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'Inquiry into and report on the use of 'fly-in, fly-out' (FIFO) and 'drive-in, drive-out' (DIDO) workforce practices in regional Australia'

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Introduction

Services for Australian Rural and Remote Allied Health (SARRAH) commends the Minister for Regional Australia, Regional Development and Local Government, the Hon Simon Crean MP for asking the House of Representatives Standing Committee on Regional Australia to inquire into and report on the use 'fly-in, fly-out' (FIFO) and 'drive-in, drive-out' (DIDO) workforce practices in regional Australia.

SARRAH is nationally recognised as a peak body representing rural and remote allied health professionals working in both the public and private sector.

SARRAH's representation comes from a range of allied health professions including but not limited to: Audiology, Dietetics, Exercise Physiology, Occupational Therapy, Optometry, Oral Health, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology.

These allied health professionals provide a range of clinical and health education services to individuals who live in rural and remote communities. Allied health professionals are critical in the management of their clients' health needs, particularly in relation to chronic disease and complex care needs.

It is noteworthy that in many smaller and more remote communities those people in need of primary health care are even more reliant on nursing and allied health services. If these local health professionals are well supported then the need to access specialist and hospital services will be reduced.

SARRAH maintains that every Australian should have access to equitable health services wherever they live and that allied health professional services are basic and core to Australians' primary health care and wellbeing.

General comments

FIFO and DIDO practices are an essential component of health service delivery for rural and remote communities in order for them to access the health care they require. It is well known that the health status of rural and remote Australians is lower than that of their metropolitan counterparts, particularly in Indigenous communities. A component of this reduced health status and higher morbidity in rural and remote Australia is as a result of poorer access to health services in primary health care, acute secondary care, rehabilitation and chronic disease management. Many rural

and remote communities do not have sufficient population mass to support the full range of health services delivered by allied health professionals, doctors or nurses. These health professionals are traditionally employed in the state government public sector, private practice or in a range of services now being funded by the Australian government.

The ideal solution is for all Australians to have access to equitable health services through locally resident teams of health service providers that are skilled, trained, supported and funded to deliver the range of health services that meet the needs of the community in which they reside. However, for many small rural communities and for much of remote Australia there may not be the immediate local population mass to occupy and sustain all members of the primary health care team, either as privately or publicly funded services. Consequently FIFO and DIDO arrangements, historically called outreach services, are part of flexible models of health service delivery to isolated geographic regions for people that would otherwise not be able to access services within that community.

However, whilst for some communities FIFO and DIDO may be the only options for the delivery of some services there are also potentially negative aspects to be considered such as the impact on both the workforce providing the service and the communities they fly/drive into and out of.

Comments against the Terms of Reference for the Inquiry

1. **The extent and projected growth in FIFO/DIDO work practices, including in which regions and key industries this practice is utilised.**

The Australian health system utilises FIFO and DIDO services to deliver a range of health services across rural and remote Australia. Key examples of such practices include the Royal Flying Doctor Service and medical specialist services provided under the Medical Specialist Outreach Assistance Program (MSOAP). In the 2011-12 Australian Federal Budget MSOAP was extended to include a range of allied health professions delivering services to remote Indigenous communities. In addition, State and Territory health systems have also provided a range of outreach services to small rural and remote communities, including visiting medical, allied health and other special programs for example mental health services.

The positive aspect of FIFO/DIDO models of service is that workforce skills not otherwise available in communities become available through an outreach model from larger centres. An example of such an arrangement is the hub and spoke model that delivers allied health services to the western corridor of Queensland from the gulf in the north to Birdsville in the south. Mt Isa provides a hub for the service delivery through the North and West Queensland Primary Health Care Allied Health Services. This organisation is funded by the Australian Government under a range of nationally funded programs, including but not limited to the Rural Primary Health Services Program, Medicare and Primary Health Care Access Programs. This model is successful in providing access to a range of allied health services in very small and remote communities that previously had little or no access to such services.

The range of specialist medical and allied health services that can be provided to rural and remote communities through FIFO/DIDO practices has the potential to the improve health and wellbeing of local residents and support local service providers in providing comprehensive care. Some examples are: early intervention for children, acquired brain injury, spinal cord injury and chronic complex disease. In addition, this arrangement provides a structure to increase the opportunity for students to undertake clinical practice education through travelling to rural and remote communities with FIFO/DIDO health professionals who deliver services.

SARRAH expects that with the move towards increased primary health care and the focus on health promotion and delivering health care, the number of health care teams using FIFO/DIDO practices in regional rural and remote Australia will grow. An ageing population and increasing burden of chronic disease will also increase demand on a workforce that does not currently exist, potentially also increasing demand on FIFO/DIDO work practices. The preferred service module would be to have health professionals living within the rural region rather than having them FIFO/DIDO. The reality is that for sustainable services a mix of well supported, locally based service providers and FIFO/DIDO models is often required.

2. Costs and benefits for companies, and individuals, choosing a FIFO/DIDO workforce as an alternative to a resident workforce.

It is arguable that a FIFO/DIDO service should only apply to short term mining communities. Longstanding rural communities should be supported with enhanced local primary health care teams backed up by the necessary level of outreach services. Reliance on FIFO/DIDO for these communities is unacceptable and is a direct consequence of the ‘blame game’ where State/Territory authorities do not direct funds to areas of highest need.

Costs in choosing a FIFO/DIDO allied health workforce include:

- Social costs such as health professionals being separated from their family for lengthy periods.
- Fatigue costs through travelling long distances to reach various work locations.
- Financial costs of travel including fuel, flights, accommodation and associated allowances.
- Costs borne by the health sector for essential time required back at the home base office to complete follow up work relating to the service delivery.
- Lack of knowledge the FIFO/DIDO staff have of the local community and therefore less optimal health care is provided unless they are working with a well integrated local primary health care team.

Benefits for the FIFO/DIDO allied health workforce include:

- Enables the allied health professionals to be located in larger towns enhancing their opportunities to access continuing professional

development and support networks. Larger towns are also more likely to maintain a critical mass of allied health professionals which assists in retention of staff and more sustainable services.

- Provides scope for specialist skills support of a residential allied health workforce based in rural or remote communities where a partnership service delivery model leads to enhanced skills. For example a Child Development Unit model in South Australia where local allied health professional staff visit communities with a Paediatrician.
- Provides valuable support for primary health care teams on the ground.

3. The effect of a non-resident FIFO/DIDO workforce on established communities, including community wellbeing, services and infrastructure.

FIFO/DIDO is not considered the best method of health service provision for local communities. The preferred option for all communities is to have a locally based residential primary health care team that is part of the community. However providing the full range of health services, especially expert services to meet the health needs of the community is often not a feasible or sustainable option without some FIFO/DIDO aspects to the service.

If primary health care team members cannot reside in every geographical community then they should be based nearby within the regional community of the area. A vital component in indentifying health workforce shortages is to assess local community health needs to determine the full range of services required and how they will operate before a funding model is applied.

Having a FIFO/DIDO workforce, irrespective of the industry sector that they are employed in, should not be considered separately from all other social issues impacting on rural communities

Welfare systems need to be replaced with a model that will reinvigorate and add to the sustainability of communities as a FIFO/DIDO workforce appears set to continue. The level of community sustainability can be assisted through increasing employment numbers above the current minimum staffing levels in place for industries such as the service sector.

In addition, labour force programs should be implemented so that local residents are trained to take on sustainable jobs, with training being available at the local level. Once trained, the local employee should receive the same rate of pay that may have attracted an out-of-town applicant. Local communities need to have control over the way in which services are delivered.

A diverse and strong community can generate meaningful community experiences including sport and the arts. Once a certain point of community depletion and welfare dependence has been reached, community sustainability and development becomes more difficult. It can be argued that FIFO/DIDO workforce models do not necessarily contribute to diverse and strong communities, although the support provided by such models may assist in retention of other people in the community. For example, if a

family has a child with special needs, the provision of FIFO/DIDO services may assist them to remain in the community.

4. The impact on communities sending large numbers of FIFO/DIDO workers to mine sites.

The impact on communities sending and receiving large numbers of FIFI/DIDO workers will be dependent upon the population characteristics of the community. Communities can expect fluctuations in the demand on infrastructure and provision of services. Primary health care vacant positions, staff turnover, burnout, irregular or infrequent services adversely impact on the health and wellbeing of local communities. For example continuity of care, consistency of provider, coordination of services and cultural safety in the largely remote Indigenous communities are all issues which have an impact on the effectiveness of health services.

In order to have effective and efficient FIFO/DIDO allied health services there is a need for local administration and infrastructure to support FIFO/DIDO arrangements. This requires sound planning through building relationships with all local health workers including allied health professionals, assistants, administrators, doctors and nurses who are vital to the successful delivery of primary health care.

5. Long term strategies for economic diversification in towns with large FIFO/DIDO workforces.

SARRAH has no comment on this matter.

6. Key skill sets targeted for mobile workforce employment and opportunities for ongoing training and development.

Recruitment and retention to all rural and remote allied health positions is difficult and there is a high turnover of staff (Humphries et al 2010). It is essential that position descriptions and advertisements are accurate to attract workers who are appropriate for the positions and understand what will be required of them. Managers may be distant from the allied health professionals' workplace and so need to have a well developed understanding of both the nature of the professionals' practice and of the rural or remote context.

Continuing professional development (CPD) is a requirement and an issue for all allied health professionals, whether they are from a registered or self regulated profession. However, working in rural and remote communities reduces the access to CPD. Allied health professionals providing FIFO/DIDO services will generally either be a generalist within their profession (i.e. have skills across a range of service delivery areas within their profession) or will have a specific specialist skill set relating to that profession (e.g. paediatrics, neurology, rheumatology). The health professionals will need to be able to access CPD in the skills sets to meet the specific health needs of the community to which they are providing a service. While some training can be accessed online, more specific education requires travelling to metropolitan centres. This can be difficult due to the extensive time and cost required

to travel to places to undertake the training and the difficulty of providing a service during absences.

The FIFO/DIDO workforce will require orientation and induction to the local community. Again some of this can be provided on line but there needs to be a contact that is familiar with the community to provide this induction. If working in a remote Aboriginal community training in cross cultural issues/cultural safety is essential.

7. Provision of services, infrastructure and housing availability for FIFO/DIDO workforce employees.

Safe accommodation, transport, and information technology support for the FIFO/DIDO allied health workforce are important issues if visits to a local community will be longer than one day. The cost of providing such infrastructure and support increases with the greater remoteness of a community. The FIFO workforce also requires a venue for the delivery of the service appropriate for that community and the type of service being provided. This may be available at the local clinic or school, but for some services, for example counselling, another venue may be required.

8. Strategies to optimise FIFO/DIDO experience for employees and their families, communities and industry.

Every community has different needs and requirements and so different strategies are required to optimise the experience and the service provided by FIFO/DIDO allied health professionals. A comprehensive health needs assessment of communities where these services are provided is essential to ensure appropriate services are provided - one size will not fit all. FIFO/DIDO allied health services need to have effective promotion prior to services being provided, and employees will require support from local staff.

Allied Health Professionals need to visit a community for sufficient time to allow for the provision of holistic health care not just assessment/screening. There needs to be time allocated to develop relationships with local workers/service providers and community members so that mutual understanding and partnerships can be created. The FIFO/DIDO allied health professional is then able to integrate within the community and potentially participate in community activities. The service is most effective if the allied health service is provided by the same person each visit. A visiting calendar is essential so that the community knows when and who will be coming to provide the service and to prepare for their visit.

The FIFO/DIDO allied health professional needs to be familiar with other health professionals who visit from regional centres, so that they can coordinate visits and refer appropriately to other service providers.

The levels of support required by the FIFO/DIDO employee and their family will depend on the length of time spent away from the home base and the distances/frequency of the travel. In setting up a service delivered by a FIFO/DIDO allied health professional, consultation with employees and families about their

needs must be included. In addition, a Memorandum of Understanding could be developed between the local health service and the FIFO/DIDO service providers to ensure that all parties understand what services are to be delivered by who and when.

9. Potential opportunities for non-mining communities with narrow economic bases to diversify their economic base by providing a FIFO/DIDO workforce.

SARRAH has no comment on this matter.

10. Expansion of local employment.

Where the delivery of allied health services via a locally based residential team is not a viable option, FIFO/DIDO allied health service provision does provide some options for the expansion of the local employment base. This can be through the training, employment and support of local residential Therapy Assistants, Community Health Workers, Community Based Rehabilitation Workers and Community Co-Workers. The employment of such local staff improves the continuity of care for the community requiring the allied health services. For remote communities it is essential that visiting allied health professionals are able to work with a local co-worker who will be able to provide cultural brokerage, and facilitate a culturally safe service to clients.

A model that works well is one where allied health assistant(s) or community nurses in some situations are trained and employed locally and supported by allied health professionals remotely and when they visit the area. This builds the capacity and skills within the community while still allowing appropriate support networks. It also helps with local knowledge and assisting with arranging clinics/services when an allied health professional visits which in turn maximises their time.

11. Current initiatives and responses of the Commonwealth, State and Territory Governments.

The Australian Government currently funds FIFO female GP services and the Medical Specialist Outreach Assistance Program which has recently been expanded to include allied health services to remote Indigenous communities. The Royal Flying Doctor Service provides clinics in remote locations, which sometimes involve allied health professionals. Rural health programs such as the Rural Primary Health Services Program provide opportunities for local communities to develop and fill gaps in services, often residential, but also available to FIFO/DIDO.

Large tertiary metropolitan hospitals, regional hospitals and the larger rural Community Health Services will often provide regular outreach services to smaller towns and communities via FIFO/DIDO. For larger providers of such services the workforce will often have more specialised skill sets than can be provided by the residential workforce or more locally based rural Community Health Service for example Paediatric teams.

Conversely, some government initiatives require private health practitioners to deliver health services and if they are not available in rural or remote areas, program funds are often unspent and/or reallocated to other larger communities. In some jurisdictions where health services are purchased, the delivery arrangements are often not coordinated creating inefficiencies and/or duplication at the local level.

12. Any other related matter.

Many allied health professionals in rural areas are employed by public health services or in Non Government Organisations such as Aboriginal community controlled health services. As a consequence, a high risk exists when there are workforce shortages or difficulties with recruiting allied health professionals, especially when services are not well positioned to provide appropriate support and to effectively retain staff. Services to more remote locations can often be reduced or stop altogether which affects the continuity of services in those settings.

SARRAH would welcome the opportunity to provide the Committee with further information or discuss any of the positions taken in this response.