

ASSOCIATION · OF

COMMUNITY HEALTH COUNCILS

FOR · ENGLAND · & · WALES

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'THE HEALTH OF THE NATION' A RESPONSE FROM THE ASSOCIATION OF CHCs

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ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

DRAFT RESPONSE TO THE GOVERNMENT'S GREEN PAPER "THE HEALTH OF THE NATION"

SUMMARY

- l RESOURCES: Many of the targets are not backed up with a strategy for achieving them and a commitment to the necessary resources.
- 2 **POVERTY:** The Green Paper does not address the link between poverty and ill-health. We recommend that the Government reconsider the recommendations of the Black Report for improving the health of the least well-off.
- 3 CONSUMERS: There should be full local consultation with the CHC, voluntary organisations and self-help groups when District Health Authorities set local targets.
- 4 SMOKING: ACHCEW urges the Government to reconsider its opposition to the proposal for an EC directive to ban cigarette advertising.
- 5 **DIET:** The targets on diet and obesity are fairly ambitious but there is little explanation as to how they will be met.
- 6 ALCOHOL: Increased resources for alcoholism counselling services are necessary.
- 7 REHABILITATION: ACHCEW proposes that a target is set to raise the ratio of employment of disabled persons in relation to regional employment levels.
- 8 MENTAL HEALTH: District-based services for community care cannot be developed cheaply. Increased resources are needed to bridge the gap from institution-based care to community care. Targets for quality and effectiveness of mental health services must be user-led.
- 9 INFANTS AND CHILDREN: Additional targets should be set for levels of provision of school health services, community dental services and availability of school meals.
- 10 PREGNANT WOMEN: Additional targets may be set, for example, for numbers of women whose health is affected by contraceptive devices and sterilisation.
- 11 HOUSING: Targets should be set for a reduction in the use of Bed & Breakfast accommodation for homeless people. More fundamentally, resources should be committed to increase the rate of building of social housing to the level recommended by the Institute of Housing.
- 12 ENVIRONMENT: Greater progress should be made in meeting EC drinking water and bathing water standards.

SCOPE AND NATURE OF THE PROPOSED TARGETS

ACHCEW welcomes the Government's initiative to introduce targets for health and health care. It is now widely recognised that targets for health could provide a useful tool to define goals, monitor effectiveness of policies followed and measure achievements. We are concerned, however, that the proposed targets are not linked to specific proposals or commitment to new resources to improve health or to increase the rate of improvements in health.

This is reflected in some of the specific targets, which seem likely to be fulfilled, or nearly fulfilled, on present trends. For example, the targets for mortality from coronary heart disease and strokes do not differ markedly from current projections. In these and a number of other areas suggested for targets in the document we would like to see more ambitious targets.

For a number of other areas the targets suggested are quite challenging, for example, those for smoking, diet, and alcohol. However, it is unclear how the targets for these areas will be achieved, in that strategies, specific proposals and resources to meet the targets are absent in the document. We are particularly concerned that the section on mental health makes no commitment to or recognition of the considerable resources necessary to provide care in the community services as an alternative to institutional care over the timescale suggested.

We would suggest that the targets for each area are made much more explicit as to the extent of improvement or increase in rate of improvement that is necessary to meet the target, together with a strategy and resource implications for achieving this.

We note that many of the health targets proposed in the Faculty of Public Health Medicine's document 'Levels of Health' set higher standards than the Green Paper and the document contains more discussion of measures necessary to meet these improvements in comparison to the Green Paper. For example, in the areas of smoking prevalence, alcohol consumption and birth control the Faculty document suggests higher targets and sets out a strategy for attaining them. In the main, where the Faculty have set higher targets and justified them, we would support these in preference to the Green Paper targets.

ACHCEW suggests that 'The Health of the Nation' should be followed up by a comprehensive plan for action relating to each of the targets. A vast amount of excellent work has already been done in this field, notably in The Black Report (1980), The Health Divide (1987) and The Nation's Health (1988).

The latter publication makes numerous recommendations for action for the health issues it covers, many of these topics coincide with those covered in the Green Paper. These should all, we believe, be re-assessed. The Nation's Health sets many targets, directly comparable with those of the Green Paper, which are in

many cases more challenging. It also puts far more emphasis on the responsibility for public policy to encourage healthy lifestyles, to reduce risks to health and to increase the use of preventive techniques.

The Black Report's recommendations also merit a full reevaluation in the light of the Government's proposals; in
particular, the emphasis on improving children's health and the
long-term benefits this may have in reducing health inequalities
as a whole. One of the main weaknesses of the Green Paper is
that it does not address the relationship between poverty and
ill-health and the considerable inequalities in health between
social classes. This is particularly disappointing since much
groundwork has already been done for a strategy to reduce
disparities in health across occupational classes (The Black
Report, The Health Divide, The Nation's Health).

TARGETS FOR EQUITY?

Equity is, as the Green Paper points out, the first principle of the 'Health for All' initiative and is the common element of nearly all other countries' strategies that have adopted the WHO targets.

If health targets are to be set, we believe they should reflect what is happening to all sections of the population. It would for example, be quite possible to meet a target without any improvement in health for the poorest social classes. The national prevalence of lung cancer, for example, tells one nothing of the huge variations in incidence between regions and between social classes. Many of the indicators for which targets have been suggested, for example low birthweight and maternal mortality rates are known to be very closely tied to social class, so to exclude this dimension in target setting does not, we believe, provide clear objectives as to how the health of the nation should improve. Where feasible, there should be appropriate targets for social classes or for aggregated manual and non-manual groups.

We are concerned by the very brief reasons given on page 105 for excluding targets for health inequalites. This implies that no action is possible to improve the situation and even that no improvement is necessary. There are a number of points we would like to make on this issue:

First, if one accepts an important relationship between poverty and ill-health as did the Secretary of State recently (Hansard, 4/6/91) and as is implicit in the Green Paper, then recent statistics on the widening gap in income between the rich and poor over the past decade become all the more alarming. The report commissioned by the House of Commons Social Security Select Committee (Low Income Statistics: Households Below Average Income Tables, 1988) shows that, on the most favourable interpretation, the income of the poorest tenth of the population rose by only 2%, compared to 33.5% for the population as a whole between 1979 and 1988. We believe that Government action to

reduce income inequalities is essential to improve the health of the nation. The brief discussion of social security arrangements on page 24 is wholly inadequate in relation to the importance of the level of state benefits and at whom they are targetted.

Secondly, there is much research that indicates that all social classes are not benefiting equally from the overall improvements in health. The Green Paper states that there is a "persistent gap" in death rates between social classes with the implication that there will at least be some benefits for all. Yet there is a wealth of evidence that points towards widening inequalities in health in many of the important areas addressed in the Green Paper - coronary heart disease, lung cancer and circulatory diseases. For example, Marmot & McDowall (Lancet, ii, 274-6, 1986) showed that in coronary heart disease while there was a decline in CHD mortality in men from non-manual classes in every region (1970/72 - 1979/83), but only in Wales was there any appreciable decline among men in manual classes. While the causes of areas of increasing health differences are not fully understood there is a consensus that poverty is an important We would, therefore, like to see a commitment in a factor. White Paper to monitoring and targets in this area, coupled with the establishment of pilot project areas for the Black recommendations for a reduction in child poverty and resources for further research in this area as a whole.

Thirdly, the Green Paper should acknowledge and address the widely recognised problem that the groups in the population most at risk are often the least likely to present for preventive screening services or to have health education available to them. There is little mention of this in the document where it discusses targets for the take-up of preventive screening services (breast and cervical cancer screening and blood pressure screening) and in relation to a number of other targets such as those for smoking, diet and alcohol which are also presumably to be achieved through increased awareness of health-damaging behaviour.

Preventive screening services and health education must, therefore, put special emphasis on the most at-risk populations and design their services to target problem areas in uptake of the service.

For example, with respect to cervical cancer, evidence shows that women in manual classes, and in particular those whose husbands have certain types of manual jobs, have greatly increased risks of developing the disease (Occupational Mortality, Part 1, 1986), yet people in manual occupations are known to make less use of cervical cytology services (Marsh and Channing, BMJ, 1986, 292, p 1173). Another important risk factor for cervical cancer is thought to be smoking, yet smoking among women in social classes IV and V actually increased between 1986 and 1988 (OPCS, SS90/2) while smoking prevalence continued to decrease in other groups.

Fourthly, it is disappointing that the Green Paper does not fully address the issue of health inequalities since a lead has already taken by many Health Authorities' Directors of Public Health in

this area. Many annual reports highlight local inequalities and make practical recommendations for health authority action and work with local authorities and community organisations on this issue. Exeter HA report, for example, the winner of the King's Fund award for the best annual report for 1990, includes targets on reductions in smoking prevalence across all social classes. ACHCEW is keen that this emphasis in many reports will continue whether or not 'equity' is included in the national targets.

CONSUMER INVOLVEMENT

The WHO 'Health For All' initiative suggested that community participation was an essential element of the attainment of the health goals it proposed. The Health of the Nation goes some way toward acknowledging a role for public participation in the health targets it sets out. On page 4 it states that the strategy "means involving people more at both strategic and operational level in discussion and decisions about options and priorities". ACHCEW is extremely interested to know what form, precisely, this consumer involvement will take at the various levels suggested and what specific role has been considered for Community Health Councils to play in this.

We believe that it is vital that there is full local consultation with the CHC and self-help and voluntary groups when District Health Authorities set local targets. CHCs should be consulted on the range of proposed targets at a local level and given an opportunity to put forward their view of priorities for health and health care and comment on established health authority priorities. CHCs have invariably built up a network of local voluntary and community organisations with an interest in health. Many CHCs also play an important role in drawing attention to the needs of less articulate groups of health service users and highlighting the importance of less glamorous parts of the health service. ACHCEW believes it should be a priority for health authorities to tap into CHC expertise in order to begin a dialogue on local health targets and key issues.

We are very concerned that there should be a recognition of the work already being undertaken by CHCs across the country in assessment of DHAs' plans for health care and commissioning NHS services. Many CHCs are involved in giving a consumer appraisal of their District Health Authorities' plans for health service contracts. This involves the following aspects:

- * Contributing the CHC's views on unmet health needs;
- * A consumer perspective on the commissioning options;
- * Drawing up quality standards for inclusion in NHS contracts;
- * Monitoring the standards of services;
- * Involvement in DHA decisions to continue contracts.

Many CHCs also have close links with their Directors of Public Health and are having an input in various ways into Annual Reports of DsPH. CHCs' consumer and user surveys and issues put forward by CHCs have been included in DsPH annual reports. In this way many CHCs are showing themselves to be a very important channel for consumer feedback and opinion to District Health Authorities.

ACHCEW is interested in the suggestion that FHSAs should "establish consumer groups to feed into the planning process" (page 49), although it is far from clear how such groups would relate to CHCs and whether they would duplicate their role or contribute some additional user input to service planning. It is also unclear why this has been proposed in relation to FHSAs only and not to DHAs.

We are concerned that there is little explanation of the status, membership and accountability of the 'English Health Strategy Steering Board'. How has this Board been established? If it is to be instrumental in setting the areas for targets for health care then there needs to be openess and concensus in the way it operates. As the foreword by the Secretary of State recognises, "a strategy imposed by Government....is valueless".

COMMENTS ON TARGETS SUGGESTED FOR KEY AREAS

SMOKING

ACHCEW urges the Government to reconsider its position regarding further restrictions on tobacco advertising and sponsorship. There is an almost universal concensus within the health service and across a wide range of other organisations that the UK should support the EC move to ban all cigarette advertising except at the point of sale. The potential benefits to the nation's health of strong measures to reduce smoking are illustrated dramatically in the Green Paper, for example, smoking contributes a third of all deaths in middle age (40 - 64 yrs). However, the Government is apparently not as prepared as our European partners to take steps that would almost certainly increase the rate of decline of smoking prevalence. While we welcome the new labelling requirements for tobacco packaging we cannot stress strongly enough our view that the Government must take the further step of banning cigarette advertising. Not to do so risks undermining all other efforts to reduce smoking.

It is extremely worrying that the rate of the reduction in smoking prevalence appears to be slowing down. There is no discussion of this fact in the Green Paper and there is no recognition that extra resources will almost certainly be necessary in this area to maintain reductions in smoking. The target for smoking is quite ambitious in the light of current trends. We are unclear as to how the targets suggested will be met without any specific additional measures and resources to reduce smoking. While we generally support the target levels

suggested we believe that a number of measures, in addition to banning cigarette advertising, are urgently needed to achieve them:

- 1) Government support for legislation to protect the right of persons to a smoke-free environment at work;
- 2) Full implementation and monitoring of EC directive on tobacco product labelling by 1992;
- 3) Implementation and enforcement of EC directive on smoking in public places;
- 4) Extension of these principles to cover all Government and public sector offices and workplaces by 1995;
- 5) Duty on tobacco products to be raised in real terms each year to increasingly reduce their affordibility in relation to average income and the effects of this to be monitored carefully;
- 6) The Health & Safety Executive to set a target of half of all UK employers to have a full smoking policy within two years.

ACHCEW also supports the Faculty of Public Health Medicine target for smoking prevalence among pregnant women - half the prevalence rate for women as a whole by 2000. Health services for women during and previous to pregnancy provide good points of contact for smoking advice and counselling and other relevant health promotion.

There is considerable emphasis in The Health of the Nation put on reducing the numbers of young people taking up smoking. The planned reduction for 16-19 year olds is from 28% to 20% (men and women) yet over the period 1980-1988 there have only been reductions of 4% from 32% to 28% (OPCS SS90/2). There is also some evidence that early teenage smoking is no longer falling (Schools Health Education Unit, Exeter University, 1991). Thus, we are particularly concerned that the only specific measure to reduce smoking is the existing HEA Teenage Smoking Programme.

Targets for smoking need also take into account social class differences in smoking prevalence. These differences are not "fixed" or immutable but have changed quite considerably over the last decade. Most significantly, the smoking rate for women in all manual occupational classes has "flattened off" at about 36% since 1984 according to the General Household Surveys. The rates for women in social classes IV and V actually increased by several per cent between 1986-1988. Most other groups have continued to experience some reduction in smoking prevalence although the rate of decrease appears to be slowing down. is concerned that targets must be set to continue to reduce smoking across all occupational classes as they have been set across age groups. 'Levels of Health' argues that the targets for smoking are unlikely to be met unless the difference in smoking prevalence between social classes is reduced.

DIET

The targets for diet relating to reductions in the intake of saturated fatty acids and total fats are challenging but it is not clear how these improvements will be achieved. We suggest two practical measures that would contribute to meeting the target:

- Compulsory labelling of all packaged food items and unpackaged items where feasible with fats, protein and salt content. This could also apply to restaurant meals, snack bars and other food premises;
- 2) Dietary standards of food provided in all Government and public sector catering premises to meet the standards and recommendations of the COMA report.

The presentation of the targets for diet would benefit greatly if the targets were translated approximately into changes in consumption of food items. The targets as they stand would be meaningless to most members of the public although it is largely through changing peoples' awareness of diet and improving levels of knowledge that progress will be made. Targets might be usefully set for the UK as a whole as follows:

- * % reduction in sugar consumption
- * % increase in wholemeal bread
- * % increase in fresh fruit and vegetables
- * % reduction in fats such as butter and lard

ALCOHOL

We note that the target for the number of men consuming over the recommended number of units of alcohol is a reduction of one third of the present number. A great deal of good work has been done to devise effective community alcohol strategies and extremely good models of this exist (Exeter Health Authority is a case in point). However, this is not seen as a high priority by some health authorities and services for counselling those at risk or alcohol-dependent are not readily available in many areas. Development of such services will demand considerable resources and therefore this area in particular will require careful monitoring if it is chosen as a key area to ensure that health authorities devote to it the necessary funding.

We also suggest the following targets which would provide important measures of success of reduction in alcohol consumption:

- 1) A target for reduction of cases of cirrhosis of the liver over a relatively long time span, to 2005 or 2010;
- 2) A target for reduction of alcohol-related traffic accidents;
- 3) A target for reduction for alcohol-related accidents in the workplace. This would need to be drawn up together with a greater emphasis from the HSE for employers to devise alcohol policies;
- 4) 'Process targets' on the affordibility of alcohol over the period to 2005 for which the other targets relate. Duties should be used to maintain and increase the price of alcohol relative to average income.

ACCIDENTS

The classifications for severity of accidents used by the Health and Safety Executive seem perfectly adequate for the purpose of target setting. This employs three categories of severity:

- fatalities
- major non-fatal injuries
- "over three day" injuries (not major but requiring more than 3 days off normal work).

We would suggest that separate targets are set for domestic, traffic and occupational accidents. In addition, it would be useful to set targets for each commercial/industrial sector. The targets need to be specific so that the relevant bodies are fully aware of the contribution they can make to accident prevention.

REHABILITATION SERVICES

We believe that it is particularly important that targets for rehabilitation services at a local level are drawn up in close consultation with the patients or service users involved. Disabled individuals may often have their own targets and service-wide targets should represent, as far as possible, the aspirations of the people involved.

The ability of people with disabilities to take up employment is extremely important, not least, for the economic and social benefit it brings to the individual. A target could be set to raise the ratio of employment of disabled persons in relation to regional employment levels.

For those people not able to take paid employment there needs to be some measure of the level of provision for useful occupations and constructive activities.

The suggested target for pressure sores is welcome although we would suggest the following further requirements on health

authorities and providers:

- * ACHCEW is aware that some patients developing pressure sores in hospital are not treated because it is 'outside the consultant's responsibility' and may increase the length of the patient's stay in hospital. Patients developing pressure sores in hospital must receive full care and treatment during the course of their stay in hospital.
- * No patient should leave hospital having developed pressure sores without full arrangements for monitoring and treatment.

The recent DoH review of incontinence services is a welcome step to improving this area and ACHCEW will be keen to see that the recommendations are put into action. We note, however, that the problem of varying and inadequate levels of provision of incontinence aids in some health authorities has not been fully addressed. We continue to be concerned that people cared for in private nursing homes often have great difficulty in obtaining appropriate or adequate incontinence aids.

We would also recommend that a much greater emphasis is placed generally on training for hospital staff to improve patient continence, an area where there is scope for improvement in patients' dependence on aids.

MENTAL HEALTH

The transition to a district-based service is assumed to be an automatic improvement in mental health services. While, of course, care in the community has the potential to be a vastly more humane and appropriate way of providing care to people with a mental illness it will only be so if it is properly resourced. Adequate community care facilities must be in place to cater for the closure of institutions. We are aware of Ministers' commitments to this but we remain extremely concerned that people discharged from the large psychiatric institutions are subsequently falling through the net and are not receiving the necessary support and care in the community. The considerable number of homeless former inpatients of institutions is evidence Those such homeless persons housed, in most cases temporarily, by local authorities could not in most cases be said to be in appropriate surroundings.

The "single measurable target" given is that the current resources spent on specialist psychiatric services are gradually given over to funding district-based services. This, however, does not take account of two fundamental issues that have long been apparent. First, care in the community is a more expensive option than care in large institutions and resources will need to increase year on year in order to effect the closure all the remaining large hospitals. Secondly, in order to provide care facilities in the community in advance of closures bridging funds, loans at the very least, are essential for health authorities to develop a district-based service. The Mental Illness Specific Grant is, in reality, a tiny fraction of the

resources necessary to develop provision for community care as the Government would accept.

We fully support the commitment to the development of facilities for asylum for seriously disabled and ill people before the closure of all the remaining large mental hospitals and we would wish to see further details of the proposed timetable for this.

On the question of targets for improvements in mental health we have a number of points to make:

- * We are unhappy with the statement (J.8 page 87) that "objective measures of describing... outcomes of care" are the priority in mental health services. Outcomes of such services are essentially subjective: the most important point is how users of services feel that they may have benefited from services. A great deal of work from MIND and Good Practices in Mental Health recently has detailed the need for a philosophy of "user-involvement" in mental health services and how it may be practised.
- * Related to the above point, "unambiguous monitors of progress" (J.9 page 87) are unlikely ever to be developed for mental health services.
- * Targets set must be "user-led" and empower individuals to set their own targets. This will crucially involve giving serviceusers real choices over their course of treatments and therapies. There must, for example, be readily available alternatives to ECT or neurolaptic drugs where the individual wishes it.
- * Outcome measures for mental health services will have to take account of the fact that some patients with severe and chronic illnesses can, at best, only be 'maintained' at certain levels of health. If outcome measures do not take account of this they will quickly be discredited.
- * There is a great deal of improvement that can be made in acute mental illness services in, for example, District General Hospitals. We believe that it is generally most appropriate for acute mental illness wards to move as far as possible toward non-clinical and residential environments.

Several Community Health Councils have developed a monitoring programme designed specifically to scrutinise the process of closure of the large mental illness and learning disability institutions and to examine the relative benefits of the quality of care in the community, whatever form it may take. Such projects may be particularly important in the light of the attempts to set targets relating to the quality of care in the community and the improvements over institutional care. We would be very happy to pass on details of the project.

Many CHCs are closely involved with the development of district-based services for mental illness as well as other community care services. We feel it is extremely important that CHCs and

other consumer organisations continue to play a role in this respect. We would wish to see greater recognition of the role of CHCs and consumer organisations in the planning process and more emphasis placed on the input they may have. Likewise, ACHCEW will continue to have a role at national level.

LEARNING DISABILITIES

The issues of the closure of large institutions and the development of care in the community apply equally to people with learning disabilities. The fact that there is no mention of targets for people with learning disabilities implies that this is not thought to be an area of 'preventable ill-health'. There is, however, vast scope for improving the quality of life of people with learning disabilities, in particular, for improving access to appropriate day-centres and schools, providing useful work and activities and reducing the burden on informal carers. In terms of prevention, there are also means of increasing parents' knowledge of possibilities of giving birth to a disabled infant through (non-directive) 'genetic counselling'. We would be interested to know what priority is attached to services such as this.

INFANTS AND CHILDREN

There are many other important areas of child health other than the level of dental caries for which targets could be set. For example:

- * levels of childhood accidents, particularly traffic accidents for which there is a far greater risk to children of parents in manual classes;
- * Numbers of infants damaged at birth through medical accidents;
- * Availability of school meals;
- * Healthy standards for school meals (implement recommendations of COMA report);
- * Minimum levels of provision of school nursing services and community dental services;

PREGNANT WOMEN

Additional indicators for possible targets:

- * Numbers of women affected by adverse effects of contraceptive methods and sterilisation;
- * Numbers of women affected by adverse effects of reproductive technologies;

- * Prevalence of post-natal depression and other aspects of 'normal' morbidity during pregnancy;
- * Adverse effects of episiotomies and other avoidable techniques sometimes used during childbith;

The target for prevalence of breastfeeding is welcome but it is not made clear as to how this could be met and what success the Breastfeeding Initiative has made so far.

HOUSING

Numerous references are made to the importance of good housing for health but the discussion and targets for this issue are completely inadequate. Health problems associated with homelessness are now widely recognised and confirmed by authoritative research. For example, the ill-effects of the use of Bed & Breakfast accommodation, particularly on children, has been well documented. However, restrictions on alternative forms of temporary housing used by local authorities, namely privatesector leased properties, threatens to increase the use of Bed & Breakfast accommodation. A number of targets can be set in relation to the homelessness responsibilities of local authorities under the 1977 Housing Act.

We suggest the short-term target that the Government take steps to enable local authorities to reduce to zero the use of B & B other than for 28 days while necessary investigations are carried out (the maximum time for investigations suggested by the Audit Commission). In practical terms it would not be feasible in the short term to exclude children altogether from B & B but this short-term target would minimise the length of stay necessary.

Another area where we suggest a target may be set is to reduce the number of 'vulnerable' people, particularly those who have been discharged from a mental illness hospital, being placed in temporary accommodation, particularly B & B, but also council or other properties where they are unsupported or inadequately supported. The target should be to increase the number of such persons being referred on to appropriate permanent housing schemes.

In the long-term the housing problem requires a vast increase in the rate of building and in the availability of 'social housing'. We note that the Institute of Housing and Shelter estimate that 100,000 units of housing are required per year in comparison to the present level of about 40,000.

ENVIRONMENT

We have the following comments to make on the targets in this area:

Drinking water

The EC standards agreed in 1980 were to be achieved by 1985 but the UK has still not managed to achieve this. We would like to see increased commitment to meeting this standard. Rather than the suggested target that "most breaches of EC standard" should be remedied by 1995) all drinking water should meet the standard by 1995.

We also support the call for a review of the maximum permitted lead levels as suggested by Friends of the Earth.

Bathing water

The White Paper 'This Common Inheritance' promised to bring bathing waters up to EC standards by 'the mid-1990s'. In view of this, we would expect all (rather than "all but a few") bathing waters to reach the standard by 1998. Also, by this time we would expect to see full implementation of the requirement to display information on the quality of bathing water. We are also concerned that there should continue to be monitoring for viruses and salmonella in water quality sampling.

Sewage disposal

In order to meet the target for bathing waters we would like to see a speeding up of action as described in 'This Common Inheritance' to reduce raw sewage disposal in coastal waters. We would urge that all discharge of raw and basically treated sewage estuarial and coastal waters end by 2000.

Air pollution

We note that no target has been set for the control of the emission of carbon monoxide.

We also note that the target for reduction in emission of nitrogen oxides is not as ambitious as that agreed by 12 other Western nations - to make a 30% reduction by 1998. Nor is the target for the reduction of sulphur dioxide emissions as ambitious as that agreed by the UN ECE Convention on Long Range Transboundary Air Pollution's Sulphur Protocol (of which most Western nations are signatories) - to make 30% reductions by 1993.