House of Commons

Health Committee

The Work of the Committee in 2004

First Report of Session 2004–05

HC 284

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Report, together with formal minutes

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Current membership

Mr David Hinchliffe MP (*Labour, Wakefield*) (Chairman)
Mr David Amess MP (*Conservative, Southend West*)
John Austin MP (*Labour, Erith and Thamesmead*)
Mr Keith Bradley MP (*Labour, Manchester Withington*)
Simon Burns MP (*Conservative, Chelmsford West*)
Mrs Patsy Calton MP (*Liberal Democrat, Cheadle*)
Jim Dowd MP (*Labour, Lewisham West*)
Mr Jon Owen Jones MP (*Labour, Cardiff Central*)
Siobhain McDonagh MP (*Labour, Mitcham and Morden*)
Dr Doug Naysmith MP (*Labour, Bristol North West*)
Dr Richard Taylor MP (*Independent, Wyre Forest*)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/parliamentary_committees/health_committee.cfm.
A list of Reports of the Committee in the present Parliament is at the back of this volume.

Committee staff

The current staff of the Committee are Dr J S Benger (Clerk), Keith Neary (Second Clerk), Laura Hilder (Committee Specialist), Christine Kirkpatrick (Committee Specialist), Frank McShane (Committee Assistant), Darren Hackett, (Committee Assistant), and Rowena Macdonald (Secretary).

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Contents

Report

1 Introduction

1. In 2004 the Health Committee had another busy and productive year. The highlights included the completion of a major inquiry on *Obesity*[1] and the commencement of another on *The Influence of the Pharmaceutical Industry* (expected to report in Spring 2005). Other inquiries were of varying lengths from one to four oral evidence sessions. We published the following reports:

First Report	*The Work of the Health Committee 2003* (HC 219)[2]
Second Report	*Elder Abuse* (HC 111)
Third Report	*Obesity* (HC 23)
Fourth Report	*Palliative Care* (HC 454)
Fifth Report	*GP Out-of-Hours Services* (HC 697)
Sixth Report	*The Provision of Allergy Services* (HC 696)

In addition we took evidence from the Secretary of State as part of our annual scrutiny of the Department's expenditure and from Lord Warner, Parliamentary Under-Secretary of State and from the Rt Hon John Hutton MP, Minister of State for Health, as part of our regular programme of questioning departmental Ministers about the whole range of their responsibilities. Table One shows the subjects covered by the Committee.

Table 1 - Subjects covered by the Health Committee 2004

Subject	Evidence Sessions in 2004	Outcome
Obesity	4	Report, May 2004
Elder Abuse	1	Report, April 2004
Palliative Care	4	Report, July 2004
GP Out-of-Hours	2	Report, August 2004
The Provision of Allergy Services	2	Report, November 2004
The Influence of the Pharmaceutical Industry	6	Report to be published
The Prevention of Venous Thromboembolism in Hospitalised Patients	1	Report to be published
Public Expenditure Inquiry	3	Evidence, October, November and December 2004
Ministerial Responsibilities	2	Evidence, March and May

[1] 71 witnesses providing oral evidence at 14 evidence sessions for the *Obesity* inquiry.

[2] All printing numbers refer to Session 2003-4

2. Much of our work in 2004 built on inquiries we conducted in previous years. In particular, we continued examining areas where present policy is deficient, concentrating again on the neglected areas of public health and social care. Our *Obesity* inquiry, which did a great deal to bring the subject to the attention of the public and Government, followed on from our previous important public health inquiries — into the tobacco industry and sexual health. The inquiries into elder abuse and palliative care continued our scrutiny of social care issues, particularly examining the links between social and health care. We have also, as in previous years, investigated deficiencies in services, for example in the provision of allergy services and the treatment of venous thromboembolism in hospitalised patients. Finally, we are proud of our record of investigating the work of Government Agencies and other public bodies. Notable work in this area included an examination of the Foods Standards Agency during the O*besity* Inquiry and a very thorough study of the MHRA in our second major inquiry of the year, *The Influence of the Pharmaceutical Industry*, following accusations that the organisation had failed to adequately assess a category of anti-depressants known as SSRIs.

3. During 2004 we undertook visits both within the United Kingdom and abroad, including a visit to the European Commission in Brussels. They form a key part of the Committee's work.

Table 2 - Visits by the Health Committee in 2004

Location	Purpose of Visit
Finland, Denmark, Sweden	Inquiries into Obesity, Elder Abuse and Palliative Care
Edinburgh	Inquiries into Palliative Care and GP Out-of-Hours Services and meeting with Members of the Scottish Parliament
Cardiff	Inquiry into The Provision of Allergy Services and meeting with Members of the National Assembly of Wales
Australia	Inquiry into the Influence of the Pharmaceutical Industry and follow-up to the inquiries into Child Migrants and Sexual Health
Brussels	Inquiry into the Influence of the Pharmaceutical Industry

4. The visit undertaken in February 2004 as part of our *Obesity* inquiry was particularly useful. It is often claimed that it is impossible for State intervention to improve people's eating habits or lead them to lead a healthier lifestyle. In Finland, we found this allegation disproved. We met the Minister for Public Health, officials in the Ministry of Social Affairs and Health and members of the Parliamentary Social Affairs and Health Committee. We also went to Helsinki University Central Hospital and a school where we saw children, who were given no choice of food, enjoying a healthy meal. We were able to gain insights into how the diet of a country which had once suffered from one of the highest coronary heart disease rates in the world had been transformed. In Denmark we met officials from the Ministry for the National Board of Health, including the Chief Medical Officer, and visited the town of Odense, where we were able to study how an advanced transport system, integrating cycle and pedestrian travel, had led the population to travel in a healthy way.

We would like to thank the FCO officials in Finland and Denmark for their exceptional helpfulness in organising this impressive programme.

5. We have taken advantage of visits to Edinburgh, as part of our *Palliative Care* and *GP-Out-of-Hours Services* inquiries, and to Cardiff during our inquiry into the *Provision of Allergy Services* to hold useful meetings with the Scottish Parliament's Health Committee and the Health and Social Services Committee of the National Assembly of Wales.

6. We would like to thank the Scrutiny Unit for the assistance provided by the staff to the Committee. During 2004 the unit provided briefing material and analysis for the PEQ and the *Obesity* inquiry.

7. Our work has also been facilitated by the helpfulness of the staff at the Department of Health, in particular those working in the Department's parliamentary section. They have kept the Committee informed of developments and ensured that the Department's memoranda to the Committee's inquiries have been produced on a time. We particularly appreciated the assistance provided to the Committee staff during the *GP Out-of Hour Services* inquiry and the continuing work in preparing the response to the public expenditure questionnaire.

8. On the other hand, we must record our disappointment at the Department's delay in producing the response to our report on *Obesity* which was published in May. We were informed that there would be a delay in replying since many of the answers would be addressed in the Department's White Paper on Public Health, a decision we accepted.[3] However, following the publication of the White Paper in November, 6 months after our report came out, there was a further, unexplained delay of four weeks before the publication of the Government's response. We see no good reason for this additional delay, which has affected the work of the Committee and delayed our debate in Westminster Hall on the report.

9. We were also appalled by the slow response in providing information to the Committee following an oral evidence session with the Secretary of State: on 8th December 2004 we were informed that we would be provided with the latest data relating to uncompleted Strategic Health Authority reviews of people wrongly charged for continuing care. The information was not provided until 24th January 2005.

Core Tasks

10. Select committees are obliged to perform a number of 'core tasks'[4]. Table 3, below, provides an indication of the tasks covered by each of our inquiries and other work performed by the Committee during the year. As the table shows most inquiries cover more than one of our core tasks.

[3] Department of Health, *Choosing Health: Making Healthy Choices Easier*, Cm 6374, November 2004

[4] See *Votes and Proceedings*, 14 May 2002

Table 3 - Core Tasks of the Health Committee in 2004

Inquiries	Objective A				Objective B	Objective C				Objective D
	Task 1	Task 2	Task 3	Task 4	Task 5	Task 6	Task 7	Task 8	Task 9	Task 10
Obesity	√	√		√	√	√	√		√	√
Elder Abuse	√	√					√			√
Palliative Care	√	√					√			
GP Out-of-Hours	√	√					√			
The Provision of Allergy Services	√	√					√			
The Influence of the Pharmaceutical Industry	√	√				√	√			√
PEQ	√			√	√	√	√			
The Prevention of Venous Thromboembolism in Hospitalised Patients		√					√			
Ministerial Responsibilities		√					√		√	
The Work of the Committee Report				√	√	√	√		√	

Objective A: To examine and comment on the policy of the Department

Task 1: To examine policy proposals from the UK Government and the European Commission in Green Papers, White Papers, Draft Guidance etc, and to inquire further where the Committee considers it appropriate

11. The Department's major publication this year was the White Paper on Public Health.[5] We are pleased that it incorporates many of the recommendations made in Health Committee reports on the tobacco industry, sexual health and obesity, as we discuss below.[6] We will be holding a short inquiry into its proposals, including an evidence session with the Secretary of State in February 2005.

12. We took advantage of our programme of evidence sessions with Ministers to question Lord Warner about star ratings, which were the subject of a consultation issued in February, entitled *Standards for Better Health: Health Care Standards for Services under the NHS*.[7] We examined the Secretary of State during the Public Expenditure evidence sessions on the review document, *Reconfiguring the Department of Health's Arm's Length Bodies*,[8]

[5] Department of Health, *Choosing Health: making healthier choices easier,* Cm 6374, November 2004

[6] See Section 4 – Impact of the Work of the Committee

[7] Department of Health, *Standards for Better Health: Health Care Standards for Services under the NHS*, February 2004

[8] Department of Health, *Reconfiguring the Department of Health's Arm's Length Bodies*, July, 2004

published in July 2004 and the White Paper published in June, entitled the *NHS Improvement Plan*.[9]

Task 2: To identify and examine areas of emerging policy, or where existing policy is deficient, and make proposals

13. More and more people are becoming obese, a condition linked to a wide range of diseases, such as heart disease, diabetes, renal failure, osteoarthritis and psychological damage. Only recently has it become a matter of serious concern to policy-makers and the policies are not yet in place to address the problems. Our report revealed a string of deficiencies and drew attention to the absence of co-ordination between Government departments over many years. In addition to the Department of Health we examined the activities of several other departments. We found that planning, urban design and transport policies have discouraged people from walking and cycling. In contrast to the situation in Finland, children have not been provided with healthy school meals. Indeed, junk food is openly sold in school vending machines and advertising unhealthy foods to children has been permitted regardless of the consequences. Our report enjoyed widespread recognition in the press and media, both nationally and internationally. We were pleased to see that many of the recommendations we made in the report were subsequently included in the Government's White Paper on Public Health.[10]

14. The Committee also undertook two inquiries which were concerned with deficiencies in social care, an area of policy perennially neglected by the Department. The *Elder Abuse* report highlighted the scandal that half a million elderly people are abused every year and the inadequate provision to deal with this very serious problem, in particular shortcomings in training. We also drew attention to deficiencies in the current provision of palliative care services during our short inquiry into this issue. We noted inequities by geographical area, by patient group and by disease group and made recommendations to improve the commissioning of palliative care by Primary Care Trusts (PCTs).

15. Deficiencies often arise where there is not a significant group of professionals to lobby on behalf of those suffering from a condition. This is what we found when we investigated the provision of allergy services. A rapid increase in the prevalence of allergy in England appears to have caught the Department unawares and both the provision and the commissioning of allergy services were found to be woefully under-resourced. We were surprised that the Government response still failed to acknowledge the need for major changes to address the problems.

16. The inquiries we are currently undertaking are revealing similar deficiencies. In our investigation of venous thromboembolism we have heard that this disease is the biggest killer of patients in hospitals: more people die from it than from MRSA and HIV/AIDS combined, but, we were told, the Department had been slow to act. Only recently has NICE been asked to draft guidelines.

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[9] Department of Health, *The NHS improvement plan: putting people at the heart of public services*, June 2004

[10] Department of Health, *Choosing Health: Making Healthy Choices Easier*, Cm 6374, November 2004

Task 3: To conduct scrutiny of any published draft bill within the Committee's responsibilities

17. Health Ministers published one draft Bill during 2004, the draft Mental Health Bill, which has been scrutinised by a Joint Committee of both Houses, assisted by the Scrutiny Unit. Two Members of the Health Committee — the Chairman and Dr Naysmith — have been members of the Joint Committee.

Task 4: To examine specific output from the department expressed in documents or other decisions

18. The Committee has undertaken a number of short inquiries to examine recent Government decisions. In 2003 as part of the introduction of the new GP contract the Government announced a re-organisation of GP out-of-hours services, to be fully implemented on 1 January 2005. In May 2004 we announced an inquiry into the likely effects of these changes. Our subsequent report highlighted concerns that insufficient thought had been given to the cost implications of the proposed changes. In the autumn of 2004 we decided to examine the effect of the proposed changes in charging arrangements for foreign nationals on the spread of HIV/AIDS. Two evidence sessions will be held in January and February.

19. The Committee has also been able to look at Government decisions as part of other inquiries. In 1997-98 our predecessor Committee undertook an inquiry into the welfare of child migrants. Responsibility for this was subsequently transferred to the Department of Education and Skills, which in 2004 proposed to reduce funding to the Child Migrant Support organisation. During the Committee's visit to Australia, in relation to the inquiry into the *Influence of the Pharmaceutical Industry,* we took the opportunity to meet child migrant organisations to discuss the proposal and on our return wrote to the Secretary of State for Education and Skills.[11]

20. We were also able to examine a number of recent decisions in our evidence sessions with Lord Warner and the Rt Hon John Hutton MP and with the Secretary of State. In particular, these sessions were a good vehicle for analysing recent decisions, notably changes in the NHS performance rating system.

Objective B: To examine the expenditure of the department

Task 5: To examine the expenditure plans and outturn of the department, its agencies and principal BDBPs

21. Each summer since 1991 the Health Committee has sent a detailed questionnaire to the Department— the Public Expenditure Questionnaire (the PEQ) which forms the basis of our annual scrutiny of Department of Health expenditure, providing the Committee and the public with an analysis of the Department's expenditure over the previous financial year.

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[11] Health Committee, Third report of Session 1997-98, *The Welfare of Former British Child Migrants*, HC755

22. The questionnaire is constantly refined, but we also ensure that some of the information sought remains unchanged from year to year to provide consistent time-series data. As a result many research institutions make use of the material. The Department devotes much time and effort to completing the questionnaire, for which we are most grateful.

23. Once the Department has returned the answers to the questionnaire oral evidence is taken from officials and the Secretary of State. In this year's session we were able to pursue serious concerns about the financial situation of a newly-established Foundation Trust and were astonished that it had run into such serious financial problems so soon after its application was approved.

24. We also examined the Government's measures for increasing choice and reducing waiting lists. We were particularly interested in examining the additional capacity needed to achieve this end and the cost implications of providing it. We questioned Ministers and officials about reports of NHS capacity lying empty while increasing use was made of the private sector. In previous years the Government established 27 NHS treatment centres and more recently has set up a number of private independent sector treatment centres (ISTCs). According to Department of Health officials the number of ISTC episodes of treatment will rise dramatically from approximately 3,000-4,000 in 2002-03 to about 248,000 episodes 'for this year coming into next year'.[12] Reports in the press have claimed that this has led to unfunded spare capacity in NHS treatment centres with Ravenscourt Park in Hammersmith having 4,000 spare slots remaining for the current financial year, and the Kidderminster centre 2,000. As a result, surgeons, nurses and theatres are under-employed, and because the centres are running part-empty, their costs are rising. The Committee questioned the Secretary of State on this subject, who replied that the occupancy rate was between 78 and 81 per cent against an optimum level of 82 to 85 per cent. The Committee contends that this occupancy rate relates only to acute general hospitals where an occupancy rate of 85% is advisable to reserve capacity for emergency and unpredictable admissions. It does not relate to Treatment Centres on sites remote from acute general hospitals that do not admit emergency patients. We are seeking to resolve this disagreement in correspondence.

25. We also questioned the Department about the premium for using the private sector. We were told:

> 'We can only make direct cost comparisons for expenditure that is covered by the 2002/03 reference cost data. This shows that for £100m of activity purchased by the NHS from the independent sector the equivalent NHS cost would be £70m, so the premium for commissioning this activity from the independent is £30m. We would expect this disparity to reduce considerably as longer term commercial arrangements between the NHS and the independent sector for the treatment of NHS patients come on line.'

The Secretary of State agreed that there was a cost, but added

[12] PEQ inquiry, 28 October 2004, Q72

> 'The reality is that we are going through the most massive transformation of any organisation anywhere in the world in the public or private sector. The last person to try anything like this was Gorbachev…'

26. Many of our other inquiries have of necessity been concerned with expenditure and, in particular, whether the Government had adequately thought through the spending implications of its decisions. We drew attention in our report to the problems which we feared might arise as a result of the new arrangements for GP out-of-hours services and we questioned the Rt Hon John Hutton MP about the implementation and cost of the National Programme for IT currently being implemented throughout the NHS.

Objective C: To examine the administration of the department

Task 6: To examine the department's Public Service Agreements, the associated targets and the statistical measurements employed, and report if appropriate

27. Throughout our inquiries we were able to examine some of the very large number of Departmental Public Service Agreement (PSA) targets. While the number of PSA targets currently being monitored by the Department has been reduced from 55 to 39 it is still large, making it impossible for the Committee systematically to examine all agreements. The situation is unlikely to be improved in the foreseeable future since the 2004 Spending Review is likely to add additional PSA targets in 2005.

28. In 2002 there were 12 categories of target. Most were addressed in the annual expenditure review, notably those relating to waiting times (Targets 1 to 3), and that requiring improvements in value for money brought about by increased efficiency (Target 12).

29. Others were considered during our other inquiries. Target 6, which seeks a substantial reduction from the major killer diseases by 2010, was examined in the *Obesity* inquiry. Target 11, seeking to reduce health inequalities by 10% by 2010 was a matter we considered in our inquires into *Palliative Care*, *Elder Abuse* and the *Provision of Allergy Services*, *Obesity,* which all highlighted health inequalities. Target 3, relating to access to a primary care professional was examined in our *GP Out-of-Hours* inquiry. Target 8, to improve the quality of life and independence of older people was examined in our inquiries into *Elder Abuse* and *Palliative Care*.

30. Throughout the Parliament the Committee has been concerned about the proliferation of targets, in particular with two main problems which this has produced. First, the NHS concentrates on those problems for which a target exists; the corollary is that if there is no target relating to a problem it tends to be ignored. We noticed this situation in relation to sexual health inquiry in 2002-03 and found a similar situation when we undertook our O*besity* inquiry this year. Secondly, the targets have perverse consequences. The requirement placed on GPs to see patients within 48 hours has led some GPs to refuse to allow patients to make appointments more than 48 hours in advance, thus making it much more difficult for those who want routine consultations to plan their lives. We are pursuing this problem as part of our PEQ inquiry.

Task 7: To monitor work of the department's Executive Agencies, NDPBs, regulators and other associated bodies

31. The Department has responsibility for a large number of executive agencies, NDPBs, regulators and other bodies. This year there have continued to be significant changes: here the organisational structure was altered; there a new body was created and an old abolished; elsewhere responsibilities were transformed. We have attempted to keep pace with the many changes during the course of the year and question the reasons for them and the likely consequences.

32. We held informal meetings with the incoming Chair and Chief Executive of the Healthcare Commission, as it prepared to take on the responsibilities of Commission for Health Improvement (CHI), which was abolished on 31st March 2004. We also questioned Lord Warner about these changes. In December we also had an informal meeting with the Commission for Social Care Inspection (CSCI), formed in April 2004, which took over from the Social Services Inspectorate.

33. In the course of our inquiries we have frequently called NDPBs before us to account for their actions. As Table 4 shows several appeared before the Committee on more than one occasion. In the *Elder Abuse* inquiry we examined and made recommendations to improve the operation of the National Care Standards Commission, CHI, the General Social Care Council, and the Commission for Social Care Inspection (CSCI). During the course of the *Palliative Care* inquiry we looked at the work of the National Institute for Clinical Excellence, CSCI, and CHAI. The Patient and Public Involvement (PPI) forums have been a constant source of concern. We have been informed on a number of occasions that they are less effective than the institutions they replaced. During the PEQ inquiry we questioned the Secretary of State, Rt Hon Dr John Reid MP about these matters and we are delighted that he agreed to re-examine the issue.

34. The Committee's current major inquiry, which is looking at *The Influence of the Pharmaceutical Industry* inquiry, amounts to one of the most thorough examinations of an NDPB the Committee has undertaken. In each of first seven evidence sessions we heard other witnesses' serious concerns about the effectiveness of the MHRA, the regulator of the industry, and in the two last evidence sessions will question the MHRA itself and the Minister.

	Inquiry						
Bodies Scrutinised	Obesity	Elder Abuse	Palliative Care	The Provision of Allergy Services	The Influence of the Pharmaceutical Industry	The Prevention of VTE in Hospitalised Patients	GP out-of-hours
National Institute of Clinical Excellence	√		√	√	√	√	
Commission for Health Audit and Improvement		√	√	√			
Commission for Social Care Inspection		√	√				

National Care Standards Commission		√	√				
Food Standards Agency	√						
National Specialist Commissioning Advisory Group				√			
General Social Care Council		√					
NHS Direct							√
NHS Alliance							√
MHRA					√		
Committee on Safety of Medicines					√		

Task 8: To scrutinise major appointments made by the department

35. None of our inquiries this year directly scrutinised major appointments made by the Department, but we did meet the chairman and chief executive designate of CHAI, Professor Ian Kennedy and Anna Walker respectively, about two weeks before the body was formally constituted. In December, about six months after CSCI was set up, we had an informal meeting with the Chair Dame Denise Platt and Chief Inspector, David Behan.

Task 9: To examine the implementation of legislation and major policy initiatives

36. The Health and Social Care Act 2003 established the Healthcare Commission. The Committee examined Lord Warner about the changeover from the Commission for Health Improvement to the new Commission for Healthcare Audit and Inspection (now known as the Healthcare Commission) just before the transition was formally made on 1 April 2004.

37. The Act also gave the Secretary of State the power to establish Foundation Trusts. The Committee examined the issue in detail in its inquiry into Foundation Trusts in 2003.[13] The Trusts were set up on 1st April 2004 and we have continued to press Ministers about their work and, in particular, the severe financial problems which are being faced so soon after their establishment. We also questioned Ministers about commissioning arrangements for specialised services, about which guidance was given by the Department in *Shifting the Balance of Power: the Next Steps.*[14]

38. As a result of the new General Medical Services contract, which was agreed in 2003. GPs are now able to opt out of the obligation to provide out-of-hours care for their patients. As of 1 January 2005, GPs will have the right to opt out in all but exceptional circumstances. Where GPs opt out, responsibility for securing out-of-hours services for

[13] Health Committee, Second report of Session 2002-03, *Foundations Trusts*, HC395

[14] Department of Health, *Shifting the Balance of Power: the Next Steps*, January 2002

their patients transfers to the PCT. Our inquiry into *GP Out-of-Hours Services* examined the probable consequences of this change in policy; the potential impact on services to the patient; how prepared the PCTs are for this new responsibility; whether opportunities to improve services are being exploited fully; and whether risks are being managed.

Objective D: To assist the House in debate and decision

Task 10: To produce reports which are suitable for debate in the House, including Westminster Hall, or debating committees

39. Two of the Committee's reports – on *Sexual Health*[15] and *Elder Abuse* - were debated in Westminster Hall during the course of the year. The *Sexual Health* debate was particularly well-attended and several Members who were not members of the Committee spoke. We had hoped for a debate on the *Obesity* report during 2004 but it was delayed because of the late publication of the response from the Department. This important report will now be debated on 10th February.

Innovations in working methods

40. The Health Committee took advantage of visits to Edinburgh and Cardiff to hold informal discussions with Members of the Scottish Parliament's Health Committee and the Health and Social Services Committee of the National Assembly for Wales respectively. The meetings provided an opportunity for Members not only to discuss their work and topics of mutual interest, but also to explore different working methods. We hope that similar meetings will take place in the future.

41. In our inquiry into Obesity we examined a health issue which relates to the work of many departments. Indeed, we found that other departments were in a better position to affect obesity and improve fitness than the Department of Health. We took evidence from the Departments of Culture, Media and Sport, Education and Skills, the Office of the Deputy Prime Minister, the Department for Environment, Food and Rural Affairs, and the Department for Transport and in our report stressed the obvious: that there has to be much better co-ordination between departments.

Impact of the work of the Committee

42. Inevitably, it is difficult to assess the impact of any select committee. A simple measure is the number of recommendations the committee makes which are implemented by Government. Some of our reports were largely accepted: many of the recommendations made in the *Obesity* report (for example, in respect of a health promotion campaign on obesity and a new labelling system for food) and of our earlier *Sexual Health* report[16] were

[15] Health Committee, Third Report of Session 2002-03, *Sexual Health*, HC69

[16] Health Committee, Third Report of Session 2002-03, *Sexual Health*, HC69

included in the Government's White Paper on Public Health.[17] Indeed the White Paper can be seen as the product of a dialogue between the Committee and the Department..

43. Another, probably more important measure of the Committee's work, is its ability to act as a major forum for addressing significant health issues. The Committee has done an impressive job in raising awareness and stimulating debate, especially when it has concentrated on examining deficiencies in existing policies. The *Obesity* Inquiry focussed attention on a subject too long neglected by the Government and generated considerable public interest. It was widely reported, in the UK and abroad, and an extensive debate about its recommendations followed. The inquiry showed the select committee system at its best. The inquiries into *Elder Abuse* and *The Provision of Allergy Services*, also highlighted issues that previously had been of low prominence. We were very pleased that, in acknowledgement of the Committee's role in investigating crucial issues facing older people, the Chairman was presented with the ePolitix Older People Champion Award for 2004.

[17] Department of Health, *Choosing Health: Making Healthy Choices Easier*, Cm 6374, November 2004

Formal minutes

Tuesday 27 January 2005

Members present:
Mr David Hinchliffe, in the Chair

Mr Keith Bradley
Dr Doug Naysmith
Dr Richard Taylor

The Committee deliberated.

Draft Report (The Work of the Committee in 2004), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 43 read and agreed to.

Resolved, That the Report be the First Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

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[Adjourned till Thursday 3 February at 10.00am

Reports from the Health Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2003–04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111 (Cm 6270)
Third Report	Obesity	HC 23
Fourth Report	Palliative Care	HC 454 (Cm 6327)
Fifth Report	GP Out-of-Hours Services	HC 697 (Cm 6352)
Sixth Report	The Provision of Allergy Services	HC 696

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)
Eight Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 (Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515 (Cm 5611)
Third Report	Delayed Discharges	HC 617 (Cm 5645)