The Pilbara – a place many have heard of, but few have ventured.

Fifty thousand people call the Pilbara their permanent home, but due to its rich sources of iron ore, crude oil, salt and natural gas deposits it means thousands of workers are flown in and out every day to service the area’s massive mining industry – also known as FIFO’s.

I have become increasingly concerned over the past few months about the health of the much needed membership of our economy and am increasingly asking if their health needs are being met.

A case in point related to Bob, a 54 year-old man who presented to the Emergency Department with an unexplained arrhythmia. He claimed to the triage nurse that he was otherwise ‘fully well’ but had a bit of ‘diabetes’. He worked Malcolm had checked his sugars in the morning BSL and it was found to be 21.6.

Bob’s case is not an isolated one. In fact, it seems there are increasing numbers of intelligent, predominantly middle aged men in our community who are suffering from chronic health conditions that are poorly managed predominantly due to the nature of their work-life arrangements.

Like many men in Bob’s situation there is a propensity for patients not to seek health care, home advice or not take responsibility or ownership for their medical issues.

According to Bob, he had never had education about his disease or discussions about the cause of lifestyle factors that could prevent progression in the future.

This got me thinking further, how do our FIFO men access this education? They work very long hours, they have minimal time to attend appointments unless it is emergency and when they reach the end of their swing, exhausted, they pack up and off home they are out of the way. It is often a pit stop where they pack up and off to the next town.

What medications was he taking and in fact had left all his pills at home. He did know his latest HbA1c though (which I thought was promising) at 10.6 per cent, which demonstrated things had been fairly out of control for some time. He did no exercise, ate whatever was served up at camp and consumed a myriad of other “black market” substances that they can pick up along the way.

I also consider the inextricably linked by some of my patients. The fact that some can seek for exhausting long hours and then continue to drink and smoke and consume a myriad of other “black market” substances that they can pick up along the way.

So how do these workers have their conditions followed up?

A couple of casual repeat scripts provided by an unsuspecting ED RMO who saw the file and thinks, excellent, this will be a quiet case, could see the patient without having to review for months. Who then makes sure that this patients HbA1c is improving, that the uric acid/creatinine ratio is adequate, that their fasting cholesterol result are within limits and that they have had their annual eye checks, podiatry visit etcetera.

From the patient’s perspective there are other underlying factors that lead to concern, for example their desire to keep sick days to a minimum and the fear of losing their jobs due to their conditions.

I also consider the invisibility held by some of my patients. The fact that some can seek for exhausting long hours and then continue to drink and smoke and consume a myriad of other “black market” substances that they can pick up along the way.

I do however understand that at some point our patients need to take responsibility for their own health and lifestyle decisions.

This is where education from a discerning local doctor can go a very long way. Education about disease, management and prevention is super important. The issue for our fly in fly out workers here in the Pilbara is, it is the same for the rest of the Pilbara population. There is a stunningly obvious lack of availability of a stable GP workforce.

Action can be taken to one or two weeks to get an appointment, time off work, all in the waiting room for up to two hours to be assessed by a doctor who then has to rush them to their day job to get back on the plane. On top of that nothing is done until they pay $60 plus the on top fees. I am constantly not understanding the patient service provided by our GPs at times to over time to deal with chronic disease management.

When will our FIFO workers with potentially preventable/manageable predominantly lifestyle related diseases, have time to visit their GP? They often go without much needed chronic disease management, as realistically the GP follow-up for the non acute matters nearly happens. I wonder if the patients themselves have considered the overall health and lifestyle impacts of not taking their disease states seriously.

So a problem has been identified. How can we attempt to develop a solution?

Does it come in the form of better patient education from the practitioners that see the patients in the emergency department? What about the role of community health educators on mine sites tackling chronic disease issues and prevention measures? What about electronic medical records as a condition of employment to allow better health information access? Or better funding arrangements so that in rural areas - where GP DMO’s run the ED’s can function more like GP’s?

Should this education come from their local GP from their home town physician?

Is the problem big enough to bring about a broader, community-wide health message via education?

That is an easy issue to tackle but I would like to propose that some of the State Government’s Royalties for Regions money should be spent educating workers, not just about injury prevention but on overall prevention and management. This could have a major impact on helping to create a healthy, happy and sustainable workforce.

After all it is the very same patients that are assisting us to keep our whole economy booming – lest we not forget them. ◗