

TABLE 4: Main source of information about vaccine

Source	Number of respondents
Doctor, baby health centre, or other health worker	9 (75%)
Friends or relatives	3 (25%)
Media	0
Total	12 (100%)

remainder (including the parent who refused the vaccine) cited friends as their information source. Interestingly none chose the media (Table 4).

The typical profile for the group was non-compliance due to an ill child (consistent with Lewis¹), belief that the vaccine was less dangerous than the disease and did not cause brain damage, and acquisition of vaccine knowledge from a health worker. As there was only one case (8.3%) in which non-compliance arose from vaccination fears, this was clearly not a major factor. The results indicate that the pertussis vaccine controversy has had little impact in Australia, but because of its size a larger study is needed for confirmation. However, these encouraging results should not be a cause for complacency. After all, "eternal vigilance is the price of freedom" — freedom from the scourge of pertussis.

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- 1 Six killers of children *World Health* 1967; 1: 111
- 2 Burgess MA. Immunisation indications for children. *Mod Med Aust* 1986; 29(5): 76-8
- 3 Cherry JD. The epidemiology of pertussis and pertussis immunization in the United States and the United States: a comparative study. *Probl Pediatr* 1984; 14: 7-77
- 4 Lewis K, Osburn LM, Lewis K, et al. Influence of child's age, knowledge and opinions on 12-month pertussis and pertussis vaccination rates. *Am J Dis Child* 1988; 142: 115-118
- 5 Radford J. Immunization in Australia: A continuing national challenge. *Med J Aust* 1988; 145: 143-145

Trends in prescribing of antihypertensive drugs in Australia

To the Editor: The article by Hurley et al. is an interesting analysis of our prescribing habits.¹ The authors provide an estimated annual comparison of monetary costs to the country for treatment with antihypertensives for the years 1977 and 1987. To do this they have used 1987 prices to calculate the 1977 annual costs.

It would be very much more valid if they could do the calculation of the 1977 costs using the actual 1977 prices and of course index those 1977 prices up to 1988 levels in line with the Consumer Price Index (CPI). I have no access to records of the earlier prices and would encourage this calcu-

lation by the authors or whomever to determine the *real* rise, assuming there has been a rise, in the monetary cost of antihypertensive treatment to the community.

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1 Hurley SF, Williams SL, McNeil JJ. Trends in prescribing of antihypertensive drugs in Australia 1977-1987. *Med J Aust* 1990; 152: 259-266

In reply: We thank Dr Daly for his comments. Actual 1977 prices were not available to us. However, it is not necessarily true that use of 1977 prices indexed to 1987 levels using the Consumer Price Index (CPI) would be more valid. The prices of Pharmaceutical Benefits Scheme (PBS) pharmaceuticals may not have changed in the same manner as the CPI, or even the medical CPI, because of the price negotiation processes of PBS and changing drug prices related to patients. In fact, by applying 1987 prices to 1977 drug usage data we have indexed 1977 usage to 1987 prices precisely.

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The case for introducing "standard drinks" labels on all alcohol containers

To the Editor: Ethyl alcohol is the only legally available drug which can be sold without any specification of the quantity of the drug present in a given container or package. The tar and nicotine content of cigarettes is clearly stated on all packets sold in Australia. Similarly, both the active ingredients and recommended dosages have to be displayed on all prescription and over-the-counter drugs.

Most recent authoritative estimates suggest that slightly fewer than 6000 Australians die each year as a consequence of alcohol consumption.¹ An increased risk of illness has been linked to the regular consumption of even moderate amounts of alcohol; for example, women who regularly drink three or more alcoholic drinks per day are more likely to suffer from liver disease.²

Current legislation only requires that the amount of alcohol in bottles and cans of drink is displayed as a percentage of total volume. This only informs consumers as to the relative strength of different drinks and not the actual amount of alcohol in a drink container.

Medical authorities have resorted to advising drinkers to limit their consumption of alcohol to amounts specified in terms of "standard drinks". For example, the National Health and Medical Research

Council recommends that women drink no more than two standard drinks per day and men no more than four.³

A standard drink is usually defined as the amount contained in the following types of drink (or approximately 10 g of ethyl alcohol):

- a 285 mL glass of regular beer
- a 120 mL glass of wine
- a 60 mL glass of sherry
- a 30 mL glass of spirits.

Research conducted by the National Centre for Research into the Prevention of Drug Abuse has identified several major difficulties facing drinkers who attempt to follow the above advice: namely, wide variations in glass size, serve size and beverage strength.⁴

Australia's National Health Policy on Alcohol has identified the need for labelling alcohol containers in a way "more readily understandable by the public".⁵ The National Centre for Research into the Prevention of Drug Abuse, in collaboration with the Western Australian Health Department, has just completed a series of experimental tests of the proposal that standard drink labels (Figure) are of more help to drinkers who wish to monitor their alcohol intake than the current labelling method.⁶

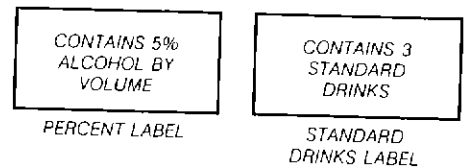


FIGURE Examples of the two types of label for a 750 mL bottle of beer

The study was performed on 257 beer and wine drinkers recruited from a busy shopping mall who we taught and tested on their knowledge of standard drinks. The main findings were:

- (1) With percentage labels both beer and wine drinkers significantly underestimated the number of standard drinks contained in bottles and cans of their usual drink.
- (2) With percentage labels subjects typically made large errors when attempting to pour a standard drink of their preferred beverage.
- (3) The addition of standard drink labels substantially reduced these errors in both the above tasks.
- (4) Subjects expressed an overwhelming preference for standard drink labels over labelling methods using percentage of alcohol by volume, grams or decigrams of alcohol.

Most drinkers are unable to follow the advice of health and road safety experts

with regard to how much is safe to drink because of a lack of appropriate product information on alcohol containers. The introduction of mandatory standard drink labels on all alcohol containers would substantially reduce this problem and is urgently required. Such a measure would constitute a very cost-effective method of raising drinkers' awareness of the concept of a standard drink and thus their personal alcohol consumption.

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- 1 D'Arcy C, Holman J. Alcohol consumption and mortality in Australia. Paper presented at the World Conference on Tobacco and Health, Perth, Western Australia, 1989.
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- 5 Ministerial Council on Drug Strategy. National Health Policy on Alcohol in Australia (and examples of strategies for implementation). Canberra: Department of Community Services and Health, 1990.
- 6 Stockwell T, Blaze-Temple D, Walker C. An experimental test of the proposal to label containers of alcoholic drink with alcohol content in "Standard Drinks". Perth: National Centre for Research into the Prevention of Drug Abuse, Curtin University of Technology, 1990.

Quality assurance in general practice

To the Editor: Professor Ian Webster writes¹, and quite correctly, in praise of the report by Ward et al.² This interpractice cooperation is to be admired and copied wherever possible; it shows the natural cooperation we expect from our general practitioners when they are not goaded by the media into personal competition. However, he appends this praise to a

sales pitch for continued quality assurance on quite tenuous thought processes. The Americans were driven into "control" by third party costs, the British were forced to upgrade themselves due to an appalling lack of morale and interest after nationalization of the British health services. But why are we to be saddled with another bureaucracy in the guise of vocational registration and quality assurance at ever increasing costs in terms of money, personnel and time?

There is no overall problem with our service to the Australian population, only arguments about the percentage paid publicly or privately, and the sniping at us by other (jealous?) professions and the media. In Australia our life expectancy, our ratio of physicians per general population and our infant mortality rate are in the same range as other countries (Table). We could compare ourselves to these countries, but we run our health services at a comparatively lower cost than most. It seems to me to be a waste of resources to add more controls, with a very small chance of improvement in service to the community.

Any malaise in general practice in Australia would be better overcome by resorting to our original inter-doctor cooperation, refutation of third party interference and a return to professional autonomy where doctors police doctors by more visible, more flexible, but stronger Medical Boards. The Royal Australian College of General Practitioners (RACGP) could then return to what it does very well, the vocational training of newer graduates, but then releasing them to fly on their own and develop their own interests in response to their own and their patients' personalities and needs.

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- 1 Webster IW. Quality assurance in general practice. *Med J Aust* 1990; 152: 339-340.
- 2 ... Earnes R, Bell S. Interpractice visits by general practitioners: implications of a pilot project for quality assurance in general practice. *Med J Aust* 1989; 151: 349-352.
- 3 ... *Britannica Annual*, 1989, 546-568.
- 4 ... 672, 706, 719, 722, 724.

Accident compensation: gates and gatekeepers

To the Editor: I wish to support the concept of Professor Hugh Burry¹ that the distinctions between causes of injury and disability have become far too blurred to continue the present system of accident compensation. It remains quite unfair that much smaller benefits are payable for even more catastrophic conditions associated with natural disease. However, a universal income maintenance benefit system would necessarily involve some reduction of benefits for accident compensation, to maintain incentives as well as to be affordable. Many groups would consider this to be a disadvantage.

The reverse is true. Compensation is a health hazard. All doctors would be familiar with the sight of two patients with similar injuries, one compensable and one not. The compensable patient is at first the happier one, since he or she feels financially secure. However, as time passes, the physical injury heals to a greater or lesser degree, and the non-compensable patient is then happy and resumes normal work and life to the best of his or her ability. At this stage the compensable patient becomes more and more miserable, but has greater and greater difficulty convincing doctors that he or she is still not well. Focusing on various aches and pains and on the claim for compensation then becomes the patient's way of life. Persistent complaints of pain sometimes lead to multiple unnecessary and unsuccessful treatments. The end result is not a happy one. The sight of the patient who is locked into abnormal illness behaviour is all too familiar. As the years pass, for him or her to admit to feeling better is to cast suspicion on the previous complaints, and also to renounce financial entitlements.

In the long term, provided that reasonable income benefits are available, compensation is good neither for the patient nor for the insurance contributor. It is also wasteful of our health resources.

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¹ Burry HC. Accident compensation and gatekeepers. *Med J Aust* 1989; 151: 451-451.

In reply: It is important to distinguish between income maintenance provided during a period of incapacity for work, and the lump sum award for damages. The former has practical value in reducing anxiety concerning solvency, but the latter all too easily becomes a bone of contention, engendering attitudes of blame and resentment, encouraging often irreversible assumption of the sick role and seldom giving rise to satisfaction. I agree that these awards are disadvantageous to all parties.

Society has yet to decide how to cope

TABLE: Life expectancy, ratio of physicians to general population and infant mortality rates in various countries¹

	Life expectancy		Ratio of physicians to general population	Infant mortality rate per 1000 live births
	Men (years)	Women (years)		
Australia	72.8	79.1	1.552	8.7
Canada	72.9	79.8	1.491	7.9
France	71.3	79.5	1.417	7.6
Japan	75.2	80.9	1.668	4.9
Norway	72.8	79.5	1.411	7.8
Sweden	73.6	79.5	1.398	5.9
USSR	65.0	73.6	1.229	25.2
UK	71.5	77.4	1.646	9.1
USA (whites)	71.3	79.5	1.417	7.6
(blacks)	65.5	73.6		