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NSW RURAL DOCTORS NETWORK

October 7, 2011

Committee Secretary,  
House Standing Committee on Regional Australia,  
House of Representatives,  
PO Box 6021,  
Parliament House,  
Canberra ACT 2600.

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

Dear Madam/Sir

Please find attached the NSW Rural Doctors Network's (RDN) submission to the above inquiry.

Should you require further information, please do not hesitate to contact me.

Yours sincerely,

Mr Mark Lynch  
Acting CEO.



## **Fly-In-Fly-Out/ Drive-In-Drive-Out (FIFO/DIDO) Response by the NSW Rural Doctors Network (RDN)**

### **General Overview**

Fly-In-Fly-Out/ Drive-In-Drive-Out health care, referred to in this response as Travel-In-Travel-Out (TITO) health care, has provided an essential service to rural and remote Australia for many years. This model of health care has been boosted considerably over the last 10 years with the introduction of the federally funded Medical Specialist Outreach Assistance Program and subsequent related health outreach programs. The benefits are significant with TITO services contributing significantly to the human capital of rural communities. It is important to stress that successful health outreach programs depend on good local day-to-day management of the TITO workforce. Local buy in, or ownership, is the key to success.

### **Background**

As a designated rural workforce agency, RDN provides support for a continuing and high quality rural health workforce in New South Wales (NSW). RDN develops and administers services and programs to improve the recruitment and retention of General Practitioners (GPs) throughout regional, rural and remote NSW, and provides a central information resource for rural medical support initiatives in NSW.

RDN is a not-for-profit, non-government organisation with more than 1000 members, including over 850 doctor members. RDN is funded by both the NSW and Australian Governments.

RDN manages a number of TITO specialist outreach services on behalf of the Australian government. To achieve good outcomes RDN has adopted a decentralised model that relies on local organisations to provide day-to-day management. RDN works with rural Divisions of General Practice/Medicare Locals, Aboriginal Community Controlled Health Organisations, Local Health Districts and some private health facilities to achieve this end.

RDN has also facilitated or is aware of a number of TITO arrangements whereby regular rotations of GPs have enabled continuity of essential hospital and general practice services in locations and situations where it has been very difficult to recruit, retain or replace doctors. In Tenterfield GPs from South Australia on short, regular rotations enabled the hospital to provide adequate after-hours services and contribute to community general practice services. In Walgett a regular roster of several GPs provided 1 week respite in 4 for the one resident GP who was also the sole Visiting Medical Officer 24/7 for the Walgett District Hospital. This TITO arrangement was critical to the retention of that GP for many years and which, with some expansion this year has thus far enabled continuous coverage and continuity of care since January despite the eventual departure of the resident GP more than a decade.

With 564 (34.6%) rural NSW GPs known to be aged 55 or more, and over 100 towns identified as being vulnerable to serious loss of medical services over the next 5 years, RDN expects greater resource to such arrangements. While first preference is for resident rural GPs, TITO arrangements are likely to become increasingly necessary as fallback workforce support strategies for existing rural doctors and as an incentive for attracting replacements for the GPs who are retiring or winding down their workload. In small towns where the arrangements involve the same doctors regularly supporting the same communities, the resulting continuity of care and GP familiarity with the community and hospital can provide high levels of community assurance and medical services. The supply of services is then not so dependant upon the health and well-being of only or two resident GPs.

### **Comment by RDN about TITO Health Services**

RDN offers the following comments in relation to the relevant Terms of Reference of the TITO review, particularly with respect to specialist outreach services:

#### **1. The extent and projected growth in TITO work practices, including in which regions and key industries this practice is utilized**

TITO is used extensively in health service provision in rural and remote areas. There are many reasons for this but, most significantly, many rural locations do not have and will never have the critical mass of population to support many types of health care practitioners locally including resident medical specialists and a range of allied health practitioners.

Federally funded health outreach has grown substantially over the last decade and services run through RDN now number more than 450, involving some 280 specialist doctors, with significant further growth expected over the next few years.

#### **2. Costs and benefits for companies, and individuals, choosing a TITO workforce as an alternative to a resident workforce**

In many respects there is no choice for many rural areas. TITO may represent the only way that residents in rural and remote areas can access health services that are somewhat comparable to those available in urban areas.

Other benefits are as follows:

- TITO specialists can provide surgical services that support local infrastructure eg operating theatres that would otherwise remain empty
- These same specialists can support local GPs to maintain their skills in anaesthetics, obstetrics etc
- TITO health care providers can contribute significantly to the human capital in rural and remote communities through the provision of education and upskilling of local health care providers in general
- By supporting local organisations to manage TITO services there is considerable local investment in making the services work and in ensuring that they are well integrated with local services.

TITO providers that are established to deliver services for the benefit of their host communities, i.e. improved access to services by lessening travel time and costs, add value to these communities and are generally constructive.

### **3. The effect of a non-resident TITO workforce on established communities, including community wellbeing, services and infrastructure**

The effect of TITO health workforce is mostly positive in terms of access to health care and support of local health care providers and organisations. Continuity of health care can be an issue in terms of such things as follow up and medical records. However, if the services are well integrated with local providers this problem is significantly diminished. As mentioned, RDN uses a decentralised model of management for TITO services and this ensures there is significant local investment in the integration of TITO services with those of local providers.

One would expect increasing local availability of TITO medical specialists and teams to have a significant positive impact upon the morale of local residents and health workers. Surveys of patients and GPs receiving and hosting such outreach services strongly confirm such expectations.

### **4. Long term strategies for economic diversification in towns with large TITO workforces**

This is not really relevant to the TITO health workforce.

### **5. Key skill sets targeted for mobile workforce employment, and opportunities for ongoing training and development**

With a TITO health care workforce it is important to ensure that the skill sets complement those of the local health workforce and do not introduce activities that are unsustainable for a particular community. A TITO workforce must be willing to provide multidisciplinary training and development.

### **6. Provision of services, infrastructure and housing availability for TITO workforce employees**

The TITO health care workforce generally only stays for short periods of time and motels are appropriate in most instances. However, there has been investment in housing for trainees including junior hospital staff, GP registrars and locums.

**7. Strategies to optimise TITO experience for employees and their families, communities and industry**

Some TITO health professionals enjoy the after hours solitude to catch up on reading, writing emails and letters etc while others seek companionship. The benefit of supporting local organisations to manage TITO health services is that they can respond to different social and support needs in appropriate ways.

**8. Potential opportunities for non-mining communities with narrow economic bases to diversify their economic base by providing a TITO workforce**

The TITO health workforce can contribute in a significant way to small communities with narrow economic bases through the employment of local coordinators and the use of local facilities including cafes and motels.

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

This response from RDN is focused on the impact of the Commonwealth Government's Health Outreach Programs, which provide much needed support for rural and remote communities. However, the TITO health workforce is much bigger than that represented by the programs referred to. Indeed, State Government funded, NGO sourced and private practitioners have provided essential health workforce support in rural and remote communities for many decades.