Commentary

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Fly-in Fly-out (FIFO) work in Australia: the need for research and a health promotion framework

After 18 months, the findings of the House of Representatives Standing Committee Inquiry into fly-in, fly-out (FIFO) and drive-in, drive-out (DIDO) work practices in regional Australia have now been released.[1] The Inquiry commenced in August 2011, conducted numerous consultation meetings and received 231 submissions. Although 'health' was not specifically mentioned in the terms of reference, many submissions contained strong views on the impact of FIFO/DIDO lifestyle on workers, their families and the communities in which they live and work.

The Inquiry's final report titled '*Cancer of the bush or salvation of the cities*' indicates that current FIFO/DIDO work practices are eating away at the liveability of many regional communities. The inquiry highlights the poor understanding of the impact of these work practices on workers, their families and host communities due to a dearth of empirical evidence. In turn, the lack of data means that governments (state and federal) are unaware of the impact of the resources boom on communities and are therefore unable to respond.

Of the 21 recommendations to the Commonwealth government contained in the report, many relate directly to the health of workers, their families and communities. The intent of the recommendations is to increase understanding of FIFO/DIDO related issues so as to potentially inform policy. Specifically, in regard to health, the inquiry recommends the following.

- *'…to develop and implement a method for the accurate measurement of the extent of FIFO/DIDO workforce practices and services….and service populations of resources communities ..'(recommendation 1)*
- *'…a study of the impact of non-residents workers in regional resources towns on the provision of medical services…'(recommendation 4)*
- *'..a comprehensive study into the health effects of FIFO/DIDO work practices and lifestyle factors...' (recommendation 8)*
- *'..research on the effect on children and family relationships of having a long term FIFO/DIDO parent...'(recommendation 10*)
- *'..research into the economic and social impacts of establishing regional centres…' (recommendation 11)*
- *' ..compile nationally consistent data …on the impact of FIFO workforces on housing, infrastructure, healthcare, social services…' (recommendation 18)*
- *'strategies to achieve fair access to health care for those living in regional and remote areas...'(recommendation 19)*
- *' Regional Development Australia committee, in consultation with regional health groups such as Medicare Locals, to have a health focus in its strategic plan...' (recommendation 20)*

These recommendations to better understand the impact of FIFO/DIDO work practices are welcomed, as in Western Australia (WA), the centre of much FIFO/DIDO work, it is commonplace

to see the FIFO/DIDO lifestyle suggested as a possible contributing factor to many contemporary social problems (e.g. psychological distress, family dysfunction, poor mental health and substance misuse.) However, many of the claims about the impact of FIFO/DIDO work practices result from anecdotal evidence and hyped media reports,[2] as there has been very little research data published in peer reviewed literature on the impact of the FIFO/DIDO lifestyle on individual and community health.[2-3]

Recent WA research sends a cautionary note to those wishing to make simple and generalised statements of cause and effect in relation to FIFO workers.[4] The study, the first large cross-sectional survey with this target group, used survey data from almost 12,000 WA residents collected through the WA Health and Wellbeing Surveillance System in the period 2008-2010, and the stereotypes were found wanting.

In this research, FIFO workers constituted around 72,000 workers or 4.4% of the working population, but were not a homogenous group. Only 5% were aged between 16 and 24 years old, 60% were 25-44 years old and over a third were over 45 years old. Compared to other workers, they were more likely to perform heavy labour and/or physically demanding work, but over a third performed sedentary work. They were more likely to be overweight or obese, drink to excess on a regular basis, and smoke more than other workers. However, despite the extended periods of time away from family and friends due to FIFO work, there was a lower self-reported prevalence of mental health problems in FIFO workers compared to shift workers and other employment types.

There are a number of possible explanations for this surprising finding: including that workers choose to adopt this lifestyle, which may lead to a selection effect, with more resilient individuals in the FIFO group compared to the general population. That does not mean, of course, that some individuals and families are not impacted adversely.

It is not that this study is in any way definitive, but in the absence of other data or higher quality studies, any assumptions about the effects of FIFO work on health remain just that. It certainly raises a range of questions about the specifics of the FIFO workforce, rostering practices, the provision of meals and exercise facilities at work sites, the shape of workplace health programs, access to primary care services, and lifestyle behaviours on returning home. Though not measured in the study, there are also likely impacts on communities (including Aboriginal communities) nearby to worksites, families and communities at home, and special groups like migrant workers on 457 visas.

A forum held in September 2012, and hosted by the WA Branch of the Public Health Association of Australia, looked specifically at the impact of FIFO/ DIDO lifestyles on health.[5] It emphasised the need for ongoing stakeholder partnerships between industry and health sectors. It called for

better research and actions 'at the coalface' and it highlighted the importance of balancing employer responsibilities for worker health, with the responsibilities of the individuals themselves.

Currently, some actions can be taken on the basis of what we know, in the form of workplace health programs to address lifestyle-related chronic disease and associated risk factors, as well as traditional occupational health and safety issues. Industry-specific aspects of FIFO work should inform physical and mental health policies. Workers should make an active decision about where they will access primary care, most often a general practitioner, whether in their home community, or in the community closest to work.

FIFO work will continue to expand in Australia over the coming years, as the mining and resources sector grows, and as part of a response to a long term urbanisation trend. Existing health promotion frameworks, even broad-based ones such as Dahlgren and Whitehead's model of the social determinants of health,[6] struggles to encompass the range of factors involved. New health promotion frameworks are needed that capture the dynamic nature of the FIFO lifestyle, for individuals and families, in 'residential' and 'workplace' communities – in other words, a framework that captures the critical role of space and place.

As recommended by the Senate Inquiry, research is required so that we can respond to the impact of FIFO/DIDO work practices. This needs to be conducted in a collaborative way between universities, industry groups, communities and workers. Part of the problem is that industry is likely to hold much valuable data, but has been reluctant to make this data public for commercial and confidentiality reasons. Future research should carefully collect baseline and longitudinal data on workers, their families and communities, and distinguish between a range of short and long term effects, both positive and detrimental, whilst highlighting strategies that amplify or mitigate such effects at an individual, family, workplace and community level.

References

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