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Use of 'fly-in, fly-out' (FIFO) workforce practices in regional Australia

Submission to the Standing Committee on Regional Australia

11 October 2011

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

Submission to the Standing Committee on Regional Australia on use of 'fly-in, fly-out' (FIFO) workforce practices in regional Australia

Introduction

The Alliance is comprised of 32 Member Bodies, each a national body in its own right, representing rural and remote health professionals, service providers, consumers, educators, researchers and Indigenous health organisations (see Attachment).

The vision of the National Rural Health Alliance is good health and wellbeing in rural and remote Australia, and it has the particular goal of equal health for all Australians by 2020. The Alliance believes that access to health care as close to home as possible is integral to achieving this goal.

The phrase “as close to home as possible” reflects the conundrum faced by policy makers, service providers and advocates in rural and remote health: knowing where to draw the line in spatial terms between the health services that an individual needs, and what can be sustained or justified financially, ethically and with clinical safety. The bases of this conundrum are distance, critical mass, and specialisation. In many cases, the greater the distance between individuals who need particular treatment, the larger the area needed to have the critical mass of patients necessary to justify investment in specialised personnel and facilities. Thus, specialised facilities for cancer treatment, MRI machines and units for high-risk births and intensive care will tend to be in central places rather than in individual people's homes or very small towns.

However, the capacity of technology ‘to deliver’ is freeing up some of these limitations. There are numerous situations in which individual people can have quite specialised health care assistance in their specific circumstances. People on oxygen can remain mobile thanks to lightweight oxygen machines; mobility for those with a physical disability can be provided through a wide range of aids; and a pain management specialist can follow up through a videoconference with the patient and their local health care provider. Further leaps forward in information technology, miniaturisation and automation are making it more feasible for highly technical services to be provided to a greater range of individuals in their own home or community. More and more the justification by governments for the absence from small communities of highly-specialised and publicly-funded facilities such as dialysis will rely only on cost or safety issues.

A health service system for small numbers of people in isolated areas consists of a suite of responses to the inherent conflict between distance and equity. Specifically, it is a system designed to balance (‘compromise’ is an unpromising word in the context) affordability, safety, staffing and access.

There are three broad options that can be employed to strike this balance: parts of the service can be provided face-to-face to the individual in their own community (even in their own home – whatever form that home takes); parts can be provided virtually; and parts can be provided by having the individual travel to or be taken to a face-to-face service elsewhere.

The precise nature of health service ‘models’ that are well-known in rural and remote areas, such as ‘outreach’ and ‘hub and spoke’, is likely to be of interest to the consumer only because they determine whether the service provider they want and need to see is perceived

as a local person who is regularly accessible, or as a person from ‘somewhere else’ who is available (say) only every second Thursday afternoon or for one week every second month.

Much of this submission discusses the pros and cons of such health services. However, with its very broad concern for the social and economic determinants of health – and given the Inquiry’s focus on workforce practices generally – the Alliance’s submission also deals with the social consequences, and thus health effects, of fly-in, fly out (FIFO) practices in, for example, the resources sector. Not only is it true that FIFO practices in health have both pros and cons: it is also the case that they are felt by those who work under such a regime, their families, and both the community from which they come and the one in which they work.

Rural health

About seven million people or 32 per cent of the total Australian population live outside what the ASGC-RA classification system defines as Major Cities. While some of them are farmers, miners, forest workers or fishermen and their families, most workers in rural and remote Australia are to be found in the retail, health, education, government, manufacturing, processing, transport and other sectors. Most of those seven million people live in regional centres and country towns of various sizes.

On average, these people have lower levels of education, lower incomes and their health risk profiles are worse than people in the major cities. For instance they experience greater physical risks, due both to relatively dangerous occupations such as farming, fishing and forestry, and to greater exposure to non-occupational risks like road accidents. They are also more likely to smoke, drink risky amounts of alcohol, be overweight and take insufficient exercise. And when they are unwell or have sudden health events, there are fewer specialised health services available locally.

People in these areas also have lower levels of access to health and other services more generally; almost all health professionals are less prevalent in rural and remote areas, some dramatically so. The need to travel to specialist services in capital cities, especially for ongoing treatment, can be costly to the individual and greatly disrupt work and family life.

Some 70 per cent of Australia’s Aboriginal and Torres Strait Islander people live outside metropolitan areas and they make up a substantial proportion of the population in rural and especially remote areas. As is well known, on average their health outcomes are substantially poorer than those of other Australians.

Notwithstanding this profile, many people choose to live outside major cities for a number of compelling reasons, including work opportunities, housing affordability, a sense of community and lifestyle factors such as peacefulness, reduced traffic and contact with nature.

Other people choose not to re-locate permanently from metropolitan centres but provide important services or take up work opportunities in rural and remote communities on a fly-in fly-out basis. Whether they live in or fly in and out of rural and remote communities, all such people are entitled to benefit from Australia’s health care system,

Benefits and challenges of fly-in fly out work practices for rural health

Fly-in fly-out or drive-in drive-out health services should never be seen as adequate or satisfactory replacements for personal, ‘hands-on’ healthcare and related services. Face-to-face interactions provide the widest suite of tools to ensure accurate understanding and

communication, as well as contributing to the human interactions that are fundamental to health and wellbeing.

Nevertheless, fly-in fly-out or drive-in drive-out health services are important for people who would otherwise have no access to essential health services in rural and, especially, remote areas. They are also important for the support and connections they provide for the many health professionals who do take up regular rural or remote practice.

This submission addresses terms of reference (a), (b), (c), (d), (f), (g), (h) and (j) of the Inquiry according to the appended list.

(a) the extent and projected growth in FIFO/DIDO work practices, including in which regions and key industries this practice is utilised

Major shortages in the rural and remote health workforce (see Table below) mean that fly-in fly-out or drive-in drive-out work practices, or outreach programs, make a significant contribution to rural and remote health.

Persons employed in health occupations per 100,000 people, by Remoteness Area, 2006¹

Occupation	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Medical practitioners	324	184	148	136	70	275
Medical imaging workers	58	40	28	15	5	51
Dental workers	159	119	100	60	21	143
Nursing workers	1,058	1,177	1,016	857	665	1,073
• Reg'd. nurses	978	1056	886	748	589	979
• Enrolled nurses	80	121	129	109	76	94
Pharmacists	84	57	49	33	15	74
Allied health workers	354	256	201	161	64	315
Comp. therapists	82	82	62	40	11	79
Ab. & TSI health workers	1	4	10	50	190	5
Other health workers	624	584	524	447	320	602
Health service managers	32	33	28	28	18	31
Total health workers	2,777	2,536	2,166	1,827	1,379	2,649

Source: ABS Census of Population and Housing, 2006

Some examples of rural and remote health outreach programs are provided in this section, and some of the issues with providing them are discussed in subsequent sections.

Primary care and health promotion

The Royal Flying Doctor Service has become a major provider of everyday essential healthcare in remote communities as well as the 24 hour emergency and transport services for which it is so well known. Clinic services, provided on a regular basis in remote locations, include medical general practice, child and maternal health, women's health, health promotion, health screening and population health services such as immunisation, mental health and other allied health services. The RFDS employs a range of staff, including management, medical practitioners, women's health doctors, registered nurses, Aboriginal and Torres Strait Islander health workers, allied health professionals, pilots and administration officers in its mission to improve the health of the nation.²

¹ National Rural Health Alliance. Fact Sheet 23. Measuring the metropolitan-rural inequity.

<http://nrha.ruralhealth.org.au/cms/uploads/factsheets/Fact-Sheet-23-rural-inequity.pdf>

² Royal Flying Doctor Service. Overview of health services. <http://www.flyingdoctor.org.au/Health-Services/> accessed September 2011.

The RFDS provides services to remote locations outside the normal medical infrastructure, i.e. in the absence of a medical practitioner or hospital that provides continuing medical services. Therefore RFDS provides a necessary and essential service to these locations.

Specialist health care

The Medical Specialist Outreach Assistance Program (MSOAP) is a national program administered at State level to support outreach services provided by medical specialists to rural and remote communities.³ MSOAP, along with the related Visiting Optometrists Scheme, was the subject of a recent review conducted by Health Policy Analysis for the Australian Government Department of Health and Ageing.

MSOAP managers vary from state to state with the Rural Workforce Agencies managing the program in WA, Victoria, SA and NSW (50%). In other jurisdictions the state government is the fund holder. The most common services provided are psychiatry, paediatrics, dermatology, gynaecology, endocrinology and cardiology. Recently the program has been expanded to provide outreach health services, including related to maternity, to rural and remote Aboriginal communities.

The NSW Rural Doctors Network (RDN) reports that MSOAP funds more than 130 medical specialist outreach services in NSW. The RDN is also funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) to increase medical specialist outreach to rural Aboriginal communities and the Indigenous Medical Specialist Outreach Assistance Program (ISOAP) now funds 40 separate services. Medical registrars are also supported under both of these programs.⁴

Alliance members report that MSOAP is successful when implemented in consultation with local communities in a way that is complementary to the health services available in the local region. Various contingencies that need to be considered in establishing and running the MSOAP program are discussed under the relevant terms of reference in this submission. However, best practice health care is generally based on medical specialists working in multidisciplinary teams including allied health professionals and nurses. Historically, MSOAP does not cover the team costs, although some improvements were announced in the 2009-10 Federal Budget – see (j) below.

Multidisciplinary health care

Funding for rural and remote outreach services to improve access to allied health and/or nursing professionals provides an important complement to national health programs that would otherwise fail to reach rural people in the absence of an adequate health workforce.

This targeted funding is often for outreach services that run out of regional or larger rural centres, rather than from Major Cities. For example, the Mental Health Services for Rural and Remote Australia Program aimed to increase services delivered through a flexible model of care, with medical practitioner oversight, in rural and remote areas, including those affected by drought throughout Australia. The Australian Government provided \$60.4 million over five years to enable non-government organisations in rural and remote communities, including Divisions of General Practice, Aboriginal Medical Services and the

³ Australian Government Department of Health and Ageing. Medical Specialist Outreach Assistance Program Guidelines. June 2011.

[http://www.health.gov.au/internet/main/publishing.nsf/Content/F408ABFB0D5AF4F6CA2577040019C193/\\$File/Attach%201%20-%20MSOAP%20Guidelines.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/F408ABFB0D5AF4F6CA2577040019C193/$File/Attach%201%20-%20MSOAP%20Guidelines.pdf)

⁴ See “outreach services” on the NSW Rural Doctors Network website at <http://www.nswrdn.com.au>.

Royal Flying Doctor Service, to provide more allied and nursing mental health services, such as those provided by social workers, psychologists, mental health nurses, occupational therapists, Aboriginal and/or Torres Strait Islander Mental Health Workers and Aboriginal and/or Torres Strait Islander Health Workers.

The report of the Final Evaluation conducted in 2009-10 confirmed that the most common model of service delivery was the outreach model, where health professional staff in a larger rural centre provided sessional or outreach services to people in other towns. For example, Flinders and Far North Division of General Practice, serving the Far North of South Australia through the program, provided outreach services to Oodnadatta and Mintabie from Coober Pedy. The second most common model was the hub and spoke model. The vast majority of service contact was face-to-face. Health professionals agreed that this was the most effective method of contact, particularly for the first session. Telephone, video-conferencing and other modes of service (such as Skype) were used to a lesser extent. The installation of videoconferencing facilities in a number of areas of service provision will potentially increase the use of this mode of delivery in the future.⁵

Locum staff

The Australian Government has recognised the importance of locum services in rural and remote areas by establishing locum programs to enable health professionals in rural and remote areas to take leave from their practice.

The Rural General Practitioner Locum Program (RGLP) provides financial assistance to allow rural and remote GPs to access locum coverage for up to 14 days in a financial year while taking a break from their practice.⁶ The RGLP provides the host GP with subsidies to offset the costs of engaging a locum, including a daily amount that goes to the host GP while they are away from the practice and an amount which the GP passes on to the locum as partial recompense for the extended time it may take them to travel to the practice. In addition there is funding to cover the cost of locum travel for remote locations or where a locum is coming from interstate that is paid directly to the travel agent or car hire company. Rural Health Workforce and its member Rural Workforce Agencies manage this program.

The Nursing and Allied Health Rural Locum Scheme (NAHRLS) provides locums to enable some of the nurses, midwives and allied health professionals in rural and remote Australia to do the professional development training they need to continue their vital work.⁷ The NAHRLS employs the locum and the scheme supports all locum recruitment, travel and accommodation costs so there are no extra costs to the health service. However, the NAHRLS then bills the health service for the pre-agreed base pay rate amount for the locum and associated on-costs e.g. payroll tax, superannuation etc. While this arrangement ensures there is minimal administrative burden to the service and the formal and proper contracting of the locum health professional, the payment does not cover any staff costs or the salary for the locum.

⁵ Australian Government Department of Health and Ageing. Mental Health Service in Rural and Remote Areas Program evaluation. January 2011 version 1.3. Final Evaluation Report. Price Waterhouse Cooper. [http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/9958DC4DF5382204CA2577B5007B7767/\\$File/MHSRRA%20Final%20Evaluation%20Report%20190111.pdf](http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/9958DC4DF5382204CA2577B5007B7767/$File/MHSRRA%20Final%20Evaluation%20Report%20190111.pdf)

⁶ About RGLP. <http://ruralgplocum.org.au/Home/About>

⁷ Nursing and Allied Health Rural Locum Scheme (NAHRLS). <http://www.nahrls.com.au/about-nahrls/>

Further examples

The Alliance received many responses to a request for information to feed into the current Inquiry in the September edition of its regular newsletter E-News. Some excerpts are provided to illustrate the extent and scope of fly-in fly-out or drive-in drive-out health services in rural and remote communities. Other excerpts are included in the relevant sections of this submission.

“Just a short comment from my experience as a fly in/fly out (drive in/drive out) pharmacist working with remote Aboriginal health services. Absolutely the best model would be for enough available resources to have people on the ground all the time to build relationships with clients and staff. But since there are not, FIFO provides access to services that remote people would not otherwise have. As the person doing the FIFO, I am often frustrated that I can’t provide a better service, but I do what I can with what I get to do the job!”

“I have been an Audiologist working in Central Australia for the past 20 years. I have seen and worked with many audiologists who fly in and out over the years. Some of these audiologists who have been flown in from interstate to service remote communities for many years are doing a good job, they get to know the communities and do a great job.”

“Whilst not the ideal option, in actuality in many rural and remote areas this would probably be a better option than varying agency staff. In my (supervisor of nursing) portfolio I have given this thought for covering nursing services in (remote location). This is already being done there for ambulance and police and if there was support for such permanent and consistent arrangements it would be an easier workforce change than trying to go alone.”

“Shortages of the health workforce go both ways; I often had to travel to the city for critical incident work where they could not get the clinicians. I can drive through the night which I often did. - - I drove 4 hours return a day, 5 days a week, to work for a mental health service in Victoria because they were short staffed. Sometimes regions are huge and workers travel large distances just to cover their normal service areas - not only in health either. There are safety and OH&S issues: the more people travel, the more fatigue is a problem. This can have a detrimental effect on health care provision: it is hard to treat someone properly after a long drive. In rural areas you have the added issues of wildlife on the roads, especially at night. All too often rural workers are just out of University which sets a different set of pressures, and flying or driving in and out puts huge amounts of stress on them and the system - not to mention families. Another major issue is resources in those areas for fly-in fly-out workers. For psychologists they cannot take all the tests they might normally use and there is also some issue about the security of patient notes. If you do fly-in fly-out work, the patients at home are not covered appropriately. For critical incidents you have a much longer term commitment to visit and revisit an incident site several times, which means you are tied up over the longer term. Another issue is the public-private sector divide, not just in the hospital setting but in other allied health areas as well. There is very poor communication between these areas and there may be a duplication of service provision in areas which might not be picked up. All too often I would travel to an area and no-one would know I was there.”

Recommendations:

- That, given the serious shortages of health and related personnel in rural and remote areas, the Committee notes the importance and range of fly-in fly-out and drive-in drive-out services in supplementing local services and thus improving access to health care for many people in rural and remote communities.
- That targeted health outreach programs must continue to be supported and improved to better meet the needs of rural and remote communities by complementing but not substituting for local health services.

(b) costs and benefits for companies, and individuals, choosing a FIFO/DIDO workforce as an alternative to a resident workforce

As discussed above, a fly-in fly-out or drive-in drive-out health workforce is a necessity rather than a choice in some rural and remote communities, due to health workforce shortages and mal-distributions.

“I think a fly in fly out service is a better option than no service at all.”

A FIFO or DIDO (or ‘outreach’) service can provide people in rural and remote communities with more timely, affordable and convenient access to health care than is available locally, particularly when it comes to highly specialised care.

“I am a rural medical director. I have been involved in relatively large numbers of fly in/fly out services, as they are often the only way to maintain a service. I am specifically talking about the provision of medical rather than other services. I am involved with two sorts of services: locum/emergency services and regular/specialist services.

Examples of regular/specialist services may include a gynaecology or orthopaedic service to a more remote location which cannot justify a full-time service or a more subspecialty service to a larger centre, such as a Base hospital receiving a cardiothoracic service. These are generally stable long-term and high-quality. They are frequently undertaken by people who have a commitment to equity and the provision of service to people who would otherwise receive nothing.

Some of these doctors set up in private practice and so there is no charge to the public purse. The return to the Dr is often that they will be able to operate on complex cases in their city practice.

Alternately, many set up in the public system but do not expect to receive generous pay. I know of several instances where these doctors have retired but ensured that there would be someone else to replace them and where the Dr has encouraged colleagues in other disciplines to come so that the community is even better provided for. These doctors provide a very valuable service. Thinking further, I think that some of them do it at a financial loss: they could certainly have earned more in the city practice but choose to come and help people.”

Rural health and aged care service providers and their clients also benefit from the contribution that FIFO/DIDO locum or agency staff can make to continuity of service delivery, for example, when recruitment for a staff vacancy is underway, or to provide cover for a staff member who is on leave or attending continuing professional development. This additional staff capacity can also be called upon in times of high demand on the service, such as a disaster response or an outbreak of illness, or to manage the challenges of a fluctuating population, for example, during the holiday season or at harvest time.

“It is relatively common to be unable to provide a service because of a lack of numbers, sickness or annual leave etc. When it is necessary to maintain that service, a fly-in is commonly used. If it is a specialist service the doctors tend to be fresh graduates, who have not yet developed a permanent practice or people approaching retirement. The service is generally reasonably good, though it can be patchy. There are frequently issues of continuity of care and, because most good services rely on an ongoing relationship, there are often things that are lost.”

There are also potential benefits for the individual health professionals who provide outreach or locum services in rural and remote communities. These include gaining broader

professional and country life experience without having to give up their city home, family commitments or professional networks.

“Ideally all health service professionals would be located permanently in the locations in which their services are delivered. Unfortunately this is not a reality that can reasonably be sustained. Having worked for the past 27 months in (--) Cape York Peninsula I have been privileged to work with a large number of dedicated health care professionals. Regardless of any merits of arguments for a live-in work force the reality is that neither I nor any of my colleagues would be able to sustain a live-in-community work arrangement.”

However, the outreach and locum services do impose additional costs for the health and aged care service providers in rural and remote communities. These include the high cost of travel to remote locations and of providing appropriate accommodation for visiting staff – for instance in remote tourist areas. In addition, rural outreach and locum services often require more experienced health professionals who are equipped to take on the rural challenges, or local health professionals who are appropriately qualified to act as mentors for less experienced visiting staff. This all adds up to a set of fees and wages that are well above baseline.

“If it is a more generalist service, such as maintaining an Emergency Department, there is a pool of doctors who generally, in my opinion, are more interested in money than in career development. They can generally do the job but I frequently had concerns at how they would cope if there was a major catastrophe or very unwell patient. All of these doctors tend to charge a higher regular services fee than really should be paid. Unfortunately there is little choice but to pay.”

Further, it is not generally practicable to fly in an agency nurse or a locum for a day or two to a rural or remote area. Services must plan for longer minimum stays and budget for the associated additional costs such as travel time and local accommodation, which are not sufficiently recognised by Government funding programs.

Individual health professionals providing outreach or locum services to country areas from their city bases also incur additional costs. For example, it is likely that they will need to retain accommodation and services in the city and forgo their usual income and any part-time or casual work while they are away. A visiting medical specialist providing outreach services in a rural or remote setting may need to cover the costs of nursing and allied health professionals such as a speech therapist or dietician in the outreach team, or cover the costs of local health professionals needed to complete the team. Funding arrangements for rural and remote outreach programs do not generally cover these essential team members.

There is much work to be done in optimising the funding arrangements for multidisciplinary health care through outreach arrangements to the benefit of the outreach providers, their local colleagues and consumers.

“Ideally it would be better if fly in fly out service was not necessary. My area of work, mental health (rehabilitation and recovery), relies on psychiatrists flying in. The time they spend here is limited and unfortunately has to be totally focused on client appointments. Consequently, the staff members rarely have time to have any clinical discussions or education or even the chance to do reviews with the psychiatrists.

In essence the down side is a) lack of time to learn from psychiatrists and b) the huge cost. Fly in psychiatrists take a significant amount out of the budget.”

Health professionals working in rural and remote communities who provide or participate in outreach services across the region may experience additional difficulties, including adjusting to life in these communities, feelings of isolation from professional peers as well as family and friends, higher costs of living and transport and travel issues. Travel time may not be sustainable, for instance in circumstances where four hours a day travel is required three times a week to service some outreach areas. Staff burnout is a concern where demand is high and backfill or support is generally not available⁸.

Recommendation:

The full costs of providing outreach and locum services in rural and remote communities must be recognised in rural and remote health funding programs.

(c) the effect of a non-resident FIFO/DIDO workforce on established communities, including community wellbeing, services and infrastructure

While the introduction of a more highly specialised visiting health workforce can seem like an efficient solution or an opportunity to promote higher quality health care, it must be done in consultation with local community members, health professionals and service providers.

“I did some work on mental health service models which still makes sense to me! The core message is that the FIFOs support the residents and not the other way round.”

One of the biggest concerns for people in rural and remote communities is that a visiting health workforce may undermine local health practitioners or contribute to the closure of existing local health and aged care services. The dismantling or deterioration of existing health infrastructure and shrinkage of the local resident health workforce makes it even harder for the community to retain its existing health professionals or to attract a new workforce – even a visiting one.

“These services undermine local providers, do not become part of the fabric of the community, encourage the view that services cannot be provided by local providers, encourage administrators to believe that recruitment is too difficult, are expensive, take private work which makes it less attractive for people to move to the town, give governments an excuse not to invest in local infrastructure. They should be restricted to specialist fields only. There should be requirements for these providers to have formal links with local providers to support their practice and ongoing professional development.”

Rural and remote communities need stronger investment in health care and infrastructure as close to home as possible, without which the contribution of a targeted visiting health workforce will fail to be realised.

Recent publications from the National Rural Health Alliance⁹ and the Australian Institute of Health and Welfare¹⁰ demonstrate the size of the deficit in rural and remote health care – both in terms of dollar figures and service occasions lacking. Between them the reports show an

⁸ These findings, as reported in the Mental Health Service in Rural and Remote Areas Program evaluation (footnote 5), are findings that recur across many different rural and remote outreach scenarios.

⁹ National Rural Health Alliance 2011. The extent of the rural health deficit. Fact Sheet 27.

<http://nrha.ruralhealth.org.au/cms/uploads/factsheets/Fact-Sheet-27-rural-deficit.pdf>

¹⁰ AIHW 2011. Australian health expenditure by remoteness: a comparison of remote, regional and city health expenditure. Health and welfare expenditure series no. 41. Cat. no. HWE 50. Canberra: AIHW. Viewed 6 October 2011 <http://www.aihw.gov.au/publication-detail/?id=6442475421>

annual shortfall in services for country people of more than 25 million services and a primary care deficit in regional and remote areas of at least \$2.1 billion in 2006-07 – the latest year for which data on expenditure by rurality are available. The rurality category relates to where the person lives, not where the service occurred. This underspend on primary care (doctors, dentists, pharmacies) contributed to the need for an extra \$830 million to be spent on acute (hospital) care for people from rural and remote areas. The Alliance estimates this to represent some 60,000 extra acute care hospital episodes. A fairer share of public expenditure on health promotion, primary care and early intervention in rural areas would reduce acute care episodes and keep people out of hospital.

And the health risks associated with no health care close to home are already in evidence in rural and remote communities – even to the extent of increased risk of motor vehicle accidents and of medical and obstetric misadventures while travelling on country roads and over long distances for healthcare. There are also major financial and family costs imposed by the need to travel for health care not available locally.

“Just as a side issue, but a very important one, I note that patient travel schemes for away from home medical treatment continue to be unsatisfactory. (I believe) a Senate inquiry made some helpful recommendation to both federal and state levels of politics, but that seems to have gone nowhere.”

Nowhere is this shortfall likely to be more apparent than in towns around high growth industries that have expanded more rapidly than the infrastructure and staff needed to provide health care for the people who live there or fly in and out to work in those industries. FIFO workers make demands on the existing services where they work but are not reflected in census figures or other assessments of population based need.

Recommendations:

- Each Regional Development Australia committee should have a health focus in its Strategic Plan and work with other agencies to ensure there are adequate health and aged care facilities and professionals for their region, with sufficient flexibility to respond to population and industry changes within the region.
- Medicare Locals should be encouraged and enabled (including through appropriate funding) to work with Local Hospital Networks and Regional Development Australia committees to ensure that health service planning is based on full population needs at local and regional level (including FIFO workers) and appropriate arrangements with specialised tertiary hospitals.

(d) the impact on communities sending large numbers of FIFO/DIDO workers to mine sites

Question and answer sessions following presentations at the National Rural Health Conference in Perth in March 2011 included growing concerns about stresses on the families and family life of the increasingly large numbers of FIFO workers in the Australian resources sector (minerals, offshore oil and gas etc). For example, there was anecdotal evidence of increasing use of telephone and internet support services by men in remote communities who were isolated or separated from their partners. With few mental health services available to them and concerns about stigma in small communities, telephone and internet services provide one way in which these isolated men can reach out for help.

It is certain that members of families left ‘at home’ also experience the stresses resulting from separation. Significant other anecdotal evidence has been provided to the Alliance, and further analysis of data is required to confirm the situation.

“This practice seems to me to be detrimental to social cohesion of both the fly-out home of the worker and the fly-in place of employment. Australia has a history of workers traveling long distances to ply their trade/skill/profession and I don’t think it was ever very satisfactory. Shearers, drovers, soldiers, fruit pickers, salesmen, machinery repair workers and many others left their families to participate in a world that consisted of work and temporary social contact with other isolated lonely beings.

The family left behind coped as best they could minus one of the authoritative adults of the household. This situation is damaging to family security because it takes workers away from their role as a foundation member of the family group. For the family the high wages come in handy of course but over a prolonged period of time the family would be just as complete if the money were simply put in the mail without the disruption of household routine of the worker coming home and trying to fit in.

The worker’s accommodation becomes an extension of the workplace.

This system should not be allowed to occur. If the Snowy Mountain Scheme could provide homes for its workers’ families, in very inhospitable places, there is no reason why mining companies cannot. From my own experience I know there is a tradition in Australian that an industry that sets up in an isolated area has an obligation to provide accommodation for workers and their families – the Wonthaggi Coal Mine was known as Canvas Town because of the tents that families lived in until the mine built houses that they rented to the miners, butter factories built villages for their workers.”

And from an adolescent health worker:

“- bad for families, bad for the community, bad for the individuals - only winners are the big corporations.”

From a member of a support group for people with mental illness and their carers:

“We are doing some early work to scope the counselling services and other community support measures available through the mining industry. Many rural families have a family member who is a fly-in fly-out worker in the mining industry, yet the counselling support services for the families seem to focus on the capital cities. Many of the women who stay at home to care for the children while their partners are doing fly-in fly-out work on the mines are not working themselves and can be very isolated. Some families moved to a mining town where the company was seeking to build a community and a local workforce, rather than fly-in fly-out, but the community infrastructure wasn’t all in place before the mine closed down prematurely. It’s not that people are saying they have mental health problems. The men are not having a close life with the women and children. They spend more time away with their workmates. And it’s not all big mining companies involved, there are smaller mines and companies involved and the investment in the people and communities varies a lot.”

Personal, family, community and workplace factors can all influence individual experiences and adaptation to the fly-in and out lifestyle. It should not be presumed that regular absences associated with FIFO employment will always impact negatively on the wellbeing of these families. Indeed there is evidence of successful adaptation to the FIFO lifestyle for people who have made purposeful and informed choices that the benefits of FIFO employment outweigh the disadvantages, although the FIFO lifestyle could impact negatively on the wellbeing of those family members who did not perceive that they had such choice.

Moreover the appropriateness of FIFO lifestyles for families and employees can change with changing needs and across the lifespan.¹¹

There is a role for Governments, communities, peak industry bodies and employers in further research to explore and improve the wellbeing of FIFO employees and their families over time. Some resources have already been developed and there is growing knowledge in this area.¹² A focus on rural areas and relevant cultural groups, including Aboriginal and Torres Strait Islander people, is justified.

Recommendations:

- Research into the impact on communities that are sending large numbers of FIFO/DIDO workers to mine sites should include impact on the physical and mental health and wellbeing of these workers and their families.
- Given the impacts of FIFO practices on both the families and communities involved, increased family support should be provided and greater attention given to community development and sustainability in areas where the practices are common.
- Companies that engage in large-scale FIFO work practices should give detailed attention to the impact on the families involved and be responsive to the needs and circumstances of specific individuals and families.

(f) key skill sets targeted for mobile workforce employment, and opportunities for ongoing training and development

The challenges for a mobile health workforce in rural and remote communities have already been touched upon. Health professionals need considerable experience and a range of generalist and procedural skills to take on a rural and remote outreach role, and need to be supported by local health professionals with high levels of experience and skills.

It will be critical that health professionals in locum and outreach positions are able to work effectively with local health professionals to build their capacity to manage on the front line when the visiting team is not there.

“More recently with the intervention many audiologists have been flown in to service communities. ...Remote work is very different to city work – well, it isn’t that different but many fly in audiologists approach it differently and treat clients differently.... just because they have had no training or experience in observing such ‘sick’ ears. Proper training needs to be given to these audiologists - and support also. And those of us who live here and have enormous amounts of experience need to be asked for input into this training and support and have our experience recognised financially.”

Health professionals providing long term care through outreach arrangements will also need to be in a position to maintain good contacts in between visits to ensure continuity of care and support for their patients and local health professionals.

Both the visiting and the local health workers will need additional capacity and relevant skills to ensure that visits, patient care and ongoing follow-up are well coordinated.

¹¹ Sibbel AM, 2010. Living FIFO: The experiences and psychosocial wellbeing of Western Australian fly-in/fly-out employees and partners. Thesis submitted in partial fulfilment of the requirements for the award of Doctor of Philosophy, Faculty of Computing, Health and Science, Edith Cowan University.

¹² For example, see “*Working Away: A Survival Guide for Families*” and the “*Mining Families Matter*” website, supported by a range of industry groups and government at <http://www.miningfm.com.au/>

“But I also notice that staff on the ground tend to get weary of yet another visitor. New FIFOuters don’t understand why they aren’t met with open arms This is not the clients but mostly the staff – the nurses who have to accommodate visitors, provide space and resources and attention that detracts from their regular duties. This is also true of the short-term locums that have not worked in the remote setting before. Between us we do put extra stress on the full-time permanent staff. There should be allowance made for this in an assessment of the workload of the permanent staff.”

Visiting professionals and local teams will need to ensure that there is adequate knowledge and experience between them to meet the ever increasing technological requirements for health care. It can be a completely different experience using high tech equipment in an area with poor phone and internet connection and no technical back-up. Transport and set-up of technical equipment is not necessarily straightforward, nor is it part of the usual skill sets required for a city specialist and may be outside the experience of local health professionals and their support staff.

The healthcare team will also need to be able to make decisions about when it is appropriate to conduct health care through an outreach setting, when this will prejudice the quality of care that it is possible to provide and the possible risks associated with providing no care – which may result in a worse health outcome or further hazards to the patient in travelling for care. Of course such decisions will need to involve the informed choices of the patient and their families.

“In my opinion, fly in, fly out services are a last resort in the event that you can’t access the specialists and allied health services within two hours’ surface travel. Their greatest drawback, unless you have telehealth backup for patient follow up, is that a patient is treated and then it falls to someone else to provide the after-care, which is usually the GP or, in the case of surgery, the nearest general surgeon. Unless the treating specialist has the courtesy to nominate a second person as an assistant, all too often there is no payment for the aftercare provided, which is quite wrong and understandably creates bad feeling between the fly-in specialist and the local medical and/or nursing workforce.”

A current example is the introduction of Medicare Benefits Items for videoconferencing with specialists for people in rural, remote and outer metropolitan areas.¹³ The MBS items will mean that when the local doctor, nurse practitioner, practice nurse or Aboriginal Health Worker provides patient support while hosting a videoconference consultation between a specialist in another place and the patient, the patient will be reimbursed for the cost of the appointment, with reimbursement for the specialist consultation fees as well.

The videoconference consultations have the potential to complement face-to-face outreach visits through the Medical Specialist Outreach Assistance Program (MSOAP). The MSOAP contact officers in each State, as well as the professional colleges, have been suggested as those who could contribute to guidance on such matters as technological and equipment requirements, best practice use of the new technology and the situations in which it may be clinically appropriate to use it, in order to support the successful implementation of the initiative.

¹³Australian Government Department of Health and Ageing. Telehealth - Modernising Medicare by providing rebates for online consultations. MBS Online downloaded September 2011.
<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/mbsonline-telehealth-landing.htm>

Recommendation:

- Professional colleges must continue to provide guidance and support for their members so that those individuals are able to provide effective and culturally appropriate outreach services and collaborate effectively with local health professionals.

(g) *provision of services, infrastructure and housing availability for FIFO/DIDO workforce employees*

The inflated costs of housing in mining towns and other areas where large industry investments are competing for local accommodation can mean that fly-in, fly-out health professionals such as locums or sessional workers are unable to obtain affordable accommodation. It is not uncommon for the employer to have to build, rent or subsidise accommodation for travelling health professionals. For example, aged care providers report that the cost of accommodation for fly-in agency staff to cover staff absences is so great as to prejudice the viability of the whole service.

Technological and health infrastructure requirements also need to be considered. This goes beyond what it is and is not possible to do locally in terms of the health facilities and local infrastructure. Large influxes of fly-in workers place strains and differing demands on existing health services that requires further investigation. The RFDS, for instance, reports anecdotal increases in remote telephone consultations and emergency evacuations, particularly in mining areas. The development of proactive responses to these strains and challenges may include an increased health workforce on the ground to extend the services available to both local people and the fly-in fly-out workers, as well as increases in remote support and outreach services. Development of the local health workforce will also contribute to local jobs and additional local business opportunities, and improve the opportunities for spouse employment to assist families that wish to relocate rather than have a family member fly in and out of the area for work.

Travelling health professionals also need high speed broadband access to maintain their connections with professional colleagues and with family and friends. The National Rural Health Students' Network has been very clear in reporting that young health professionals will have serious reservations about taking on postings in places with poor connectivity because of the negative implications for professional development, continuing education and maintenance of professional support networks.

Governments, the resources industry and other employers of fly in fly out workers may have a particular role in developing best practice guidance on the facilities and services that need to be in place to support this type of employment practice.

Recommendation:

- The full costs of health outreach or locum programs for rural and remote communities must be covered in all government viability supplements, funding schemes and infrastructure rounds, including the costs for necessary infrastructure (including housing, consulting rooms and equipment).

(h) strategies to optimise FIFO/DIDO experience for employees and their families, communities and industry

It is critical that any fly-in fly-out health workforce is sufficiently well planned to ensure that the people providing the service and the local health professionals are able to work well together, complement each other's work and have the time and resources to do this.

“I did FIFO for 2.5 years and loved it. 7 on and 7 off is best. 8/6 OK; 2/1 sucks. 4/1 is terrible.”

“If (various FIFO arrangements) are to continue, there needs to be a liaison person or a staff member part of whose job is to ease the burden on stretched staff who have to cope with inexperienced newbies. That way, it is an accepted, structured part of the role with dedicated resources on the ground to help FIFO. Yes. We are there to help, but unless FIFO have been there regularly and know the people and the way the place works, they can't just walk in and instantly help. Helping the helpers needs to be in someone's job description.”

Local health professionals could also work with the fly-in fly-out care providers to tailor services to meet the needs of a particular community through 'shared care' arrangements, for example when national screening programs are delivered through outreach services. Local remote area nurses or other health care professionals may be well-placed to assist people during traumatic times such as a positive result being identified through a mobile breast cancer screening unit, or to encourage participation in national bowel cancer screening programs, especially where there is no local medical practitioner.

The Alliance is also keen to see improved support services for the fly-in and fly-out workforce of other industries and for their families, such as those in the mining sector. Many of these families live in rural and remote communities and almost without exception the work they do is in rural and remote areas. Adequate investment in health services is an important element of this support.

As well as providing essential care, the health and aged care sectors help to sustain the local community through jobs and businesses. The availability of good local jobs, both in the resources and services sector, provides local young people with the incentive to succeed at education and training, so contributing to the long-term health and wellbeing of those young people.

Expenditure on health services in rural and remote areas can be seen as an investment in the ongoing capacity of those areas to continue their production of food, wealth and exports, rather than merely as a cost to the Federal Budget. This is particularly the case given the medium-term savings which would be generated through the sort of health care which can keep people out of hospital, including comprehensive primary care as close to home as possible, equitable access to GPs and other primary care providers and a greater focus on health promotion and illness prevention.

The industries involved in enlisting fly-in fly-out workforces have a responsibility to ensure that health infrastructure is an early part of their planning and development and is in place and operational well before the workforce arrives for its first shift.

(j) current initiatives and responses of the Commonwealth, State and Territory Governments

Expansion of the Medical Specialist Outreach Program (MSOAP), mentioned at (a) in this submission, was announced in the Federal Budget for 2009-10, including better cover for multidisciplinary care for Aboriginal and Torres Strait Islander people with chronic and complex conditions. In addition, MSOAP will provide assistance for obstetricians, registered midwives, maternal and child health nurses, and allied health professionals as members of multidisciplinary service teams to deliver outreach maternity services.

The Alliance welcomes the potential benefits for pregnant women and new mothers who live in parts of rural and remote Australia where access to services related to maternity is limited. However, the background to this measure provides a good example of why fly-in fly-out solutions are not sufficient to replace local services. The need for the program stems from the closure of a large number of maternity services in rural hospitals in recent years, associated with the decision by many procedural GPs to cease their obstetric practices. Once the maternity service closed, the viability of the hospital itself was often compromised. The problem is that the new mobile maternity workforce under MSOAP will rely on an infrastructure that may no longer be present, including maternity ward facilities, ultrasound capabilities and support for front line health professionals and patients when the team is not present.

The Alliance welcomed the regional round of the Australian Government's Health and Hospitals Fund (the second tranche of which is currently in train) which includes funding for infrastructure such as student accommodation that could also be used by visiting outreach staff, upgrades to information technology to support increasing use of electronic health records by visiting and local staff, and additional treatment rooms to accommodate visiting health professionals.

Infrastructure funding has also been made available through the Government's super clinic program and, for the upgrade of infrastructure in existing general practices, through the National Rural and Remote Health Infrastructure Program (NRRHIP).

State governments have also invested in infrastructure through public health networks including high speed broadband connections that support videoconferences, for example for case conferencing or grand rounds including local clinicians and those who visit on a sessional basis. However, many visiting health professionals will be running clinics outside public hospital settings where commercial high speed broadband is simply not available.

The national e-health program will contribute to improve the potential of fly-in fly-out healthcare through supporting and enabling better coordination of health services and improving availability of a person's health information.

“As a remote clinic, fly in/fly out services are an appropriate form of servicing the remote communities. Some points to consider are:

- better co-ordination of services so people can be seen by two or more visiting services on a day. This would prevent excess travel and client costs. It may even save the Government money by flying specialists together. In areas where HACC (Home And Community Care) transport is in operation (to transport the clients to the clinic) it would also cut costs.
- a much better sharing of information between specialists so there is a continuity of care and appropriate follow up can be arranged.

- a better summary of clients that have been seen so all medical information can be kept on file.”

In particular, the development of the Personally Controlled Electronic Health Record (PCEHR) for implementation in July 2012 should contribute to better continuity of care in fly-in fly-out settings for health care providers and workers. It will enable the secure sharing of health information between an individual’s healthcare providers, while the individual is able to control who can access their PCEHR. The Department of Health and Ageing is responsible for managing the design and implementation of the Personally Controlled Electronic Health Record (PCEHR) system in association with consumers, the National E-Health Transition Authority, states and territories, clinicians, health sector stakeholders and key market partners.as a joint initiative of the Commonwealth, State and Territory Governments.¹⁴

The Alliance remains concerned that there is not an integrated and planned approach to investment in a balance of essential health services close to home and outreach and locum health services for specialised and back-up capacity.

“Fly in fly out is crucial for many regional areas. I have done a fair bit of that as have other (regional mental health professionals). Costs are significant as are pressures on the clinician and their families at times. The benefit to communities is huge with the side benefit that the community gets a clinician they can talk to and that do not have to worry about them being in the same community.”

Recommendation:

- A National Rural Health Plan should be developed as a matter of urgency, with clear strategies and targets for achieving equal health outcomes and fair access to services for the people of rural and remote communities by 2020. It should include appropriate parameters to define the complementary roles of local and outreach health workforces.

Conclusion

FIFO and DIDO services are crucial parts of current and future health services for the people of rural and remote Australia. They are therefore strongly supported by those people, not as a sufficient or adequate replacement for face-to-face health care but as part of the necessary compromise between the tyranny of distance and the justified expectation of equity of access to services.

The Alliance is confident that the Inquiry will reflect the importance of FIFO and DIDO in the context of health services and will endorse the need for continued support for such services from the public purse. This is justified both by the serious rural underspends through systems that aim to be universal (MBS, PBS), as well as by the major contribution that a healthy FIFO workforce makes to the nation’s wealth and wellbeing.

Specifically, the full costs of FIFO health services (eg for accommodation, equipment) must be recognised in rural and remote health funding programs, and the health professional Colleges must continue to provide necessary support to those of their members who undertake such work. The design and operation of FIFO health services must provide

¹⁴ Australian Government Department of Health and Ageing. PCEHR Concept of Operations. Downloaded October 2011. <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/pcehr-document>

support to providers already on the ground and improve their sustainability and performance, rather than ‘flying overhead’.

The Alliance is concerned about the social and health impacts of FIFO work practices on all four parties: the FIFO workers; their families; the communities in which they live; and the communities in which they work. Further evidence is needed about the effects on these parties, and both governments and the private sector should combine to investigate and provide whatever special support may be necessary.

FIFO health services and work practices more generally are part of the rich fabric of rural and remote Australia. The issues raise many complex challenges and the Alliance looks forward to working with Federal, State and Territory Governments on a National Rural Health Plan which, among other things, will provide a public record of progress made with strategies for achieving equal health outcomes and fair access to services, including through fly-in fly-out services.

Terms of Reference

Standing Committee on Regional Australia

Inquiry into the use of 'fly-in, fly-out' (FIFO) workforce practices in regional Australia

On Tuesday 23 August 2011 the Minister for Regional Australia, Regional Development and Local Government, The Hon Simon Crean MP, asked the Committee to inquire into and report on the use 'fly-in, fly-out' (FIFO) and 'drive-in, drive-out' (DIDO) workforce practices in Regional Australia.

The Committee invites interested persons and organisations to make submissions addressing the terms of reference by Friday 7 October 2011.

The Standing Committee on Regional Australia will inquire into and report on the use of 'fly-in, fly-out (FIFO) and 'drive-in, drive-out' (DIDO) workforce practices in regional Australia, with specific reference to:

- a) the extent and projected growth in FIFO/DIDO work practices, including in which regions and key industries this practice is utilised;
- b) costs and benefits for companies, and individuals, choosing a FIFO/DIDO workforce as an alternative to a resident workforce;
- c) the effect of a non-resident FIFO/DIDO workforce on established communities, including community wellbeing, services and infrastructure;
- d) the impact on communities sending large numbers of FIFO/DIDO workers to mine sites;
- e) long term strategies for economic diversification in towns with large FIFO/DIDO workforces;
- f) key skill sets targeted for mobile workforce employment, and opportunities for ongoing training and development;
- g) provision of services, infrastructure and housing availability for FIFO/DIDO workforce employees;
- h) strategies to optimise FIFO/DIDO experience for employees and their families, communities and industry;
- i) potential opportunities for non-mining communities with narrow economic bases to diversify their economic base by providing a FIFO/DIDO workforce;
- j) current initiatives and responses of the Commonwealth, State and Territory Governments; and
- k) any other related matter.

Attachment

Member Bodies of the National Rural Health Alliance

ACHSM	Australasian College of Health Service Management
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare & Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CHA	Catholic Health Australia (rural members)
CRANaplus	CRANaplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group)
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RHW	Rural Health Workforce
RFDS	Royal Flying Doctor Service
RHEF	Rural Health Education Foundation
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
RNMF of RCNA	Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia—Rural Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health