To the Editor: The paper by Wilson et al.[1] demonstrating the effectiveness of a minimal intervention programme by general practitioners in the cessation of smoking in the Australian context was both interesting and useful.

However, as a general practitioner who has used the Smokescreen programme successfully for four years, I would like to challenge the view expressed in the editorial by Chapman.[2] He states that a brief intervention, although less successful for individual patients, is more important from a public health point of view than a more effective, intensive programme such as Smokescreen. This is based on the assumption that more doctors will take up the brief intervention. However, his editorial contains two good reasons why this fundamental premise of his argument is unfounded.

Firstly, an intervention programme with a very modest success rate of 4.3% is unlikely to inspire widespread confidence in general practitioners. Practising doctors need positive reinforcement to maintain their ongoing commitment to a behavioural change programme. Seeing positive results with patients from an intervention is an important element in determining whether it will continue to be offered and the commitment with which it is delivered. Smokescreen's proven success rate of 36% over three years provides a basis for confidence in this programme.[3]

Secondly, Chapman argues that the "stand alone" nature of the Smokescreen programme provides a financial barrier to its use. Most practising doctors would disagree. The harsh economic realities of general practice are such that there is a financial disincentive to incorporate an extra service (for which no extra remuneration is provided) into a consultation which is already undervalued by Medicare. While the Health Insurance Commission has a strong interest in encouraging doctors to provide such free services, most practising doctors do not see this as fair or reasonable. In contrast, Smokescreen provides a fair return for the doctor's valuable professional time.

Smokescreen has been taught to 3500 general practitioners and has a proven track record over eleven years.[4] On the other hand, there is no evidence that minimal interventions will be widely adopted as Chapman assumes. In fact, for the above reasons, I would argue that their penetration will be limited.

None the less, it is desirable that a selection of interventions for smoking cessation is available for use in general practice to allow for the variability in the personal preferences of the doctor, the time available and the needs of the individual patient. Doctors may then make a rational choice for any given situation.

I await with interest the new Smokescreen programme for the 1990s which is soon to be launched in Australa and which provides such a range of options for the general practitioner, from brief to moderate interventions.

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1. Wilson DH, Wakefield MA, Steven ID, et al. "Sick of Smoking": evaluation of a targeted minimal smoking cessation intervention in general practice. *Med J Aust* 1990; 152: 518-521.
2. Chapman S. General practitioner anti-smoking programmes: which one? *Med J Aust* 1990; 152: 508-509.
3. Richmond RL, Austin A, Webster IW. Three year evaluation of a programme by general practitioners to help patients to stop smoking. *Br Med J* 1986; 292: 803-806.
4. Webster I, Richmond R. Utilisation of "Smokescreen" smoking-cessation programme [Letter]. *Med J Aust* 1989; 151: 487-488.

Some solutions to the shortage of general practitioners in rural Australia

To the Editor: The article by Max Kamien and Ian Butterfield was well presented.[1]

I am a non-metropolitan general practitioner from a rural background. One explanation (for the lack of country students in medical schools) that has not been explored is cost. The city student has accommodation, food and transport provided by his or her family at a much lower cost than that expended by country parents to keep students away from home.

The extra cost is particularly significant for medical students because of the length of the course. In addition, the long semesters make part-time and holiday work difficult.

I believe that the financial disincentive must be addressed at the undergraduate level if the answer to rural practitioner shortage is to lie in medical education for students from non-metropolitan areas.

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1. Kamien M, Butterfield IH. Some solutions to the shortage of general practitioners in rural Australia. *Med J Aust* 1990; 153: 105-114.

To the Editor: The three-part article by Kamien and Buttfield discusses the problems involved in obtaining doctors for remote rural areas.[1]

This problem could perhaps be more realistically viewed from the other side: namely, what do isolated rural areas offer, and do they, in fact, need a resident doctor?

Firstly, the paradox of needing doctors who are experienced in obstetrics and anaesthesia before going to the bush is that once they are there, there is not sufficient clinical work to enable them to stay. For example, to perform competent lower-segment caesarean sections one would need to be performing at least one per month.

Secondly, the social isolation and lack of adequate educational facilities for children make the isolated rural option unattractive. In fact, the larger centres with populations over 10 000 which have better facilities, do not seem to have the same problems recruiting doctors.

Next, the availability of telephone and radio communication and the standard of road and air transport in most isolated regions mean that medical emergencies can safely be evacuated to larger centres, and still would be, even *with* a resident doctor.

A system of trained nurses or clinical officer type positions could be set up, where standard protocols for the treatment of common conditions could be drawn up and used to supply the vast majority of the medical needs of small communities. This could be complementary to a weekly or monthly visit by a doctor, similar to the primary health care schemes operating throughout the Third World.

I have spent five of the last ten years since graduation working in isolated rural areas in Africa and am currently working in a city general practice (I am looking for a rural practice!).

I think that it is wrong to view the problem only from the perspective of the requirements for doctors and, in the end, much less cost effective for the community.

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1. Kamien M, Buttfield IH. Some solutions to the shortage of general practitioners in rural Australia. *Med J Aust* 1990; 153: (1)105-107, (2)107-112, (3) 112-114.

Alcohol taxes: the case for reform

To the Editor: Richardson's paper on the subject of alcohol taxes[1] is grossly flawed in its calculations, and has been structured in such a way as to exhibit a clear bias against wine.

There can be no justification for the use of data that are four years old when current information is available. During the period 1985-1986, the sales tax on wine was 10%; it has since been raised to 20%. Richardson has also ignored the effect of State licence fees, although he has included excise. For practical purposes both are a form of taxation. The rate and application of licence fees vary from State to State, but for practical purposes add at least 10% to the wholesale value.

Therefore the situation in July 1990 is that taxes add 30% (and not 5.6% as Richardson suggests) to the selling price of wine — because the retailer applies a mark-up on the tax component as well as the product. If one ignores the retail mark-up (40%) on the tax, the tax component of the wine price becomes 16.4%.

Richardson's attempt to calculate a rate of excise applying to the three beverage groups is meaningless, for it ignores the inherent high cost of production of wine. The greater part of beer and spirits is water, straight from the mains supply.

What is much more meaningful is the bottom line as far as the consumer is concerned namely the price the consumer pays for a litre of alcohol — and there has been no attempt to address this at all. Once again, on current figures, and prices prevailing in the discount stores, the price for a litre of alcohol in beer is $31, in standard spirits is $54 and in wine, by the traditional 750ml ($9) bottle, is $100. Alcohol in even the cheapest bottled wine ($3.99) is dearer than it is in beer.

Alcohol in cask (or soft-pack) wine is a different matter, at about $18 per litre. However it should be realised that the product is heavily discounted and that, while the lowering of the alcohol level in these products is desirable, it remains illegal. There is an urgent need for the government to drop the standard minimum alcohol level for wine. Consumption of cask wine has fallen markedly in the last year.

Discounting is the legacy of the Trades Practices Act, and begs the question of whether liquor may be the one exception where free trade is not in the interests of the consumer. The situation is also compounded by the clumsy administration of licence fees by the States (certainly in South Australia), where the fee is calculated on trade turnover of the previous financial year. In a tightly competitive market, the only way for retailers to survive is to turn over significantly more liquor than the year before.

So here we have three pieces of government policy that are conspiring to pour more alcohol down the national gullet. I will agree with Richardson's closing comment that more research on the tax aspect is needed; the whole subject of liquor marketing and taxation is very complex and poorly understood by those who don't understand the product.

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1. Richardson J. Alcohol taxes: the case for reform. *Med J Aust* 1990; 152: 619-620.

In reply: The chief points in my editorial were as follows:
1. On the basis of a conservative interpretation of existing research it can be shown that a decrease in alcohol consumption will result in significant economic, social and health related benefits.
2. Alcohol taxes and the *pattern* of alcohol taxation in Australia have not been based upon a consideration of social or economic welfare. In particular, they have arbitrarily favoured wine.
3. Increasing the rate of taxation and rationalising its pattern could simultaneously increase consumption benefits and reduce the social and economic costs of alcohol related ill health.

It is true that the figures cited in the editorial are somewhat out of date; there are reasons for this. However the conclusions of the study remain unchanged and Wilson's criticisms do not alter them.

I agree that the marketing and taxation of liquor across Australia are very complex. For that reason credible research must be based upon a careful collection and classification of nation-wide statistics. It is simply not good enough to take indicative figures from the local discount store as Wilson appears to suggest. The research cited in the editorial employed the latest available data collected and collated by the Commonwealth. There are, inevitably, sizeable time lags between the collection of such statistics and their publication in the credible form required for research. These statistics did omit State licence fees. Their