RACP
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Prioritising Health

2021 Western Australia election statement

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,000 physicians and 8,500 trainee physicians across Australia and New Zealand, including 1369 physicians and 684 trainee physicians in Western Australia (WA).[1] The College represents a broad range of medical specialties including general medicine, paediatrics and child health, geriatric medicine, infectious diseases, cardiology, respiratory medicine, neurology, oncology, addiction medicine, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, and rehabilitation medicine.

The RACP acknowledges the traditional owners and custodians of the land on which our members practise, live, and teach. We extend our respect to all Aboriginal, Torres Strait Islander, and Māori people and value the importance of their ongoing connection to land, sea, sky, and community. We pay our deepest respect to Elders past, present, and emerging. And together we re-state our shared commitment to advancing Aboriginal, Torres Strait Islander, and Māori health and education as core business of the College.

Executive summary

The RACP and its WA Regional Committee are committed to working with all political parties on the development of health policies that are based on evidence, informed by specialist expertise and experience, and focused on ensuring the provision of high quality healthcare accessible to all, and integrated across primary, secondary, and tertiary services, as well as across the public and private sectors.

Our four priority areas reflect the clinical expertise and professional experience of our members, as well as the opportunities for improvement that physicians and trainee physicians encounter in the course of our work across the state:

1. Wellbeing of the specialist and trainee specialist workforce
2. Doctors' wellbeing during a pandemic
3. Reducing the harms of alcohol, including by minimum unit pricing
4. Geriatric and related services.

We place emphasis on these priorities in rural and regional areas, where workforce limitations stretch existing services and cause inequities across the state in areas of longstanding importance to the Fellowship in Western Australia such as child health, climate change and health, and Aboriginal and Torres Strait Islander health.

Our objective is to advocate for improvements to the WA health system so it continues to operate at a world-class level, delivering good health outcomes in a sustainable way that works well for patients and physicians alike.

We recommend that the government:

1. Commits to the wellbeing of the specialist and trainee specialist workforce

- Commits to providing a positive workplace culture and working conditions for trainees and physicians and providing workforce models that support high quality specialty training, including support for research.
- Works collaboratively with the RACP and other stakeholders to eliminate bullying and harassment in the specialist workforce.
- Adopts or develops a set of agreed principles for a respectful culture in medicine, similar to those developed by the NSW Government.
- Becomes a signatory to our Health Benefits of Good Work principles, an initiative from the RACP's Australasian Faculty of Occupational and Environmental Medicine to further champion health, wellbeing, and supportive workplace culture in the health sector.

2. Ensures doctors' wellbeing during a pandemic

- Continues to support vaccination in line with the national COVID-19 vaccine roll out strategy, with initial focus on Phase 1a (quarantine and border workers; frontline health worker sub-groups for prioritization; aged care and disability care staff; aged care and disability care residents).[2]
- Ensures that workforce planning takes into consideration disruptions caused by any further outbreaks.
- Ensures support for health services to continue training and assessment for medical specialist trainees in this pandemic. This requires rostering and resourcing to enable participation in education, study leave, and exam preparation and attendance.

In relation to PPE,[3] the RACP has called on all governments to:

- Commit to a target of zero occupationally acquired healthcare worker COVID-19 infections.
- Ensure frontline health care workers have access to necessary PPE (in public and private hospitals as well as residential aged care settings), along with suitable PPE training and fit-testing.
- Report on health care workers testing positive to COVID-19 by age group, occupation, primary workplace, and whether the infection was occupationally acquired.

3. **Reduces the harms of alcohol, including by minimum unit pricing**

- Introduces minimum unit pricing for alcohol.[4] [5] [6]
- Invests in alcohol and other drug treatment sector reform through access to a multidisciplinary workforce and increasing workforce capacity through professional development, investment in physical infrastructure, addressing unmet demand for treatment, and providing for a range of treatment models.
- Increases funding for prevention services to reduce the incidence of alcohol and other drug misuse.
- Delivers appropriate infrastructure and data collection systems for alcohol-related medical consultations, ambulance call outs, emergency department presentations and hospital admissions, and for other key issues such as family violence.
- Introduces a system of ongoing monitoring of alcohol-related harm including harm to others, especially within the hospital sector, and for monitoring and analysis of assessments and diagnoses of FASD.

4. **Commits to high quality geriatric and related services**

- Commits to developing a long-term statewide strategy for the provision of geriatric and related services in WA, mapped to need and estimated future need, covering hospital and community settings.
- Ensures there is appropriate funding to meet the needs of ambulatory and community settings (including residential aged care facilities) for palliative medicine, geriatric medicine and other physicians, and to ensure that trainee physicians can work and train across the state.
- Commits to working with the Australian government to provide appropriate (and age-appropriate) accommodation and care services in WA for non-geriatric patients, including people with intellectual disabilities and people with dementia and related diseases.

Overview

Beyond the drive for medical excellence, the RACP is committed to developing policies, programs, and initiatives which will improve the health of communities and address the inequities that underpin poor health outcomes. Patients should have access to an integrated and well-coordinated health system. Governments should take a whole-of-government approach to improve health, including addressing the social determinants of health.

The RACP is committed to advancing Aboriginal and Torres Strait Islander health and education as core business of the College, implemented by a comprehensive Indigenous Strategic Framework. We are a founding member of the Close the Gap Campaign for equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030, and we advocate strongly in conjunction with valued partners including Indigenous peak health organisations.

This statement sets out our advocacy priorities for the coming years.

The Impact of COVID-19

Due to the epidemiology of the novel coronavirus that causes COVID-19 and the need for an effective, cohesive, and proportionate public health response, we are not making specific recommendations about it in this statement except in respect to physician and trainee wellbeing. However, as the sole accredited provider of specialist medical education for public health physicians, infectious diseases physicians, and respiratory physicians and paediatricians (among other specialties), we seek and expect opportunities for our Fellows and the College to contribute to Western Australia's ongoing management and response to COVID-19.

In addition to death, suffering, grief, societal disruption, and social distancing around the world, the COVID-19 pandemic poses challenges for the next WA government and the specialist medical community alike. Simultaneously, the pressure to mitigate and combat the coronavirus has brought about real collaboration and ingenuity, which the incoming government should support and foster. The foundation of innovation must be a stable, well run, and well resourced health system.

Lessons can be learned from the effective approach taken by community-controlled Aboriginal and Torres Strait Islander health organisations and practitioners in WA and nationally to combat the impact of COVID-19. This Aboriginal and Torres Strait Islander led approach has been pivotal to identifying the issues, setting priorities, and proposing solutions for culturally informed strategies relating to the COVID-19 response, including in remote communities. Self-determination has been fundamental to the positive outcomes, as has a consistent equity lens.

We also acknowledge the critical contribution of public health physicians to the COVID-19 response in Western Australia and throughout Australasia. The RACP has produced *Public Health Physicians: Protecting, Promoting and Improving Health for the Whole Community*, a statement that articulates for government decision-makers the value of Public Health Physicians credentialled as Fellows of the Australasian Faculty of Public Health Medicine (FAFPHMs) to the contemporary public health workforce and their capacity to contribute to the broader health system.

Our priorities

1. Wellbeing of the specialist and trainee specialist workforce

Doctors' health and wellbeing is a growing concern within the RACP, and within the medical profession and the community more generally, prompted by several tragic early deaths of doctors in training. A steadily increasing literature and a profession-wide consensus supports wellbeing being taken seriously.

We have long known that junior doctors report high rates of burnout, emotional exhaustion, and cynicism,[7] and our members see this first-hand. All RACP's WA trainees are simultaneously engaged in postgraduate specialist medical training and work in accredited training locations throughout the state's health system.

The RACP recognises that high quality specialist training is demanding and that there are intrinsic pressures and stressors within medical workplaces. We believe that improving the health and wellbeing of trainees requires the cooperation of government, hospitals, health services, specialist colleges, training supervisors, doctors' own doctors, and doctors themselves.

The RACP has previously joined the New South Wales Government, other colleges, educators, and regulators in endorsing the NSW Health *Statement of Agreed Principles on a Respectful Culture in Medicine,* which recognises that "past practices and behaviours have not always met the accreditation standards required to provide a safe, inclusive and respectful environment." The development of a comparable Statement of Agreed Principles in Western Australia would be a powerful signal about workplace culture and expectations.

The RACP is determined to take an active role in shaping a healthier training culture for doctors. While recent improvements to working hours and culture in medicine are a good start, more needs to be done to address the untenable working hours and unacceptable behaviour in some hospitals and training sites.

Our new accreditation standards reflect our expectation that all training sites provide a safe, respectful working and learning environment and address any behaviour that undermines self-confidence or professional confidence as soon as it is evident.

The RACP seeks a continuing commitment from all political parties to work in partnership with the College in finding ways to combat discrimination, bullying, harassment, and racism. This includes taking proactive steps to enable, normalize, and accommodate safe work arrangements and practices, and to support all aspects of a physician's work including leadership, training, and career development opportunities in a way that is appropriately mindful of family and other care responsibilities.

Bullying or harassment of any kind is totally unacceptable—to or from Fellows, trainees (of the RACP or other colleges), non-trainee junior doctors, other health practitioners, or anybody. The RACP has zero tolerance for such behaviour.[8]

While working conditions are improving for junior doctors, albeit gradually, there are also areas of improvement for senior doctors. At present, many physicians and paediatricians have only enough time for clinical duties. The RACP would like the government in office after the election to explore measures that support senior doctors' ongoing professional development, and flexibility to conduct research. These are key

to maintaining Western Australia as an international leader in health care and are key to enhancing Western Australia's position in the highly competitive research marketplace.

Rural and remote specialists already face professional challenges that can impede good patient care as well as practitioner wellbeing. We urge an appropriate focus on rural and remote workplaces as part of the government's responsibility to maximise wellbeing.

Our recommendations reflect the RACP's strong support for building a safe and respectful culture of training for junior doctors, and high-quality specialist care for patients.

The RACP recommends the incoming Government:

- Commits to providing a positive workplace culture and working conditions for trainees and physicians and providing workforce models that support high quality specialty training, including support for research.
- Works collaboratively with the RACP and other stakeholders to eliminate bullying and harassment in the specialist workforce.
- Adopts or develop a set of agreed principles for a respectful culture in medicine, similar to those developed by the NSW Government.
- Becomes a signatory to our Health Benefits of Good Work principles, an initiative from the RACP's Australasian Faculty of Occupational and Environmental Medicine to further champion health, wellbeing, and supportive workplace culture in the health sector.

2. Doctors' wellbeing during a pandemic

Over and above morbidity and mortality from COVID-19's physical effects, published literature attests to higher rates of anxiety, distress, insomnia, and symptoms of depression among doctors and nurses in outpatient clinics and wards for patients with the disease.[9]

In addition, there is established literature examining the effects on healthcare workers of previous novel infectious diseases including Severe Acute Respiratory Syndrome (SARS CoV-1) patients. For example, in 2003, Toronto healthcare workers caring for SARS COV-1 patients reported higher levels of burnout, psychological distress, and post-traumatic stress compared to a control group. [10]

Another study of SARS in Taiwan indicates that, in addition to readily conceivable reasons for emotional distress such as fear of contagion, concern for family members, stigma, and interpersonal isolation, "conscription of non-specialists into infectious disease work" was associated with the presence of significant emotional distress.[11] It is important that health systems and the governments that run them take active steps to minimize the psychological impact which we know can result from such work.

A rapid review and meta-analysis conducted by Australian researchers in 2020 examined the psychological impact on healthcare workers who worked during viral epidemics such as SARS (2003), H1N1 Influenza (2009), Middle East Respiratory Syndrome (2012), H7N9 Influenza (2013), and Ebola virus disease (2014):

> *[F]actors for psychological distress included being younger, being more junior, being the parents of dependent children, or having an infected family member. Longer quarantine, lack of practical support, and stigma also contributed.*[12]

The meta-analysis found the following factors to be protective for psychological wellbeing:

- Frequent short breaks
- Adequate time off work
- Family support
- Clear communication between hospital and staff
- Faith in infection control measures
- Access to psychological support services[13]
- Development of staff support protocols
- Access to adequate PPE

- Seeing infected colleagues getting better
- A general drop in disease transmission
- Age and experience was correlated to lower stress.

It is clear that psychological support and a range of practical measures can make a difference in reducing psychological morbidity among healthcare workers. While the epidemiology of COVID-19 is different to previous viral epidemics, these findings may point to potential strategies the WA Government can institute, promote and encourage.

Media and medical literature have reported deaths by suicide among healthcare workers in multiple countries. While noting that many deaths by suicide are multi-factorial, treating patients who are unable to have visitors is a specific burden on hospital staff. Doubtless an emotional toll falls on those who provide end of life care to patients who die of COVID-19 while unable to see their loved ones.

The WA Government should generate a state-specific healthcare worker wellbeing strategy that is dedicated to the mental health and wellbeing of healthcare workers and other essential workers, based on the National Mental Health and Wellbeing Pandemic Response Plan. That national plan identifies that:

> *There is a particular risk of deterioration in the mental health of frontline and health workers who are actively involved in responding to the COVID-19 pandemic in the short and long term. The physical experience of providing safe care, heightened physical isolation from loved ones, hypervigilance, higher demands in work, and reduced capacity to access social support all heighten the risks for these essential workers. Research from previous pandemics confirms this, demonstrating increased rates of PTSD among these workers.*

This National Plan has been supported by National Cabinet and was developed with the leadership of other jurisdictions (New South Wales, Victoria, and the Commonwealth). It is a WA Government responsibility to deliver on the actions which the Plan outlines and "encourage[s]."

We are particularly concerned about COVID-era challenges to the workforce supply model in WA, which can no longer rely on practitioners from abroad (at times, even from interstate) being able to travel freely to take up positions.

The potential for widespread COVID-19 infections in WA generally has detrimental effects on doctors' wellbeing, even aside from the potential for direct effect from contracting COVID-19 in their workplaces. We know this has been the case in previous viral outbreaks.[14] Indeed, there is some evidence that while small case numbers are obviously desirable overall, the impact may be worse for the particular health care workers who care for one patient only.[15]

The incoming government has a duty to develop robust arrangements to provide continuity of care for patients (including for non-COVID-19 related healthcare, including in rural and regional areas) while maximising policy settings, actions, and activities that most effectively support doctors' wellbeing.

In relation to doctors' continuing wellbeing during the pandemic in 2021 and beyond, the RACP recommends the incoming government:

- Continues to support vaccination in line with the national COVID-19 vaccine roll out strategy, with initial focus on Phase 1a (quarantine and border workers; frontline health worker sub-groups for prioritization; aged care and disability care staff; aged care and disability care residents).[16]
- Ensures that workforce planning takes into consideration disruptions caused by any further outbreaks.
- Ensures support for health services to continue training and assessment for medical specialist trainees in this pandemic. This requires rostering and resourcing to enable participation in education, study leave, and exam preparation and attendance.

In relation to PPE,[17] the RACP has called on all governments to:

- Commit to a target of zero occupationally acquired healthcare worker COVID-19 infections.
- Ensure frontline health care workers have access to necessary PPE (in public and private hospitals as well as residential aged care settings), along with suitable PPE training and fit-testing.

- Report on health care workers testing positive to COVID-19 by age group, occupation, primary workplace, and whether the infection was occupationally acquired.

3. Reducing the harms of alcohol, including by minimum unit pricing

Alcohol remains one of the most harmful drugs in Australia and a leading contributor to disease. Alcohol is responsible for 4.6 percent of the total disease burden across Australia and is a factor in over 30 diseases and injuries. In Western Australia, it has been estimated that 5.6 per cent of the disease burden is attributable to alcohol use, the second highest rate in Australia.[18]

While the prevalence of Fetal Alcohol Spectrum Disorders (FASD) in Australia is unknown, seminal studies in the Kimberley and prison in WA have established high prevalence. Nationally alcohol is the most common preventable cause of neurodevelopmental disability. Qualitative reporting shows that many children who had been exposed to prenatal alcohol are experiencing learning and emotional difficulties. A large number of affected young people are coming into contact with the juvenile justice system.[19]

Alcohol-related harms create enormous social and economic costs to Australian society, with estimates putting the figure at between $15 billion and $36 billion annually.[20] This is a cost of between $604 and $1450 per person per year.

The RACP's Alcohol Policy, developed jointly with the Royal Australian and New Zealand College of Psychiatry, provides an in-depth review of the evidence and provides recommendations on effective policies to reduce the harms of alcohol.[21]

Evidence shows that a coordinated public health approach to reducing alcohol consumption is required to comprehensively tackle the harms associated with alcohol. As well as addressing harmful consumption, the RACP is calling for an increase in the availability and range of treatment services for those with alcohol addiction.

Minimum unit pricing (MUP) can be the next major public health reform in Western Australia. Its time has come.

We note that the Final Report to the Western Australian Government of the Sustainable Health Review includes minimum unit pricing as one of two priorities designed to reduce harmful alcohol use by 10 per cent by July 2024.[22] Since heavy drinkers of alcohol and young people are sensitive to changes in the price of alcohol, MUP can be used to:

- cut rates of underage alcohol consumption
- reduce both regular consumption of large volumes of alcohol and episodic binges, and
- encourage safer consumer choices.[23]

Physicians are passionate about minimum unit pricing because where it has been tried in Australia, it works. After one year of MUP in the Northern Territory, the data shows:

- reduced emergency department presentations
- reduced alcohol-related assaults
- reduced alcohol-related domestic violence.[24]

The incoming government should use price signals and targeted investment to amplify harm minimization by:

- Introducing minimum unit pricing.[25] [26] [27]
- Investing in alcohol and other drug treatment sector reform through access to a multidisciplinary workforce and increasing workforce capacity through professional development, investment in physical infrastructure, addressing unmet demand for treatment, and providing for a range of treatment models.
- Increasing funding for prevention services to reduce the incidence of alcohol and other drug misuse.

- Delivering appropriate infrastructure and data collection systems for alcohol-related medical consultations, ambulance call outs, emergency department presentations and hospital admissions, and for other key issues such as family violence.
- Introducing a system for ongoing monitoring of alcohol-related harm including harm to others, especially within the hospital sector, and for monitoring and analysis of assessments and diagnoses of FASD.

4. Geriatric and related services

Western Australia has good geriatric service availability in many areas but expanding access beyond metropolitan areas remains a challenge. The availability of geriatric medical and psychogeriatric services should be expanded, including by outreach and telehealth.[28] Combined with the aging population, gaps in service coverage means WA requires a range of measures designed to support the quality of life of all people in the state.

Residential aged care facilities (RACFs) have their services precariously stretched in an operating environment that has seen state government funding reductions to other providers of related services. RACFs must currently provide the full breadth of highly specialised medical services to younger and older patients which include:

- Acting as a specialist dementia service managing the full range of 'difficult to manage' behaviours.
- Providing high quality medical and nursing care to older people with highly complex care needs.
- Administering hospice care for the dying, bearing in mind the average life expectancy in RACFs is just over two years, meaning that 30% of residents die each year. Most would like to die among family and friends, but RACFs often lack the physical environments or the trained staff to facilitate good end of life care.
- Delivering medical, nursing and behavioural management for younger people with brain injury and other neurodegenerative diseases.
- Providing medical services and a suitable environment for the 60% of residents in residential care with dementia, of whom many have multidisciplinary needs including chronic cognitive and psychogeriatric problems, leading to challenging behaviours which cannot be managed in physically unsuitable environments by staff with very limited training.
- Providing a rehabilitation unit for people discharged from hospital with delirium or deconditioning resulting from acute illness.[29]

We are concerned that residents of non-metropolitan areas may be receiving inequitable and inadequate services and call on the next Government to work with us to improve access to medical specialists throughout Western Australia.

The RACP calls on the incoming government to:

- Commit to developing a long-term statewide strategy for the provision of geriatric and related services in WA, mapped to need and estimated future need, covering hospital and community settings.
- Ensure there is appropriate funding to meet the needs in ambulatory and community settings (including residential aged care facilities) for palliative medicine, geriatric medicine and other physicians, and to ensure trainee physicians can work and train across the state.
- Commit to working with the Australian government to provide appropriate (and age-appropriate) accommodation and care services in WA for non-geriatric patients, including people with intellectual disabilities and people with dementia and related diseases.

The Way Forward

High quality and local training of junior doctors, including physician trainees, is crucial to ensuring the availability of a competent specialist workforce to meet current and future healthcare needs.

The incoming government must be cognisant of, support, and value the contribution made by physicians to training junior doctors within the WA health system. Direct clinical care is the ultimate role of most specialist

medical practitioners, but their duties to that end include indispensable non-clinical activities such as supervision, research, mentoring, and management.

The incoming government should acknowledge that these activities constitute an essential investment in WA's future specialist workforce, including in regional and remote areas and in specialties with relatively few practitioners in the state, and:

- Recognise that the training of physicians is an integral part of the delivery of healthcare services, and commit to services having suitable physical resources and sufficient protected time for teaching, supervision, and research.
- Continue to work with the Commonwealth and other states and territories in undertaking workforce planning.
- Ensure that any post-election new directions in clinical workforce are only developed and implemented with appropriate consultation leadership from physicians and the RACP.

The RACP calls on all political parties and candidates to make a commitment to the health of all people in Western Australia extending beyond the election cycle, and to deliver effective evidence-based and expert-informed health policies.

We look forward to working collaboratively with the incoming government and all successful candidates to improve the health of all people in Western Australia.

To provide us with a response to these election priorities or to seek more information about the RACP and the WA Regional Committee, please contact Dr Peter Dewar, Senior Executive Officer, by emailing RACPWA@racp.edu.au.

[1] As of 30 June, 2020.
[2] See RACP media release, January 26 2021.
[3] The RACP conducted a survey of Australian members on PPE in 2020. A precis of results is available here, from which the report is also downloadable, along with a selection of international media coverage and a summary of our call to governments.
[4] See RACP Fact Sheet on minimum unit pricing.
[5] See RACP select bibliography on minimum unit pricing.
6 See The Case for a Minimum (Floor) Price for Alcohol in Western Australia, WA Alcohol and Youth Coalition
[7] National Mental Health Survey of Doctors and Medical Students (beyondblue, 2013, dataset and executive summary available by request).
[8] See Respectful Behavior in College Training Programs, and Statement on Safe and Respectful working environment (7 February 2019).
[9] Lai J, Ma S, Wang Y, et al. Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019. *JAMA Netw Open.* 2020;3(3):e203976.
[10] For example, see Maunder R, Lancee W, Balderson K, Bennett J, Borgundvaag B, Evans S et al. Long-term Psychological and Occupational Effects of Providing Hospital Healthcare during SARS Outbreak. Emerging Infectious Diseases. 2006; 12(12):1924-32;doi 10.3201/eid1212.060584.
[11] Chen CS, Wu HY, Yang P, Yen CF Psychological distress of nurses in Taiwan who worked during the outbreak of SARS. Psychiatr Serv. 2005;56:76–9 10.1176/appi.ps.56.1.76
[12] Occurrence, prevention, and management of the psychological effects of emerging virus outbreaks on healthcare workers: rapid review and meta-analysis, BMJ 2020;369:m1642, *BMJ 2020; 369 doi: https://doi.org/10.1136/bmj.m1642.*
[13] It is possible that access to psychological support services is a protective measure indepently of whether those services are utilized. Further investigation of this point would potentially be warranted.
[14] Lin C, Peng Y, Wu Y, Chang J, Chan C, Yang D. The psychological effect of severe acute respiratory syndrome on emergency department staff. Emergency Medicine Journal. 2007;24(1):12-7;doi 10.1136/emj.2006.035089.
[15] See Styra, Rima et al. "Impact on health care workers employed in high-risk areas during the Toronto SARS outbreak." *Journal of psychosomatic research* vol. 64,2 (2008): 177-83. doi:10.1016/j.jpsychores.2007.07.015, including this finding: "[t]he level of contact (number of patients with SARS treated) has an important mediating effect on the degree of PTSS experienced. Data showed that caring for only one patient with SARS is significantly more stressful than caring for none or caring for two or more patients with SARS."
[16] See RACP media release, January 26 2021.
[17] The RACP conducted a survey of Australian members on PPE in 2020. A precis of results is available here, from which the report is also downloadable, along with a selection of international media coverage and a summary of our call to governments.
[18] Australian Institute of Health and Welfare, 2016. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011.
[19] See Bower C, Watkins RE, Mutch RC, et al, Fetal alcohol spectrum disorder and youth justice: a prevalence study among young people sentenced to detention in Western Australia BMJ Open 2018;8:e019605. doi: 10.1136/bmjopen-2017-019605 which found FASD prevalence of 36%.
[20] The Royal Australasian College of Physicians. Alcohol Policy, p 1.
[21] The Royal Australasian College of Physicians. Alcohol Policy. Our alcohol advocacy webpage includes additional recommendations to reduce the rates of FASD and other alcohol-related physical and psychological health outcomes connected to alcohol use in pregnancy and breastfeeding; recommendations to strengthen licensing provisions; and recommendations so that better data collection can ensure targeted and evidence-based policy.
[22] WA Sustainable Health Review Final Report, p. 50, with implementation to include:

1. "Introduction of a minimum floor price for alcohol with regular adjustments for inflation, guided by reform in the Northern Territory.
2. "Health system action plan for alcohol-related violence aligned to whole-of-government approach to family and domestic violence including the WA Alcohol and Drug Interagency Strategy 2017–2021."

[23] The small increase in the cost of alcohol that might affect moderate drinkers must be seen in the context of the total health, social and economic costs of excessive alcohol use. Minimum unit pricing preserves consumer choice while promoting healthier options. Under MUP, alcohol will remain widely accessible in Australia and adults will remain free to make their own choices. The idea is to reduce the hazardous levels of use by the heaviest consumers and support healthier choices for all users.
[24] Specifically, the Northern Territory Alcohol Harm Minimisation Action Plan August 2019 Update, shows:

- a 17.3% reduction in emergency department presentations in July 2018 to June 2019 compared to the same period in 2017-2018
- In Katherine, a 42.5% reduction in alcohol-related assaults in April-June 2019 compared to October-December 2017
- In Alice Springs, there were 45% fewer alcohol-related assaults, 37% fewer alcohol-related domestic violence assaults and 33% fewer alcohol-attributable emergency presentations between 2017-2018 and 2018-2019.

[25] See RACP Fact Sheet on minimum unit pricing.
[26] See RACP select bibliography on minimum unit pricing.
[27] See The Case for a Minimum (Floor) Price for Alcohol in Western Australia, WA Alcohol and Youth Coalition

[28] We note here the joint statement of the Faculty of Psychiatry of Old Age of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australian and New Zealand Society for Geriatric Medicine (ANZSGM), "Relationships between old age psychiatry and geriatric medicine."
[29] RACP submission to the Royal Commission into Aged Care Quality and Safety (December 2019), p. 41.