had the Scottish economy and earnings grown in the same way that the UK's had and had Scottish tax rates been the same as in the rest of the UK. That is how the block grant adjustment relates to income tax.

10:15

There is a similar block grant adjustment relating to social security, in which we ask what would have been spent in Scotland if Scotland had remained part of the UK social security system,

and then that block grant is given to Scotland. However, if Scotland makes decisions that mean that it spends more than that, the increase falls entirely on the Scottish budget. If Scotland has different policies from the UK, such as the Scottish child payment, they fall entirely on the Scottish budget. The consequences of the reforms that are made to the way that social security is delivered fall on the Scottish budget.

There was a review that addressed some of the questions as to how the fiscal framework operates in Scotland, but under the existing framework, those are the implications of decisions that are being made by the Scottish Government and the Parliament.

Emma Harper: Okay, thank you.

Paul Sweeney: The biggest commodity in the national health service is time. There are opportunities to boost productivity through capital investments and to tackle inefficiencies through targeted process improvements, but GPs, for example, say understandably that they are too busy firefighting to undertake any sort of innovation or process improvement. Do panel members have examples from other countries of models of innovation that have demonstrably improved productivity and that have helped to deliver positive health and social care outcomes?

Philip Whyte: I am really sorry—no.

Paul Sweeney: Okay. Written submissions to the committee have noted that the short-term nature of national targets is having an impact on clinical priorities, with decisions made to satisfy expectations as opposed to measuring long-term impact. Do panel members have a view on alternative measures—perhaps through budgeting—that could be used to monitor performance and would allow for longer-term planning? How do we shift from short-termism to a longer-term funding and service delivery model—bearing in mind the complex interactions between the Treasury and the Scottish Government?

Professor Ulph: One of the reasons why we published our first "Fiscal Sustainability Report" in March was precisely to try to get people to understand the longer-term trends that are happening in both spending and in funding and resources. By understanding the longer-term trends, we can start to think about making different decisions about how we want to prioritise spending. That was exactly the motive for producing that report, which provides more information and more background to help us to understand the consequences of pursuing existing policies over a longer period of time.

As the convener said, the Scottish Government has already responded to our report by applying a higher growth rate of 4 per cent to health and social care expenditure, rather than 3.5 per cent. That is exactly the kind of impact that that long-term framework of thinking will have; it will help MSPs, the Parliament and the Government to understand the long-term implications of existing policies for funding and spending.

Philip Whyte: I have two points to make. The first is on budgeting. I used to work in the Government, so I know that setting budgets is a difficult process. If we go back to last year's resource spending review, we ended up with level 2 figures, which is better than what we had previously for the understanding of long-term budget outcomes or potentials, but level 2 figures obviously do not provide any kind of detail.

For example, we got a health and social care level 2 budget. I get that there is huge uncertainty around funding over this parliamentary session—we saw the same last year with the mini budget, when funding went up and then down within a few weeks—so budgeting is very difficult, but we need to at least attempt to do it. If we get a level 2 figure, one of two things has happened. Either the level 3 assumptions beneath that are known, but the Government has chosen not to publish them—there tend to be valid reasons for that—or the level 3 figures are not known and the level 2 figure is potentially not informed by where the Government is going to put the money. There needs to be some attempt to move to a level beneath level 2 whenever it comes to long-term budget setting.

I go back to what I said before about targets: I do not think that they are inherently wrong, albeit that I know that health boards are now expected to adhere to or meet a huge number of targets. The elective backlog, for example, was a national-level, top-down target—or at least an ambition—that the Government set in its NHS recovery plan. It was good to set that, but Audit Scotland has flagged that it is unclear what modelling went into arriving at that national-level figure.

As I said, we know that capacity, waiting lists, specialties and everything else all vary hugely by health board, so you need to think about what bearing that has and what contribution you expect each health board to make to that national-level outcome. You do not know unless you have taken a bottom-up approach.

Those are the two points that I would make. On funding, we need to try to drill down a level, and on targets, while it is right to set them, you need to ensure that they are formed from a bottom-up approach.

Paul Sweeney: Can you elaborate on the evidence base for longer-term objective setting and setting those budgets accordingly? An interesting example might be health and social care partnerships cutting a programme without

any reference back to the centre and the impact that that might have on national performance. Do we need to do more to improve those metrics and key performance indicators?

Philip Whyte: With regard to outcomes-based budgeting, we are not there yet. At the start of the current parliamentary session, there was a commitment to increase the health budget by 20 per cent by the end of the session; that has been met already.

However, I am not sure where that 20 per cent increase came from. It is not a bad thing—obviously it is good—but I do not know why it was 20 per cent and not 25 or 15 per cent. It has been met already, so do we need to increase it now to the end of the current parliamentary session because meeting it halfway through the session must mean that we underestimated the increase that was required?

Even just at national level, with targets or commitments like that it is about trying to better understand the evidence base that has informed them, why you want to increase the budget and what the increase is being spent on.

The same thing happens if you take it down a level. There will be a lot of committee discussions about things such as the national performance framework. The NPF is described in Government as its north star—I always torture this cliché, so I apologise in advance. North stars are good. if I get lost, I can follow the north star and have a good idea of where I am going, but that does not mean that I do not run the risk of falling off a cliff unless I actually know what my route is. It is fine to have that big national-level macro north star to follow, but you need to know what your route map is, and I do not think that we have those lower-level targets, or whatever you want to term them. Outside the targets that have been set nationally, I am not sure whether we know where we are going yet.

Paul Sweeney: That is helpful—thank you.

Carmen Martinez: I am sorry—can I make a point?

The Convener: Yes, of course.

Carmen Martinez: On the back of the budgets and data, the Scottish Women's Budget Group would support a review of the integration of health and social care and how that is working, in particular in relation to shared budgets and how the impact of decisions that are taken in relation to social care can influence health and other services.

For example, East Lothian Council clearly stated in its budget papers for this year that the increased funding that it got for wage rises would not be passed on to the integration joint board. In addition, Glasgow city integration joint board has had to make £21 million of cuts to its budget, with its budget papers recognising that those cuts will increase the waiting lists for people who need care packages, will reduce day care services and care home beds, and might lead to a failure to meet its statutory duties.

Again, that suggests that there is a continuation of looking at things in silos, which means that decisions do not take into consideration the consequences and the long-term bigger picture.

Evelyn Tweed (Stirling) (SNP): Good morning, panel, and thank you for your contributions so far. A number of respondents to the committee's call for views said that there was a need for public engagement in relation to health and social care spending and the choices that need to be made. In general, is that a good idea? How can it be done well in order to ensure that we do not increase people's expectations in the wrong way? I put that question to anyone who would like to come in.

Professor Ulph: Again, I am really sorry, but we do not comment on those kinds of issues.

Carmen Martinez: We think that there needs to be a conversation about what people expect from health and from care, and taxation probably needs to be included as part of that conversation. Following on from previous questions, there might also be a conversation about how we empower people to think about their health and what choices can be made—for example, in relation to food, which we talked about earlier.

As for how you do it, we do not really have a view, because we have not engaged with that, but we are happy to discuss that with our members and get back to you.

Philip Whyte: Public engagement is a good thing. One thing that I often come back to when thinking about how to fix the system is that it comes back to the shift in where we deliver care. Over the past few years, we have been through a redesign of urgent care. You could argue that that was a very grand title for what the reforms actually were but, to take just one example, there was advice to not present at accident and emergency. A number was provided that people could ring to be triaged, and they could then determine whether they needed to present at A and E. The aim was to reduce A and E numbers, for obvious reasons, but it was also about recognising that people often do not need to go into a secondary setting and that there will be other avenues of support.

If you want to talk about shifting the balance of care, that is absolutely the appropriate thing to do, and it was the right thing to do, but there was uproar. We talk about the health service as a national service and as a right and an entitlement. There was uproar that people were being told not

to go to A and E. Political attention was paid to the issue and the public were not too sure what to do. You could argue that the way that that was communicated and the way that people were engaged were wrong. However, I think that that highlights the tension that we sometimes have.

People want more GPs and want to be able to see their GP but, at the same time, they obviously want to be able to go to A and E at any time of day, with whatever ailment they have. That is part of the problem. We need to be able to have a grown-up discussion about what the health system is for, what the individual bits of the health system are for, how people access them and whether the way that it is set up now is appropriate. With the change in advice on presenting at A and E, I certainly think that the way that it was perceived did not bear any relation to what the reform was trying to do. There is potentially fault on all sides for that, but that provides a really useful microcosm that shows that, actually, we are not yet able to have that grown-up debate about alternative models of care, because even something like that caused untold amounts of anguish and upset.

Evelyn Tweed: I will come back on some of those points. Generally, it is felt to be a good idea to have an open and transparent conversation with the public about health and social care and how we move forward with it. However, going on your comments, it will maybe not be that easy, and it will have to be very well thought out.

Philip Whyte: The NHS is absolutely the jewel in the crown of public services, and that applies across the UK. That means that people have a huge emotional attachment to it—none of you will be strangers to that. It is often the very largest political football that gets batted around. Well, footballs do not get batted around, so that was a bad metaphor to use, but there is huge public attachment, and there is also huge public pressure, attention and so on. Therefore, on both sides, something has to give, and that is incredibly difficult. It is easy for me to sit here and say that, but I have no solutions for how you do that. However, something has to give if we are to be able to start thinking about how the system is set up, designed and delivered. If we do not do that, we will persist with the model that is chewing up resources in secondary care and still not delivering the primary care that people need in communities.

Evelyn Tweed: The comments that you have made are very good, and I agree that these conversations are sometimes difficult, because the public think about things in a different way. The communications that I saw going out from the Scottish Government about, say, social prescribing and multidisciplinary teams, made people start to have a conversation with each other about how to do things better, so we have to do it, even if it is difficult.

10:30

Emma Harper: I am thinking about community pharmacy as another way to direct people—pharmacy first, for instance—and our national treatment centres, which have been established so that elective surgery can be done and emergency beds are not taking up the space for elective patients. That work has been done, but I feel like we are spinning plates sometimes because none of it is an overnight fix. I used the example of Professor Pekka Puska in Finland: it took three decades but, with that approach, he reduced the mortality of men from cardiovascular disease by 80 per cent.

Is the Scottish Government going in the right direction when it comes to budget choices around health and—on the back of Evelyn's question—when it comes to helping people manage expectations as well?

Carmen Martinez: The Scottish Government knows what the issues are and it has taken some good steps. However, there are issues around implementation, for example, or evaluation of some of the initiatives. I am thinking now about the women's health plan, which was approved a year or two ago and was meant to be funded with Covid-19 recovery funds. We submitted freedom of information requests to NHS boards and two came back to us. NHS Lothian said that

"There is no specific central funding attached to the Women's Health Plan, and no specific funding has been allocated to delivering the priorities, aims and actions in Lothian".

NHS Highland said that it was "still trying to ascertain" whether it held

"information to provide a response".

From that example, we could say that the Scottish Government has indeed taken some steps—it identified a need to decrease health inequalities and considered women's health—but we do not know how successful that women's health plan will be because no budget has been attached to it. In conclusion, more could be done.

Emma Harper: I suppose that it is an NHS board's responsibility to deliver. The Government has a plan but the NHS board would be the one to deliver the women's health plan in NHS Lothian, for instance. NHS Lothian would propose how it would monitor the delivery of its plans and the outcomes that it has achieved.

Carmen Martinez: Yes, I suppose. The plan comes from the Scottish Government, so there will be some way to measure or follow up on it.

The Convener: We move to our final theme.

Sandesh Gulhane: This question is for Professor Ulph. You started by saying that there is an opacity around primary care spending. Is data regarding specific Scottish Government commitments in the budget, such as mental health commitments, sufficiently transparent to allows us to monitor it effectively ?

Professor Ulph: I keep apologising to you because, as I have said, we do not forecast spending on health. We do not go down to the level of detail to know what data is available in order to produce forecasts for health spending. I am not able to comment on the adequacy of the data, because we just do not forecast health.

For the projections that we did for the fiscal sustainability report, we drew on some data about the breakdown of spending into primary and secondary healthcare, so we had some data in order to make our projections. However, the figures that we used are pretty rough and ready, and we were just doing long-term projections from that starting point.

When we do our budget forecasts on income tax and social security, we have much more detailed data, which we use to feed into our forecast. We spent a lot of time working with both His Majesty's Revenue and Customs and Social Security Scotland to make sure that we have the data to do our forecast. Every year, we publish a statement of data needs relating to where we think that there are still gaps in the data that we need in order to do our forecasts better and to improve the accuracy of our forecast. However, because we do not forecast health spending, we have never published a statement of data needs in relation to health data.

Sandesh Gulhane: My second question is for Carmen Martinez. Social care is often seen as a Cinderella service, whose sole job is to prop up the NHS, allow speedy discharges and allow hospitals to work more efficiently, but it needs to be seen as a vital part of the care that we provide. When it comes to looking at how social care data is used to see how we can make improvements, do you think that we have adequate data? If not, what is missing?

Carmen Martinez: I do not think that I will be able to give you the detail as to what is missing right now, but I can get back to you afterwards. However, there is definitely some data missing, because when we wrote our report, we had to base some estimations on data from England. Therefore, there is definitely a gap.

To go back to your previous question about data and what is missing or not, this month, Audit Scotland published a report called "Adult mental health". It made remarks about the complexity of the current system and how that makes it more difficult to develop and provide person-centred services. Multiple organisations are involved in the planning, funding and provision of adult mental health services, including the integration joint boards, health and social care professionals, the NHS, councils and third sector organisations. Sometimes, trying to get data from them is quite complicated. I go back to my earlier point about how the Scottish Government should work with NHS boards and integration joint boards to improve accountability arrangements.

On data and budgets, there are integrations of health and social care, but we know that most of the budget usually goes to health. We would say that social care is still underfunded and undervalued. That needs to be tackled and improved so that we get greater outcomes and improve prevention. It must be at the centre of the system.

Sandesh Gulhane: Thank you.

My last question is for Philip Whyte. As a taxpayer, when money is spent, I think that it is important that we know where it is spent and that there is an audit trail of that spending. When it comes to health, is it too simplistic to want to know where our money is being spent and how?

Philip Whyte: I do not think that it is simplistic. If we look at secondary healthcare, there is an issue that, once money hits a health board's budget, it is very difficult to know what sits beneath that for each individual health board. That data is really difficult to find so, quite often, you have to do it after the fact, once audited accounts are produced. There is the idea that, once it has left the Scottish Government budget and gone into health boards, it should equally be split out at a level beneath that. That may tell you where it is being spent, but I am not sure whether it tells you what outcomes it is having. It will definitely not tell you whether it is being spent in the right way. I have done this for a long time and still could not tell you. I would not know where to start shifting money around.

Data is an issue. There are issues around funding. Take for example the really good commitment from the Government that 10 per cent of all front-line health spend will go to mental health by the end of the parliamentary session. Because that is delivered through health boards and it is up to them to determine how much money they put where, you have no idea whether it is being delivered and, more importantly, who is doing the heavy lifting of delivering it. Things like that become impossible to track.

There is an issue with the transparency of where money is going. The more important thing is data. Data exists across multiple different sources.

It is incredibly difficult to find and, even if you do find it, it is often not made user friendly. On transparency and data, every committee that is doing its pre-budget scrutiny and work beyond that is probably having a similar discussion, because the situation is not unique to health. However, because health is such a complex area, it becomes even more heightened in health.

The ultimate point is that we have good data on outcomes and diseases but it is much more difficult to find that and genuinely understand what is driving it and, more importantly, how we start to shift it.

Professor Ulph: It is important to understand the distinction between social security spending and other forms of spending. One feature of social security spending is that it is, in essence, demand led. Once the Scottish Government has set the eligibility criteria, the rates of pay that it will pay for certain conditions, the way in which the benefits will be delivered and the information that it requires from people who are applying for benefits, the level of spending is determined by the number of people who turn up and claim those benefits. You do not get to choose the amount of spending; it is determined by the people who claim the benefits. It is not like—

Sandesh Gulhane: Forgive me, I was not talking about benefits.

Professor Ulph: I understand that. My point is that you do not get to choose certain elements of overall budgeting. You do not get to choose the amount that is spent on social security. What you get to choose is how you spend the rest between health, education and other portfolios. With the spending on social security, you determine the conditions under which people can apply, but the amount that is ultimately spent is determined by who turns up and claims it.

That is why, when we produce our fiscal reports, we produce the overall budget, subtract social security spending and say that that is the budget that is left to spend on everything else. If you are going to have a discussion about whether we have the right information and are making the right decisions about what we spend on different areas, one area of spend over which you do not have the same degree of control is social security.

Sandesh Gulhane: Thank you.

Paul Sweeney: I will pick up on some of the modelling that has been done in the productivity paper that you prepared, Professor Ulph.

The number of people in the NHS workforce in Scotland would make it the fourth largest city in Scotland. I think that the head count sits at 181,000 people, so it is the biggest employer in Scotland by a considerable distance. That clearly has an effect on national performance in terms of productivity. Do you have any thoughts on whether we can improve our analysis of the productivity of the NHS workforce in informing national policy?

Professor Ulph: Most of the work that we have done on productivity has been on productivity across the economy as a whole. That feeds into what is happening in the health service, but we have not done a specific study of productivity in the health service per se. We have looked at the consequences for the health service of productivity in the rest of the economy. We have just published a paper that shows how different assumptions about productivity have different impacts on the overall fiscal sustainability of the Scottish economy.

Paul Sweeney: I might come back to you to ask for further information about the potential for doing deeper analysis on the national health service and its productivity. That might be of interest to the committee, so thanks for that insight.

10:45

The Convener: Thank you. Does Emma Harper have a very brief question?

Emma Harper: Yes, and I need to remind everybody that I am a currently registered nurse. I forgot to say that at the beginning.

I have a quick question about the economy. Normally, we take gross domestic product as a measure of how successful a country is. However, we now have a Cabinet Secretary for Wellbeing Economy, Fair Work and Energy, so we are looking at wellbeing and we know that, if we help to get people out of poverty, that can support them into being more productive. Do you agree that supporting a wellbeing economy is an approach that we can take to how we budget for health? It will be relevant across portfolios when we are talking about things such as housing and poverty and addressing the issues that we face in Scotland.

Philip Whyte: The simplest answer might be that I will not go into that today but will put something in a follow-up note. We have done a lot of research at UK level on exactly that: one of the consequences, from an economic perspective, of the decline in health is the effect on productivity, and vice versa, if we were to get a healthier population, what does that do for the economy? I could provide some of that in a note. I do not know whether Carmen Martinez wants to say anything.

Carmen Martinez: I am not sure that I have anything to say about the wellbeing economy just now.

Emma Harper: I am asking because I am the co-convener of the wellbeing economy cross-party

group and we have had lots of interesting discussion about how it is good to support wellbeing as a nation and not just to measure productivity on GDP.

Carmen Martinez: I think that it is important to have a healthy nation, and by improving health outcomes you might also have more people who are able to enter the labour market. When we did the cost of care modelling report, we were also thinking about job creation and making the care sector more competitive and attractive, bearing in mind the number of unpaid carers in Scotland and how that could help to bring people into the labour market, especially in the context of a shrinking workforce, which we know of from the Scottish Fiscal Commission's report.

You cannot take GDP as an absolute measure of how well the economy is running. It is just a measure. It does not take into consideration care, for example, and we also know that, although it is good to have a growing economy, or so they say, it does not always translate into greater outcomes, equality or equity. It is something that is there, but a wellbeing economy might measure success in a way that is more appropriate, considering the policy commitments.

Emma Harper: Thanks.

The Convener: I thank the witnesses for their evidence to the committee this morning.

Subordinate Legislation

Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment (No 2) Regulations 2023 (SSI 2023/243)

10:48

The Convener: The next item on the agenda is consideration of one negative instrument. The purpose of the instrument is to increase the charges that are recovered from persons who pay compensation in cases where an injured person receives national health service hospital treatment or ambulance services. The increase in charges relates to an uplift for hospital and community health service inflation.

The policy note states:

"The NHS charges are revised annually from 1 April to take account of Hospital and Community Health Services (HCHS) pay and price inflation. The last revision took effect from 1 April 2023, applying the estimate for HCHS inflation at that time of 2.8%. As a result of subsequent NHS pay deals, the latest estimate for HCHS inflation is 5.3% ... This midyear tariff uplift addresses the significant gap between forecast and actual pay inflation."

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 12 September 2023 and made no recommendations in relation to the instrument. No motion to annul has been lodged in relation to the instrument.

As members have no comments, I propose that the committee does not make any recommendations in relation to the negative instrument.

Members *indicated agreement.*

The Convener: The next meeting of the committee will briefly consider a negative instrument and that will be followed by a joint meeting of selected members of the Health, Social Care and Sport Committee, the Social Justice and Social Security Committee and the Criminal Justice Committee to scrutinise drug policy. At our meeting on 3 October, the committee will receive an update from the Minister for Social Care, Mental Wellbeing and Sport on the National Care Service (Scotland) Bill and we will continue with our pre-budget scrutiny.

That concludes the public part of our meeting today.

10:50

Meeting continued in private until 12:02.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba