Evidence of Dr Ian McKee MBE to the Commission on Parliamentary Reform, January 2017

I present my views under the checks and balances section of the commission's remit.

My Background

Member of the Scottish Parliament 2007 – 2011

Member of Health and Sport Committee, Subordinate Legislation Committee (deputy convener) and other short term committees.

Parliamentary Liaison Officer to Nicola Sturgeon MSP during her term as deputy First Minister and Cabinet Secretary for Health and Wellbeing.

General Medical Practitioner in the RAF and Edinburgh from 1966 – 2006.

Awarded MBE for services to healthcare in 2006

Member of the Scottish Medical Research Ethics Committee 2001 – 2005

Member of the Lord Provost of Edinburgh's Commission on Social Exclusion 1998 - 2001

Scope

I confine my submission to the way in which the Scottish Parliament deals with health matters although some of it can relate to the wider field.

Submission

According to the Scottish Parliament website the role of the Health and Sport Committee is to scrutinise the Scottish Government's policies and expenditure in relation to the following matters:

Public health
Sport
Physical health and wellbeing
NHS, including workforce and pay, public appointments and performance
Primary care including GP's, NHS 24, dentistry and optometry
Acute services
Health and social care integration
Mental health
Carers
Health protection
Health improvement

In the current session of parliament the committee has decided to test all activity against the following aspects:

The impact it has on health inequalities
The extent to which it has a prevention focus
Long term cost effectiveness and efficiency
The implications of the UK's EU exit.

I make the following points;

1) This is an impossible workload for a committee of 11 members meeting once or twice a week, only when parliament is in session. Health alone accounts for nearly £ 14 billion a year in Scotland, the Scottish NHS employs over 160,000 staff, and the fields listed above cover a huge range of diverse activities. But to meet the above objectives the committee would also have to scrutinise activities in a far wider field. To give one example, public health involves adequate housing, heating, food standards, road safety etc, few of them the responsibility of the cabinet secretary for health and wellbeing. The origins of health inequality lie also in the areas of education, taxation and benefits, employment, local authority expenditure, transport and other government departments. Many government departments working in these fields are not even the responsibility of the Scottish government as they cover reserved issues and report to Westminster.
Could this workload be lightened? In one sense it should be extended because there is no mention in the above list of the need for post legislative scrutiny. In the past the fact that the Scottish Parliament had only recently been established meant that post legislative scrutiny was hardly required but now there is an increasing corpus of legislation which should surely be critically reviewed.
The only element which should be removed from the responsibilities of the committee is sport. The heading, 'physical health and well-being' encompasses all that is required for the health of Scotland. Sport, as a separate heading, tends to mean elite sport and it was obvious from evidence the committee took in session 3 that elite sport is very often far from healthy. The long term effects for those involved in the top levels of sport, football, rugby, athletics often result in permanent injury. Whilst many of the participants felt that this was a price worth paying for the success they experienced, it should not be the remit of a health committee to support this activity. We also found that in general success on the sporting field did not result in an increased number of participation by others at healthier levels as a result and that there was no evidence of any health gain from previous Olympic or Commonwealth Games investments. Yet in session 3 we devoted 25% of our time to sport, time which should have been spent on health topics.

2) My experience in session 3 was that health expenditure was presented in such an arcane way that it was impossible to scrutinise effectively. For example the territorial health boards swallowed up about two thirds of the health budget but reported financially at a different time, so this expenditure could not be investigated by the committee, or by the finance committee for that matter. This should be changed so that all health service expenditure is easily available for scrutiny.

3) The health committee has neither the experience nor the expert resources for effective scrutiny. In session 3, by chance, the committee had two medically qualified members, Dr Richard Simpson and myself, with experience between us of general practice in deprived areas, academic and research medicine, psychiatry, drug addiction and infectious diseases treatment. We also had a member with a social care background. I can point to questions asked of witnesses and aspects of legislation modified which benefited from that experience but that session was an exception and there were aspects of the vast field covered in which we had no expertise. Occasionally there are financial resources to recruit an expert adviser to consider aspects of budget or other matters but for most of the time we were reliant on advice from outside sources. The problem was that these sources very often had specific agendas of their own, or sometimes did not give the time and effort to advise when legislation was put out to consultation. I can give examples from session 3 of instances when specialist bodies failed to comment on sections of bills relating to their fields of expertise and which if unaltered would have resulted in flawed legislation.

So what is to be done?

Proposals that parliamentary committees should meet more often or have more members are non-

starters for a variety of good reasons. Even if this could happen there is no guarantee that members would have amongst them enough relevant expertise to function effectively.

In Westminster's bicameral legislature, the upper chamber has the role of scrutinising legislation from the elected chamber and hopefully contains a body of expertise that can assist in this process. No one is proposing such an arrangement in Scotland but what I do suggest is the formation of several extra-parliamentary special committees with members who have expertise in a particular area. The members could be recently retired senior figures in their field who still feel they have something to contribute. The Health Committee would appoint members and choose only those applicants whose input would be welcomed. Such extra-parliamentary committees could consider proposed legislation, the health budget, subjects passed to them from the Health Committee or topics which they identify as worth investigating. Members would not be paid but would receive administrative support. They would report to the Health Committee whose members would decide what further action, if any, need be taken. The benefit of such a system is that Health Committee members would then be able to focus on specific, identified areas worthy of parliamentary scrutiny rather than the haphazard choosing of topics that is the case today.

Over recent years I have mixed socially with recently retired health workers of every description and am certain that there are many who would welcome the opportunity to serve in this way, putting to good use the knowledge and experience they have gathered over the years.

I have made this suggestion in the field of health as this is my area of knowledge but I am certain that it could apply to other areas such as health and local government.

Hope this is helpful and I am happy to discuss further if required.