

House Standing Committee on Regional Australia

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

A Submission by General Practice Network NT (GPNNT) in consultation with the Northern Territory Department of Health (DoH)

Introduction

The Northern Territory (NT) provides extensive acute and primary health care services to a population that has a high percentage of Indigenous clients and is "very remote". Workforce requirements are identified on a needs basis taking into consideration population size as well as local morbidity. Whilst in theory a resident workforce more easily ensures continuity of care and better health outcomes particularly when caring for patients with chronic conditions, recruitment for long term resident medical, allied health and dental workforce has proven to be an unsustainable model despite considerable and long term efforts on behalf of the Northern Territory Government (NTG) as well as the Aboriginal Community Controlled Health Organisations (ACCHOs), and NT Health Workforce (NTHW), a unit of GPNNT. Consequently the use of Fly-In Fly-Out (FIFO)/Drive-in Drive-out (DIDO) models is essential to the delivery of primary health care throughout the Northern Territory.

Overview of the Northern Territory Healthcare System

The 2006 census showed that of the total NT population 22.4% lived in areas officially classified as "very remote". Given the relatively small total population of approximately 230,000 across the 1.3 million square kilometres of the NT, it is easy to see the complex challenges that are faced when delivering health care. There are a total of five public hospitals and one private hospital in the NT. The NTG also delivers primary care to over 54 remote communities via its Remote Health Centres. In the "very remote" communities Primary Health Care (PHC) is provided through the Remote Health Branch as a NTG service or PHC is provided by an ACCHO. In the major regional centres, such as Katherine, Darwin and Alice Springs, PHC services are delivered by a wide range of providers and health professionals. Key PHC providers include private providers (General Practitioners (GP), Nurses and Allied Health Professionals), NTG Community Health Centres, Non-Government Organisations (NGO) and Aboriginal Community Controlled Health Services (ACCHS).

Terms of Reference:

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

NT Health Workforce has seen an increased level of what could be termed FIFO/DIDO employment within both the NTG Health Centres as well as through the ACCHO in recent years. The models utilised in some remote sites differ from the traditional FIFO/DIDO practice in that they offer rotational models, i.e. where 2 GP service a community on a month on, month off basis; or where GP are resident in communities from Monday to Thursday and then spend Friday to Sunday in the nearest regional centre. This model, used by the Katherine West Health Board, is described in more detail later in the submission. Identified regions where FIFO/DIDO models are used include Katherine, Barkly, Utopia and Kintore. An ACCHO in Kintore has recognised that a FIFO/DIDO practice can increase retention rates amongst remote area nurses (RAN) and as a response is increasing the number of RAN that are offered this employment structure. The FIFO/DIDO model of employment increasingly seems to suit the personal circumstances of some health professionals.

Key points within the public health sector include:

- NTG Remote Health service delivery for health care to its 54 health centres is almost entirely based on a FIFO/DIDO model for the provision of primary care medical staff, allied health, dental and specialist medical care.
- Approximately 20 remote health centres managed by the ACCHO also rely on FIFO/DIDO as a health service delivery model.
- Commercial flights are utilised as much as possible.
- At least 3 charters per day are undertaken to remote communities.
- Staff FIFO air charters do not include the patient travel to major centres which include inter-hospital transfers intra and interstate.
- DIDO is utilised, more commonly in Central Australia than in the Top End, for shorter distances (less than 350km) and Top End road travel is significantly adversely affected by the wet season for 3-6 months of every year due to flooding, impassable dirt roads, and road damage.
- Dental and Child Oral Health Services are provided in a FIFO or DIDO model across the NT. The Central region has a 4WD truck with a self contained clinic that visits 43 communities. The Top End has placed oral health facilities in all major communities and uses a FIFO model to provide services to 31 Communities. The visiting oral health team consists of 6 Dentists and 10 Dental Therapists. They spend a week per month in larger communities. Communities with less than 800 people have a visiting oral health service 2 days every month.
- Health Development services are delivered to over 50 communities across the NT by teams of health professionals in 15 different disciplines including Public Health Nutritionists, Women's Health Nurses, Child Health Nurses and Remote Outreach Midwives.

- FIFO and DIDO are essential delivery models in closing the gap for Indigenous health care and are likely to increase in the future supported by and in combination with advancing e-health technology solutions.
- NTG provides comprehensive specialist outreach services across the entire 80+ remote clinics (54 NTG Remote Health Centres and 31 other health services) through FIFO/DIDO model. The Specialist Outreach Service includes medical specialist visits (surgical, paediatric, psychiatry, obstetrics etc) and allied health services with an average of 15 visits per week. Outreach services are an essential component of providing equity of access to remote communities particularly Indigenous clients. Moreover, specialist outreach services will be enhanced by the introduction of telehealth (videoconferencing services).
- In the NT there are three hearing services which operate a FIFO/DIDO model to provide services to remote communities. This includes Australian Hearing (a federal government service), NTG DoH service and Hearing Health Program (HHP). The HHP initially started as a short term NT Emergency Response (the intervention) project to respond to the extent of outstanding referrals as a result of the Child Health Checks. As time has gone on the project has received ongoing funding. The target population is Indigenous people under 21 years of age living in remote communities. A service is provided to all PHC throughout the NT in both NTG and ACCHO. The central service is located in Darwin and predominantly operates on a FIFO model. Audiologists and Ear Nose and Throat (ENT) nurses are sent to communities to assess children's hearing and to diagnosis ear disease. The team works with the PHC to develop a treatment plan for that child, which may include surgery. A 'Teleotology' model has been implemented where the Audiologist and Nurse travel to a community, review a child, collate all current data on that child, send it to a ENT specialist in a metropolitan hospital, who on the basis of that information will decide whether to place that child on the surgical wait list or not. The workload is substantial due to the extremely high prevalence of otitis media. At present they are reliant on locum Audiologist for these trips. There is a nationwide shortage of Audiologists, so it has been extremely difficult to recruit Audiologists in the NT. Locums usually come for a two week block. For this financial year they are aiming to have 60 trips to remote communities throughout the NT.

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

Established in 1998, the Katherine West Health Board Aboriginal Corporation (KWHB) is the sole provider of primary health care services to predominantly Aboriginal clients over a 162,000 sq/km region on the western side of the Northern Territory. This enormous area of rolling bush and river country extends from Katherine in the North East, through the Victoria River region, and down to Lajamanu on the edge of the Tanami Desert. KWHB employs Full Time GP in the larger communities of Lajamanu, Kalkarindji, Yarralin and Timber Creek. For some time now they have been operating a flexible working environment for GP who may choose to reside in community or operate on a FIFO basis. GP fly out by small aircraft on a

Monday morning, dropping off at each community and returning Thursday afternoon. Friday is spent at the KWHB head office in Katherine where administrative tasks are carried out as well as the opportunity for the team to take a joint strategic approach to planning the delivery of primary health care services across the region. This joint approach is very valuable both for GP and for the organisation as a whole, and provides GPs with important peer support. In addition it offers GP a work life balance where they develop community relations but also have access to the town facilities on a regular basis.

NTG provides all after hours care across the NT including the ACCHO sites. The NTG provides this using a 24/7 roster of telephone based GP called Remote Medical Practitioners who live in the larger centres. This support assists with the retention of resident remote GP by reducing their 'on call' burden.

As stated in the 'Rural Health Workforce Strategy Report' (Woolcott Research, September 2011, p5, *Barriers to becoming a Rural and Remote GP*) 'perceived isolation and distance from family and friends was a barrier that transcended across all segments, with many participants describing this as one of the major barriers to them considering a career in the country. As the restricting factor of remoteness is decreased it benefits to employers is the increased ability to recruit.' An Aboriginal Medical Service in Central Australia has benefited from a remote area GP who has so far completed near to 10 years at the same clinic. This has been attributed to the DIDO model of employment that allows him to live in Alice Springs with family whilst commuting to the clinic for work. This has enabled long term continuity of care and relationships between the community and the GP to be built. This is invaluable when treating chronic conditions and has also increased the effectiveness of 'on call' services as the GP already knows the patients and their families.

Some of the issues to the NT DoH associated with FIFO/DIDO include:

- Recruitment for long term resident medical, allied health and dental workforce has proven to be an unsustainable model despite considerable and long term efforts on behalf of the NTG as well as the ACCHO.
- In the remote public health system, the resident staff are nursing staff and Aboriginal Health Workers. They are supported by telephone with 24 hour rostered Remote Medical Practitioners. The teams share a common access to local clinical information systems and Shared Electronic Health Records to assist in patient management.
- Costs to the communities are lack of on site medical practitioners especially in emergency and urgent situations. There is also potential for disrupted continuity of patient care which is by necessity managed by other support mechanisms.
- Urgent and significant medical cases are flown to Darwin or Alice Springs utilising an emergency FIFO/DIDO service or on the FIFO patient travel scheme.

Some of the benefits to the NT DoH associated with FIFO/DIDO include:

- Benefits to the community are that medical services are available regularly and reliably on a face to face basis. Models of care are built around the FIFO model to maximise medical, allied health and dental specialist time. In addition, innovative

models of 'program support' at a distance have been developed utilising and supported by modern technology.

- Benefits also include the fact that the services can be delivered by long term employees which is important clinically for continuity of care and culturally for the Indigenous community members.

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

In Indigenous health settings, the cultural imperative to separate men's and women's business means that there is some advantage in providing male and female health professionals. FIFO/DIDO provides a model where this may be more achievable.

FIFO is an essential alternative to the market failure of recruiting medical personnel to remote communities. The remote communities are grateful for all service provision and FIFO ensures there is some service provision rather than none at all. Providing residential accommodation to the standard required by professionals is problematic in remote communities in the NT, even where the accommodation is well established.

Infrastructure such as access to adequate bandwidth is becoming increasingly important to support FIFO health service delivery models when critical aspects of the health service are provided on-line. This is a particular problem for many sites in Central Australia and some sites in the Top End that are serviced by satellite and are not on the fibre connection plans of the NBN. Improved service would significantly support closing the gap into the future.

It is important to note that only 7 of the 30 remote sites in Central Australia have bitumenised air strips. The remaining 23 are composed of gravel which is considered a less safe landing surface. All strips are critical infrastructure for routine medical visits and emergency transfers.

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

Whilst the FIFO/DIDO model is essential to health service delivery across the NT it is also important to recognise any external impacts that may jeopardise its effectiveness. Excessive strain on limited healthcare services can lead to negative impacts on the resident community.

Of significance is the burden placed on services which have been developed and funded based upon the demography of the local population. A FIFO/DIDO workforce is counted statistically within their home base community and they are expected to obtain non urgent services in their home community. However they often will utilise routine services provided by the remote community whilst on their mining site eg visiting specialist, dental etc. This puts pressure on a system developed for the local residents.

6) key skill sets targeted for mobile workforce employment, and opportunities for ongoing training and development;

Continuing Professional Development (CPD), particularly within the healthcare sector, can be difficult to access when residing in a remote location. It has been identified that ease of access to CPD can enhance the ability to retain employees long term and therefore decrease costs associated with recruitment. Using a FIFO/DIDO model ensures that employees will have the ability to access CPD regularly in an urban setting. Health services across the Northern Territory are increasingly utilising technology in the form of Webinars, teleconferences, SKYPE and MMS to increase the level of communication and support for GP in remote locations.

Member Services within GPNNT offer a range of CPD distribution methods to ensure access is available in remote locations. Member Services deliver face to face CPD in the major towns in the NT including Tennant Creek, Katherine, Gove, Darwin and Alice Springs. Webinar has recently been introduced to support GP residing in remote locations. There will also be Webinars available for allied health and nursing professionals in the near future. CPD grants are available to remote based GP to assist in accessing CPD, including interstate conferences and courses that may not necessarily be available in a more remote area. Member Services offer these grants as an avenue to ensure that GP can continue to reside in their remote location without compromising on professional development. Funding for these services is vital to ensure remote area GP are attracted to residing and remaining in remote practice.

Within the public health sector, orientation and training are essential components to successful service delivery. All off-site health service providers are required to fly to the communities that they are providing services to at least once per annum. Orientation and training is required for utilising the technology as well as understanding the limitations of the level of health service capability that exists in the remote health centres where the clients are situated. Online opportunities exist for education and training in the clinical information systems and other technology (e.g. videoconferencing), however, none of this can replace the value of a site/face-to-face visit to a community to get an understanding of the geographical isolation and physical and human resource limitations which are unique to each remote site.

7) provision of services, infrastructure and housing availability for FIFO/DIDO workforce employees;

Upon consultation with health professional employers throughout the Northern Territory it has been identified that lack of housing and the high cost of living is a major restriction when recruiting new employees. DIDO services have been utilised for travelling Allied Health Professionals (AHP) throughout the Territory to overcome this inhibitor. A campervan or temporary accommodation has also been utilised for these employees to

increase the access to these services despite the lack of housing. The small population of a number of communities in the Northern Territory consequently do not require a full time health professional. For example a current program operating in Utopia for the last 4 years has consultations with the clinic staff and community to identify gaps in AHP service provision. The funding available for this program has facilitated regular AHP visits between 0.3-0.5 FTE ensuring the health needs of the community are met. Whilst each AHP does live interstate, they have extensive experience in Indigenous health in the NT. In addition, one AHP team member has now relocated to Alice Springs permanently. This model of service delivery has enabled the AHP to build relationships of trust within the community and to provide continuity of care to community members through regular visiting services. For example, the same podiatrist and physiotherapist have been visiting for 4 years and the dietician for 3 years.

DoH has found that for most employees in the public health system, appropriately equipped and aesthetic accommodation, even for short periods such as one night per week, is essential to recruitment and retention of FIFO and DIDO staff, as their expectations are from a perspective of a city dweller where accommodation usually is of an extremely high standard. Numbers to be accommodated and standards of accommodation are commonly underestimated and are often the 'show stopper' in providing adequate FIFO and DIDO services (i.e. if the Doctor has to sleep in the health centre treatment room they don't usually want to come back for another FIFO/DIDO visit). Access to on line entertainment and services is also an essential infrastructure requirement where professionals are isolated from other professionals and educational and training opportunities.

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

NT Health Workforce currently has a number of strategies aimed at supporting GP and their families residing in remote communities. A family support weekend is held in Darwin and Alice Springs each year allowing GP and their families an opportunity to network with others that are residing in remote locations. NT Health Workforce administers the GP Rural Incentives Payments program which offers financial incentive to work and live in a remote location for an extended period of time. Communication and information distribution is an important tool to ensure that GP residing in a remote location feel connected. An info link through NT Health Workforce publications 'Ochre' and 'Weekly PHaCTs' has been developed to help retain health professionals in remote locations and ensure industry information and news is distributed. Managing expectations prior to commencing remote employment is very important. To assist with this, various strategies are utilised including site visits, community profiles, Stories from Country (short community documentaries shown to health professionals) and the Rural Emergency Skills Training (REST) program. GP that are employed on a rotational model such as one month on then one month off are offered these services when they commit to a long term contract to support continuity of care for the community. Rotational models of employment utilising FIFO/DIDO have been

implemented by various health services when recruitment of a resident GP has not been possible. This ensures that the needs of the community are still met at times.

The NT DoH proposes:

- That suitable and plentiful accommodation is an essential component of FIFO/DIDO service sustainability. Fluctuations in requirements and growth need to be accommodated.
- That accommodation is often the 'show stopper' or the bottle neck where it is well established that the service is required but it takes years before there is accommodation available to house the service provider so no service is supplied until the accommodation is built.
- The aesthetics and functionality of the health centre itself is also important – if it is a pleasant place to work that is helpful. If the Health Centre has an 'inadequate' emergency room, the staff may feel this places them at risk as they do not feel that the infrastructure supports 'safe practice'.
- That accommodation for families in the NT for FIFO/DIDO is not a requirement. Medical professionals usually travel without their families on short term visits on a weekly basis.
- That free access to online services such as television and internet are essential for employees to be able to keep in touch with their families and their external communities. It has been suggested that commercial cleaning of departmental accommodation at a determined repeated interval will encourage return visits from the visiting medical workforce.

10) current initiatives and responses of the Commonwealth, State and Territory Governments;

Commonwealth funding from the Department of Health and Ageing enables NT Health Workforce to support GP and employers in remote locations. As the NT Rural Workforce Agency, we are funded to ensure that health professionals are well supported in rural and remote settings. Consequently, we administer a variety of programs such as locum programs (including the National Rural GP Locum Program), Rural Locum Relief, Family Support, 5 Year OTD Scheme, Rural Health Professionals and the NT Pre-Employment Structured Clinical Interview for prospective GP. In addition to workforce programs GPNNT delivers a range of programs and services including Chronic Disease, Mental Health, Practice Support and eHealth initiatives.

Current initiatives through the NT Department of Health include:

- Current initiatives in telehealth by the Commonwealth - Health eTowns initiative in the NT and the 'online' MBS telehealth item numbers will both support and enhance the FIFO/DIDO workforce models.
- NTG has requested that the Remote Medical Practitioners providing 24/7 telephone support to the 85 remote health centres be eligible for the online telehealth MBS item numbers.

- Utilisation of online and remote support services is an essential component of successfully delivering health care in a FIFO/DIDO model and technology supported service provision is likely to expand to fill further gaps.
- The DoH Division of Remote Health leads the implementation of the recommendations on the minimum standards for the entire NT given in 'The Review of Remote Health Emergency Equipment, Rooms, Training and Vehicles'.

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