

No Transport No Treatment

Community transport
to health services in NSW



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Table of Contents

| | | |
|-----------|--|----|
| | List of figures | 3 |
| | List of tables | 3 |
| | Acronyms | 5 |
| | Executive summary | 6 |
| 1. | Introduction | 10 |
| 1.1 | Aims | 10 |
| 1.2 | Methodology | 10 |
| 1.3 | The sample | 11 |
| 1.4 | Limitations of the research | 12 |
| 1.5 | Structure of the report | 12 |
| 2. | Context | 13 |
| 2.1 | Community transport in NSW | 13 |
| 2.2 | Funding of community transport | 14 |
| 2.3 | Health transport policy in NSW | 16 |
| 2.4 | The NSW Government State Plan | 17 |
| 2.5 | Changing demands for health related transport | 17 |
| 2.6 | The impact of changes to health service provision | 20 |
| 2.7 | Regional differences in health and transport | 21 |
| 2.8 | Regional differences in cancer incidence and treatment | 23 |
| 2.9 | Indigenous people and health related transport | 24 |
| 2.10 | Research on health related transport needs | 24 |
| 3. | Results | 28 |
| 3.1 | Number of health related trips | 28 |
| 3.2 | Service provision models | 28 |
| 3.3 | Proportion of trips to health destinations | 30 |
| 3.4 | Day of travel | 30 |
| 3.5 | Users of health related community transport | 30 |
| 3.6 | Health destinations | 30 |
| 3.7 | Type of clinic visited | 31 |
| 3.8 | Distance travelled to health facilities | 32 |
| 3.9 | Methods of managing demand | 32 |
| 3.10 | Unmet need/demand | 34 |
| 3.11 | Client contributions | 36 |
| 4. | Health related transport: An Aboriginal perspective | 38 |
| 4.1 | Issues in Aboriginal transport | 38 |
| 4.2 | How Aboriginal people travel to health appointments | 41 |
| 4.3 | Health service providers and community transport | 43 |
| 4.4 | Issues for Aboriginal transport industry workers | 44 |
| 4.5 | Improving health related transport for Aboriginal people | 45 |

| | |
|---|----|
| 5. Solutions | 46 |
| 5.1 The NSW Government State Plan | 46 |
| 5.2 Increase funding for non-emergency health related transport | 46 |
| 5.3 Allocate resources so health transport is available to all | 47 |
| 5.4 Prioritise access of Aboriginal people to health transport | 47 |
| 5.5 Increase the role of public transport | 49 |
| 5.6 Include transport as part of all health planning | 51 |
| 5.7 Collect data on transport needs | 53 |
| 5.8 Conclusion | 54 |
| Appendix I. | 56 |

Figures

| | |
|----------|---|
| Figure 1 | Population aged over 65 years in NSW, 2006. |
| Figure 2 | Projected population aged over 65 years in NSW, 2031. |
| Figure 3 | ARIA index map of NSW. |
| Figure 4 | Service provision models for health related community transport. |
| Figure 5 | Health destinations served by community transport in each Are Health Service. |
| Figure 6 | Types of demand management measures used in rural and urban community transport groups. |

Tables

| | |
|---------|--|
| Table 1 | Participating community transport providers by Area Health Service |
| Table 2 | Community transport funding by government program |
| Table 3 | Provision of health related trips by paid and volunteer drivers. |
| Table 4 | Most visited clinics by community transport services. |
| Table 5 | Demand management measures used by community transport groups. |

Acronyms

| | |
|---------|---|
| AAS | Area Assistance Scheme |
| ABS | Australian Bureau of Statistics |
| ACE | Adult Community Education |
| AHS | Area Health Service |
| AIHW | Australian Institute of Health and Welfare |
| AMS | Aboriginal Medical Service |
| ARIA | Accessibility/Remoteness Index of Australia |
| ATSI | Aboriginal and Torres Strait Islander |
| ARIA | Accessibility and Remotes Index of Australia |
| CDEP | Community Development Employment Program |
| CT | Community Transport |
| CTP | Community Transport Program |
| CPI | Consumer Price Index |
| CSO | Community Service Obligation |
| DADHC | NSW Department of Ageing Disability and Home Care |
| DVA | Department of Veterans' Affairs |
| GCMO | Gold Coast Mobility Office |
| GP | General Medical Practitioner |
| GSAHS | Greater Southern Area Health Service |
| GWAHS | Greater Western Area Health Service |
| HACC | Home and Community Care Program |
| IPART | NSW Independent Pricing and Regulatory Tribunal |
| IPTAAS | Isolated Patients Travel and Accommodation Scheme |
| HNEAHS | Hunter and New England Area Health Service |
| MDS | Minimum Data Set |
| MoT | NSW Ministry of Transport |
| NCAHS | North Coast Area Health Service |
| NCOSS | New South Wales Council of Social Service |
| NGO | Non-Government Organisation |
| NSCCAHS | Northern Sydney and Central Coast Area Health Service |
| NHS | UK National Health Service |
| PET | Pensioner Excursion Ticket |
| POW | Prince of Wales Hospital |
| PTS | Patient Transport Service |
| RACV | Royal Automobile Club of Victoria |
| RDF | Resource Distribution Formula |
| RTA | NSW Roads and Traffic Authority |
| SESAHS | South East Sydney and Illawarra Area Health Service |
| SWSAHS | South West Sydney Area Health Service |
| TAFE | Technical and Further Education |
| TFH | Transport for Health Program |
| WSAHS | Western Sydney Area Health Service |
| YACS | NSW Department of Youth and Community Services |

Executive Summary

“Community transport providers in NSW refuse an estimated 90,000 requests for transport to health services each year.”

Transport to health services is vital. Put simply, patients cannot be treated if they cannot attend their appointments.

Community transport offers non-emergency transport to people who are unable to travel by car or public transport, with a strong focus on providing services for older people and people with disability. However, health-related transport is increasingly using a greater proportion of the community transport budget. Community transport groups supply approximately 680,000 health-related trips per year in NSW. Many providers are routinely forced to refuse requests for transport to health treatment with some services closing their books on requests because they do not have the resources to meet demand.

The Cancer Council NSW (TCCNSW), Council of Social Service of NSW (NCOSS) and the NSW Community Transport Organisation (CTO) commissioned a major study of community transport in this state. The report, the first of its kind, examined the pressures of non-emergency health-related transport faced by community transport providers. A third of community transport providers were surveyed, including those who service remote and Indigenous communities.

The report found that thousands of people across the state are finding it difficult to access the health treatment they need, and community transport providers are struggling to address demand.

Key Findings

This report makes 5 key findings in relation to the delivery of health transport services by community transport providers in NSW.

1. There is increasing demand for transport to health services in NSW.

The delivery of health services in NSW has changed significantly over the years.

There has been:

- A concentration of services in fewer hospitals
- Moves towards early discharge and increasing use of day surgery
- A decline in the number of general practitioners in regional areas.

These changes have meant that people have to travel more often to access health services; people without access to a car or reliable public transport face the prospect of not receiving treatment because of access problems.

As such, demand for community transport has increased substantially. Community transport providers have more than doubled the number of trips they provide to health services over the last ten years: from 240,000 in 1996 to 680,000 trips in 2006. The proportion of trips that serve health facilities has grown from 16% to 28% of total community transport trips. As such, Community transport providers in NSW refuse an estimated 90,000 requests for transport to health services each year.

2. There is inadequate funding for transport to health services.

NSW Health only provides 10% of the funding for the 680,000 trips provided by community transport providers to health services. This means that providers must either draw from other funding sources or fundraise in order to meet demand. Inadequate funding for transport to health services has also meant that existing government programs (such as the Home and Community Care program) are inundated with requests for health transport, while also struggling to provide transport for other target destinations, such as shopping services and social outings for older people, people with disability and carers.

3. Both metropolitan and rural areas have health transport problems.

There is inconsistent provision of health-related transport across the state. Transport for Health program funding is not available to all community transport groups. Many country groups do not have access to paid drivers or vehicles and in some location's resources are consumed by long distance trips, especially to regular therapy appointments.

Community transport providers must turn away requests for transport to health services on a daily basis. Although this is a state-wide phenomenon, the problem appears more acute in urban areas. Metropolitan community transport providers refuse an average of 1 in 6 requests for health transport.

Urban community transport groups also spent more of their time providing transport to health services compared to other trips: among urban groups 44% of trips were to health treatment, compared with the state-wide average of 28%.

4. Indigenous groups are disadvantaged regarding health transport

Indigenous people appear to be the most disadvantaged in terms of access to suitable transport services to health services. This is related to:

- The low number of people in some Indigenous communities with driving licences or cars
- Issues of distance and a lack of public transport
- Low socioeconomic status and a reduced ability to purchase transport services
- The poor health status of many Indigenous people
- Culturally inappropriate transport services.

Many Indigenous people rely on family and friends for transport to health services, or on community services that do not normally provide transport. In some cases Indigenous people must walk long distances or hitchhike to access services.

5. Cancer patients are also disadvantaged regarding health transport.

Although cancer is one of the most common causes of morbidity in our society, with 1 in 3 people affected in their lifetime, access to transport for cancer patients can be difficult. The necessity for specialised vehicles, concerns about the side-effects of cancer treatments, and the problems these issues raise for staff and volunteer drivers have led to problems in community transport for cancer patients. Dialysis patients can also face transport problems due to the frequency and complexity of their treatment.

Solutions

The report makes a number of recommendations to improve the provision of health transport services in NSW. The NSW Government has made a commitment to improving services and outcomes within A New Direction for NSW: State Plan. There is now an opportunity for Government to develop strategies systematically that will make a positive contribution to the health and wellbeing of NSW residents. The solutions proposed within this report are relevant to goals and priorities within the State Plan and will contribute towards achievement of targets. In order to address the significant problems faced in ensuring connectivity to health services; it is recommended that the State Government of NSW take the following steps:

1. Increase funding for non-emergency health-related transport

There is a chronic shortage of funding for the NSW Government's Transport for Health program. The NSW Government currently spends less than \$1 on transport through this program for every \$1000 that it spends on general health services. Increased funding for health-related transport would reduce the number of people missing or delaying health appointments because of transport issues. This would also have the advantage of releasing existing community transport funding for other important transport roles.

"The responsibility for medical transport appears to be a grey area... in the meantime people are not receiving the service they need..."

TP&M interviews,
Western Sydney, 2005

"We were told of one woman in an isolated community who has to attend treatment three times per week. She has transport arranged for one day and has to hitch-hike on the other two days..."

TP&M interview,
Northern Rivers, 2005

The Cancer Council NSW, the Council of Social Service of NSW and the Community Transport Organisation recommend an increase of NSW Health funding for non-emergency transport services from the current less than \$3 million to \$10 million per annum. It would make sense for funding for community transport services to be coordinated by one agency, such as the Ministry of Transport.

2. Allocate resources so health transport is available to all

It is inequitable that people are not able to access health services because of where they live or who they are. Adequate resources should be available to each Area Health Service to meet community needs in the local region. Indigenous people face substantial problems accessing existing services: active steps must be taken to work with service providers and the community to remove these barriers.

3. Include transport as a part of all health planning

Transport should not be a barrier to accessing health services. If health services are restructured, government must ensure that people can travel easily to them. Transport should be an essential element of health planning. This should include planning for the provision of transport to treatment centres including those providing cancer treatment and dialysis. The government is urged to measure and report on its progress in solving transport problems relating to access to health services.

Recommendations

Recommendation One

Increase NSW Health funding for non-emergency transport services from the current amount of less than \$3 million, to \$10 million per annum.

NSW State Plan: S1, S2, F1, F2, F3, F5

Recommendation Two

That the distribution of growth Transport for Health funds to community transport groups be more equitably distributed across the state, taking into account population profiles, health indicators, the location of health facilities and the relevant costs of providing transport.

NSW State Plan: S1, S2, F1, F2, F3, F5

Recommendation Three

That the NSW Government develop a strategy to address access to health transport by Aboriginal people that includes consideration of: resources and funding for services, planning and coordination, access to motor vehicles and licenses, geographic isolation, patient travel assistance and accommodation schemes, cultural appropriateness of existing services, and information on public and community transport services.

NSW State Plan: F1

Recommendation Four

That the NSW Ministry of Transport work with NSW health to support bus operators to develop demand responsive flexible bus services that serve hospitals and other health facilities.

NSW State Plan: S2, S6, F1, F2, F3, F5

Recommendation Five

That NSW Health work with local and non-government service providers and other government agencies to develop a regional planning process for health transport.

NSW State Plan: S1, S2, S6, F1, F2, F3, F5

Recommendation Six

That systems be put in place by Health Transport Units and community transport operators to aggregate demand so that more effective use can be made of available transport resources and services.

NSW State Plan: S1, S2, S6, F5

Recommendation Seven

That NSW Health review discharge planning procedures to ensure that patient transport needs are prioritised at discharge and for future health treatment.

NSW State Plan: S2, F1, F3, F5

Recommendation Eight

That Area Health Services establish transit lounges at major health facilities and that major hospitals reserve areas near to hospital entrances for short-term parking reserved for use by community transport, Area Health transport and Ambulance transport services.

NSW State Plan: S2, S6, F1, F2, F3, F5

Recommendation Nine

That all Transport for Health data be made publicly available.

NSW State Plan: S1, S2, S6, F1, F2, F3, F5

Recommendation Ten

That a periodic unmet transport needs data collection among funded community transport operators should be undertaken regularly by the Ministry of Transport.

NSW State Plan: S2, F1, F3, F5

1. Introduction

This research project was a joint initiative of The Cancer Council NSW, the leading cancer charity, the Council of Social Service of NSW (NCOSS), a peak body for non government human service organisations, and the Community Transport Organisation, the peak body for community transport providers. Transport Planning and Management were commissioned to undertake the research and compile the report.

1.1. Aims

There has been growing anecdotal evidence from community transport (CT) providers in NSW of increasing demand for transport to health treatment. Growing demand for health transport places pressure on CT providers to do more with limited resources and reduces the capacity of providers to offer transport to other important destinations, such as social and recreational journeys. In many cases, CT providers are reporting that they must increasingly refuse requests for transport to health treatment, because they have no capacity to respond to growing needs.

The aim of this research was to analyse the scope and nature of the demands for non-emergency health related transport on CT providers in New South Wales and the resource implications which result from this demand.

The project objectives were to:

- Quantify the nature and extent of the provision of health-related transport provided by CT groups
- Assess the impact of the demand for health related transport on CT providers in relation to their other transport functions
- Estimate the extent of demand for health related transport that cannot be met by CT providers
- Identify and analyse variations in the provision of health related transport by CT groups and the unmet need for these services in relation to demography, health conditions, service models or service policies
- Identify and analyse the impact of the use of different service models and service policies.

The project included a focus on access for cancer treatment and analysis of service differences between rural and metropolitan Area Health Services (AHS).

1.2. Methodology

The research design involved the collection and analysis of both quantitative and qualitative data from CT providers geographically spread across the four metropolitan and four rural Area Health Services, using the following methods:

- a) Travel survey data:** Information about the provision of health related CT services for a one week period was collected from 38 CT providers. A total of 42 CT providers were invited to participate and 38 responded. Information collected included age, gender and details of all health related transport trips over the period including origins, destinations, type of facility visited, times and dates. All identifying information was deleted from the records by the participating groups to protect client confidentiality.

b) Interviews with CT providers: A structured interview was conducted with 12 CT providers; by telephone to rural providers and face-to-face with metropolitan providers. The interviews aimed to collect qualitative information about how non-emergency health related services were delivered, and gather the views of providers about the nature of the demand and problems and solutions for meeting the demand.

Additionally, information from two group discussions supplemented the individual interviews. One discussion group was held with providers in the North Coast AHS and the other with providers in the South Eastern Sydney/ Illawarra AHS.

A total of 19 groups were invited to participate, out of which 12 were interviewed, 2 declined, 4 did not respond and one participated in the (North Coast) discussion group. Of the 12 that were interviewed 9 also returned their short survey (see below).

a) CT interviewee survey data: Each CT provider who was interviewed was asked to complete a short, self administered survey to collect information about their service to enable comparisons to be made between the information from the interviews and the Travel Survey Data.

b) Unmet needs survey: Participants in the travel survey and the CT provider interviews were invited to complete by email the unmet needs survey along with a number of other groups. Those who opted into this additional survey kept a record of unmet requests for transport. This involved a short self-administered survey based on records of requests for health related transport. This aimed to provide some information about the types of services that agencies have difficulty in providing and why services are refused.

Agencies were asked to provide information about the requested date of travel, frequency of requested travel, destination and clinic to be visited, reason for refusal and whether the person was referred to another provider and the result of that referral. Participants in the travel survey and the CT provider interviews were invited to complete the unmet needs survey along with a number of other groups. A total of 16 CT providers responded to the unmet needs survey. Additionally, information from the South Eastern Sydney/Illawarra AHS CT providers, who had completed the survey for another project, was included.

c) Consultations with Indigenous service providers: Staff from eight Aboriginal Health Services around the state were interviewed. These telephone interviews were conducted by two former Aboriginal Transport Workers. The consultants also attended a meeting of the State Aboriginal Transport Workers Forum and also met with the NSW Ministry of Transport Aboriginal Transport Coordinator.

1.3. The sample

Sampling took into consideration the number of CT providers in each AHS region, the size of the locality where the providers are based and the remoteness of the locality based on the ARIA index, in an attempt to ensure a reasonable spread across the current distribution of CT providers. Consideration was also given to coastal versus inland locations for Great Southern AHS and Hunter/New England AHS. The number of groups participating in the project in each AHS region is shown in Table 1.

Table 1. Participating community transport providers by Area Health Service

| Survey Type | Area Health Service | | | | | | | | |
|---------------------------------|---------------------|---------------------------------|-------------|-----------------------------------|------------------------|-------------|------------------|-----------------|-----------|
| | Sydney South West | South East Sydney/ Illawarra | Sydney West | Northern Sydney/ Central Coast | Hunter/ New England | North Coast | Greater Southern | Greater Western | Total |
| Travel data | 3 | 5 | 4 | 4 | 6 | 3 | 7 | 6 | 38 |
| CT interviews | - | * | 2 | 2 | 2 | 1* | 2 | 3 | 12 |
| CT interview survey | - | - | 1 | 2 | 1 | 1 | 1 | 3 | 9 |
| Unmet needs survey | - | 6 | 1 | 2 | 4 | 1 | 1 | 1 | 16 |
| Total study participants | 4 | 10 | 6 | 6 | 9 | 3 | 10 | 10 | 50 |
| CT providers in each AHS | 9 | 15 | 7 | 9 | 23 | 6 | 32 | 18 | 119 |

*Group discussions were held in two AHS with a number of transport providers attending.

1.4. Limitations of the research

Overall a total of 50 CT providers participated in the project, which represents more than 40% of all CT providers in NSW. This sample size is sufficiently robust to provide an indication of the issues facing CT providers in their delivery of transport to health destinations.

Nevertheless there are limitations. For example, it is difficult to compare representation across regions because of the variability in the resources of CT providers and the populations they serve. Similarly, the travel survey data represents a relatively short period of time within a calendar year – it does not account for the ‘seasonal’ fluctuations in demand that CT providers are likely to experience. Thus, the data was corrected for these fluctuations.

Although there are large amounts of data collected by transport providers, their funding bodies and health services, it is difficult to analyse systematically or spatially, because of different jurisdictional boundaries used by the government departments (namely transport and health), different data collection requirements by the different funding bodies, and different collection methods used by the providers themselves. Further, under-reporting in the Home and Community Care (HACC) Minimum Data Set information currently collected by this Commonwealth/State government program and an absence of publicly available data about transport activity funded under the NSW Health Transport for Health program and the Department of Veterans’ Affairs, limits the potential to draw definitive conclusions from these sources. The interviews conducted as part of this project aimed to overcome some of the research limitations described above, by providing in-depth information on the key issues that face the CT industry.

It is acknowledged that the mix of face-to-face, telephone and survey responses used in this research will limit the strict comparability of results arrived at by different methodologies. For example face-to-face structured interviews were used for metropolitan providers and telephone interviews for rural providers: it can be expected that this use of different methodologies will affect comparability between metropolitan and rural responses for structured survey results.

1.5. Structure of the report

The methodology and findings from the interviews and surveys conducted as part of this research are set out in Chapters 1 and 3 of this report. The background and policy context of community transport in NSW is described in Chapter 2, as well as a literature review of previous health related transport studies. Consultations with Aboriginal health and transport workers are presented and discussed in Chapter 4. Suggested actions required to redress the inequities in health related community transport are recommended in Chapter 5.

2. Context

Improving the health of the population is a priority concern of state and federal governments. Access to health care services by all people in the community is a critical factor in determining health outcomes.

The availability of suitable transport, beyond emergency ambulance assistance, is integral to enabling access to health care services. Where the use of private motor vehicles or public transport is either not available or not practical, the demand for non-emergency health related transport falls largely to community transport providers. The purpose of community transport (CT) is to meet the needs of specific transport disadvantaged groups in the community including isolated families, the frail aged, younger people with disabilities, and their carers. As such, CT provides transport disadvantaged people with access to recreation, shopping, education, medical care, social services and social contact, where conventional private or public transport systems are not generally considered viable or appropriate.¹

Approximately 119 state government-funded CT groups currently exist in NSW. Transport Planning and Management were commissioned to undertake research investigating the scope and nature of the demands for non-emergency health related transport on formal CT providers in NSW. This report aims to inform policy development, service provision and resource allocation in this area. Services regarding cancer treatment were a focus of this project. Transport provided by family and friends did not form part of this research.

2.1. Community transport in NSW

Passenger transport has always occurred informally through communities, families, friends and neighbours providing assistance to people who face barriers to accessing transport. The first formal community transport service established in NSW was the Bathurst Community Bus which was approved by the state government in 1978 and which still operates today. In 1981, the Department of Youth and Community Services (YACS) provided a grant to Kogarah Community Aid and Information Centre for research into the needs of aged and disabled people. The research, which was undertaken by the Geography Department of the University of Sydney, led to the establishment of the St George Community Transport Project.²

In 1983, YACS funded nine CT projects totalling \$72,250. In the meantime CT groups were lobbying the Minister for Transport to take responsibility for the new industry sector. Successive ministers refused on the grounds that it was a form of welfare and not a transport service. Representations to the Premier Neville Wran eventually lead to the Ministry of Transport taking responsibility for CT and the establishment of the Community Transport Program. Other financial support came from local government, Area Assistance Schemes and the Community Employment Program. CT workers at this time concentrated upon planning activities, identifying unmet needs, modifying existing services, hiring spare capacity to start new services, making greater use of community buses, and starting share-ride taxi and hire car services.³

However, direct service provision was on the horizon. The Community Transport Organisation (a peak body for those involved in CT issues) argued strongly that the new Home and Community Care (HACC) program should include a transport sub-program, which is what eventually happened in NSW. Funding from this source grew from \$4.9 million in 1991 to over \$20 million last year with the bulk of the funding being used for the development and delivery of direct services.

“The purpose of community transport is to meet the needs of specific transport disadvantaged groups in the community including isolated families, the frail aged, younger people with disabilities, and their carers.”

The initial focus of the CT industry in NSW was shopping, transport to day-care and outings. This role has shifted towards the provision of transport to health destinations. Health related transport is increasingly using a greater proportion of CT budgets and has become the main focus of transport by volunteers in rural areas. A report completed for the NSW Health Department in 2001, highlighted the role CT played in access to health services. The researchers found that 40% of publicly funded non-emergency health related transport in NSW was provided by the CT sector, a greater proportion than either the Ambulance Service or the Area Health Services.⁴

Demand for health transport has also changed the way in which CT operates in NSW, with an increasing focus on 'individual transport' (i.e. the use of a car and driver to provide more intensive support to clients) as opposed to 'group transport.' Some CT groups initially refused to provide individual or health related transport but specific funding from the HACC program for this purpose rapidly expanded this mode of CT. Individual transport was initially delivered predominantly by volunteer drivers, however paid drivers have become more prevalent, particularly in urban areas. Although many individual transport services are open for any purpose, in practice most now concentrate on transporting people to and from medical facilities. For example, a metropolitan CT service that participated in this research reported that over 95% of its individual transport trips pertain to health facilities.

It is important to note that a large number of non government human service providers also deliver transport as a core component of their service package, even if they are not formally recognised for this role. This can include organisations such as community health, residential aged care and supported accommodation providers. Home and Community Care funded Neighbour Aid providers also provide community transport services, many to health related destinations.

2.2. Funding of community transport

Whilst CT groups have been very inventive over the years in finding ways to finance their operations, most funding now comes from a limited number of sources. Some of this funding is used for general CT (which includes health related transport) services whilst some funding is specifically allocated for the provision of health related transport. The main sources of funding for CT are shown in Table 2.

Table 2. Community transport funding by government program*

| Program | 2006-2007 \$ |
|---------------------------------|-----------------|
| Home and Community Care | 26.2 million |
| MoT Community Transport Program | 2.9 million |
| Area Assistance Scheme | 660,000 |
| Transport for Health* | < 3 million |
| Department of Veterans' Affairs | N/A |

*Notes: The NSW Health Transport Program in 2006/07 was allocated \$15.9m, of which funding for non-emergency transport services was unreported, but can be estimated to be between \$1 and \$3 million. No data was available at this time this report was published on funding through the Department of Veterans' Affairs regarding community transport.

The main source of funding for CT is via the Commonwealth/State HACC program. Government allocates HACC funding through a formula which is partly based on population size. The overall increase in funding through HACC has increased considerably as a reflection of changes in population. The formula does not however take into consideration geographical differences and variations in distances to access health services. HACC-funded transport services are restricted to people who meet the HACC eligibility criteria. People requiring CT who fall outside of these criteria generally have to rely on transport provided by the Community Transport Program (CTP) funds or other sources. The funding available through CTP is not responsive to demographic change nor geographic variations, and has not been increased (beyond indexation for inflation) to meet changing needs. Area Health Service funding for CT is not available in all regions, but has been increased in recent years.

The provision of health related transport tends to be more expensive on a unit cost basis than most other forms of transport because of the increased administration involved in booking and scheduling each individual trip and the one-to-one nature of many trips. Indeed it can be reasonably estimated that the provision of a passenger trip on individual transport (the vast majority of which is health related transport) takes more than twice as many resources as does a passenger trip on group transport.⁵ This has implications for the available resources for health transport, as shall be discussed further in Section 5.

Some information about fares and donations was gathered from CT groups surveyed for this project which indicated that these groups raised about 20% of their income 'through the fare box.' It is estimated that the total income from this source across NSW could be about \$5 million. This project was unable to obtain information about funding for health related transport by local governments or the Department of Veterans' Affairs.

HACC clients

Most funding for CT is provided by the HACC program. This program aims to prevent inappropriate or premature admission to residential care by providing a range of community support services, including transport, to frail older people, younger people with a disability and their carers. The Department of Ageing, Disability and Home Care estimates that the HACC target population in NSW is just over 558,500 people.⁶ However, being eligible for the program does not guarantee a service.⁷

A significant proportion of HACC funding is used to transport HACC clients to health appointments. As stated above, delivery of health transport can be comparatively resource intensive, relative to other forms of transport. For example in one eastern Sydney community transport provider survey paid administration hours were spent on health transport than other transport (59% and 41% respectively, which reflects the labour-intensive nature of organising individual trips). In the one group that used volunteer administrators, 74% of their time was spent organising health related transport.⁸ Strong demand and the relative resource intensity of health transport services will compromise the ability of community transport providers to respond to other community needs.

Clients of other funding programs

Some groups also receive other funding from the Ministry of Transport through the Community Transport Program (aimed at addressing transport disadvantage at the local level by primarily facilitating efficient use of transport resources that exist within the community) and the Area Assistance Scheme (which facilitates and supports community development and the integrated provision of services in regions undergoing rapid urban growth or change).⁹

In some areas, such as North Sydney, South Sydney and Leichhardt, local councils fund shuttle bus services which may be used to access health facilities among other destinations. These services are open to all residents.

2.3. Health transport policy in NSW

In 2001, the NSW Health Department commissioned a report on non-emergency health related transport.³³ The report recommended the establishment of Health Transport Units within each Area Health Service and Health Transport Networks in each area. Most of the report recommendations were incorporated into a new model for non-emergency transport called Transport for Health. This model became a policy directive of the Department in August 2006, which means that its implementation by every Area Health Service in the State is mandatory.¹⁰

One effect of the policy directive is to amalgamate a number of separate funding programs for non-emergency health related transport into one, called Transport for Health. It includes the following former programs:

- The Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)
- The Health Related Transport Program
- Inter-facility transport (non-Ambulance)
- Statewide Infant Screening-Hearing Program
- Services funded under the former Transport for Health Program.

The Transport for Health program aimed at supporting Area Health Services to be more strategic in identifying, consolidating and integrating a full range of transport services and resources to increase effectiveness and reduce duplication. Furthermore it promoted the use of a mobility management approach to non-emergency transport by all Area Health Services, through coordination between the appointments system and transport service providers, the encouragement of closer cooperation and the development of partnerships with external service providers such as the community transport industry.

There is funding available specifically for health related transport through the Transport for Health Program. Eligibility for support under this program is wider than for HACC.

Transport for Health (non-emergency health related transport) services are to be provided on the basis of a patient's inability to reasonably gain access to local health services by either public or private transport, rather than inconvenience.¹⁰

In practice passengers whose trips are subsidised by Transport for Health in rural areas are taken to regional and Sydney-based health facilities as well as local facilities. As with the HACC program, Transport for Health is based on eligibility rather than entitlement. Priority should be given to requests for assistance that will have the effect of preventing the development of a medical condition or reducing the chance of an existing health condition becoming more severe.

Non-emergency services provided by the NSW Ambulance Service do not form part of the Transport for Health program. One of the aims of the Transport for Health policy is to transfer some of the responsibility for Non Emergency Health Related transport from the Ambulance Service of NSW to the Transport for Health Program.

However, as NCOSS has pointed out:

A significant injection of funds will be required by the NSW Government into Transport for Health and other programs to replace the current NEHRT services provided by the NSW Ambulance Service.¹¹

Whether these funds will be made available and whether the policy will affect the demand or supply of CT is yet to be seen.

2.4. The NSW Government State Plan

There is a policy context for improving access to health services, as described in *A New Direction for NSW: State Plan*.¹² The NSW Government have made commitments to healthy communities through improving access to quality health care, improving survival rates and quality of care for people with chronic illness, and fairness and opportunity through improved health outcomes for Aboriginal people. These priorities correlate with improved transport to health treatment. Health transport improvements also link strongly to other priorities in the NSW State Plan, including reduced avoidable hospital admission, improved outcomes in mental health and increased participation for people with disability.

Chapter 5 provides an outline of how proposed solutions in this report relate to the NSW State Plan.

2.5. Changing demands for health related transport

Over the past twenty years the provision of health related transport by CT groups has steadily increased. This has been in response to a number of factors including regional demographic shifts, and changes to health care service provision, transport policy and funding.

The impact of demographic change

Significant shifts in the demographic profile of regions within the state reflect two broad social trends, namely:

- The ageing of the population, which involves an increasing proportion of the population represented by people in older age groups, along with increasing life expectancy.
- Domestic migration, which involves shifts in residential location leading to declining population in some regional areas and rapidly increasing populations in other areas. Most notably has been a growth in the population of coastal areas, and a decline in some inland regional areas.

The increasing numbers of people living beyond their eighties has meant that there more older people who can no longer drive or use public transport. The lack of feasible transport alternatives for older people has arguably resulted in increasing demand on CT providers, particularly for transport areas that have not responded adequately in relation to the provision of flexible and accessible services. Concern has been expressed both by the CT industry and its funding organisations that, as the demand for health related transport grows, other CT functions, such as for shopping and social activities, will be overtaken. This has particular resonance as CT is an important means of addressing social isolation.

Other concerns regarding the ageing population have included the long-term sustainability of using volunteer CT drivers for long journeys with passengers that are frailer and less mobile. The projected growth in the proportion of older people in our population is illustrated in Figures 1 and 2.

Figure 1. Population aged over 65 years of age in NSW, 2006.

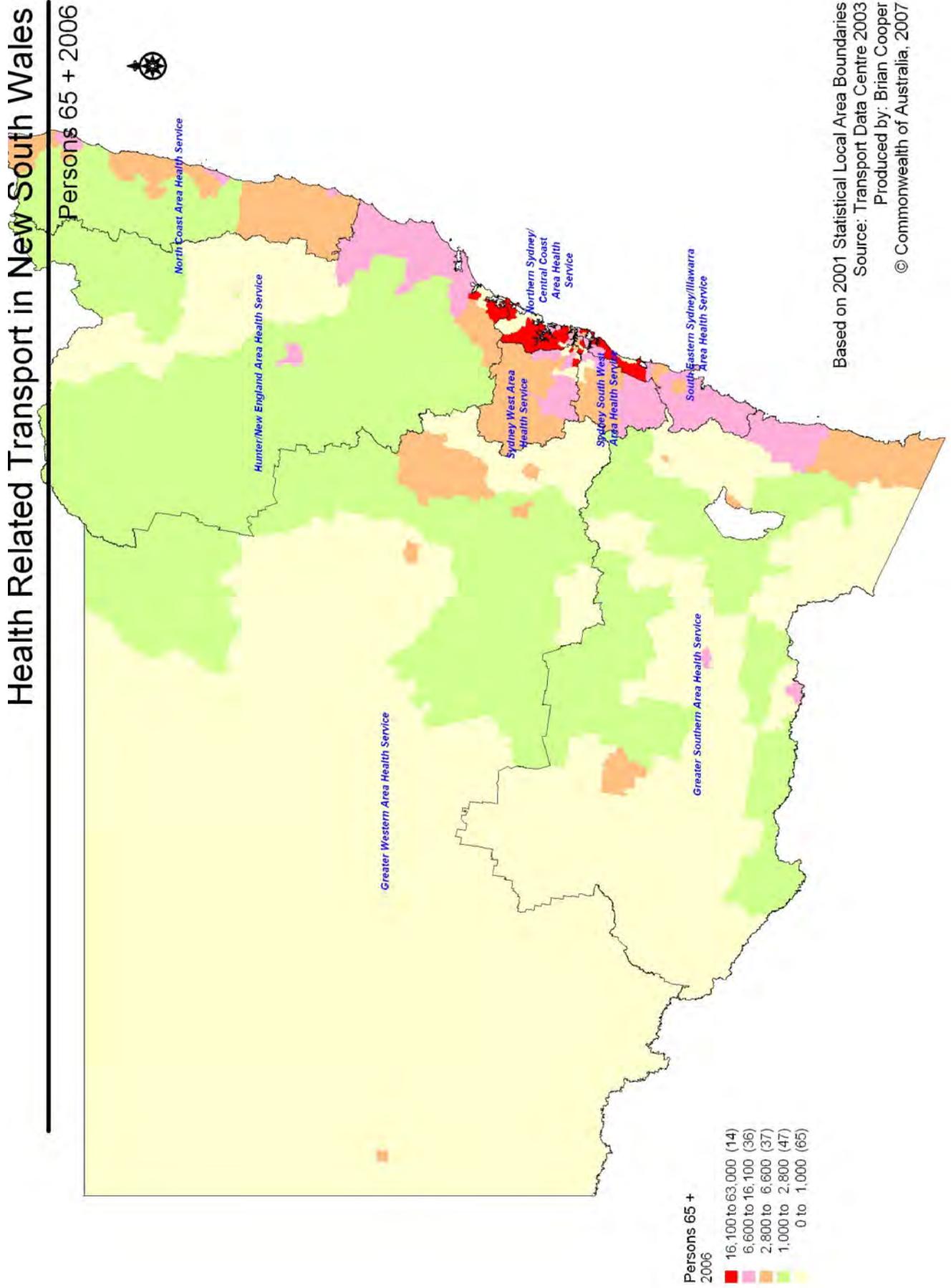
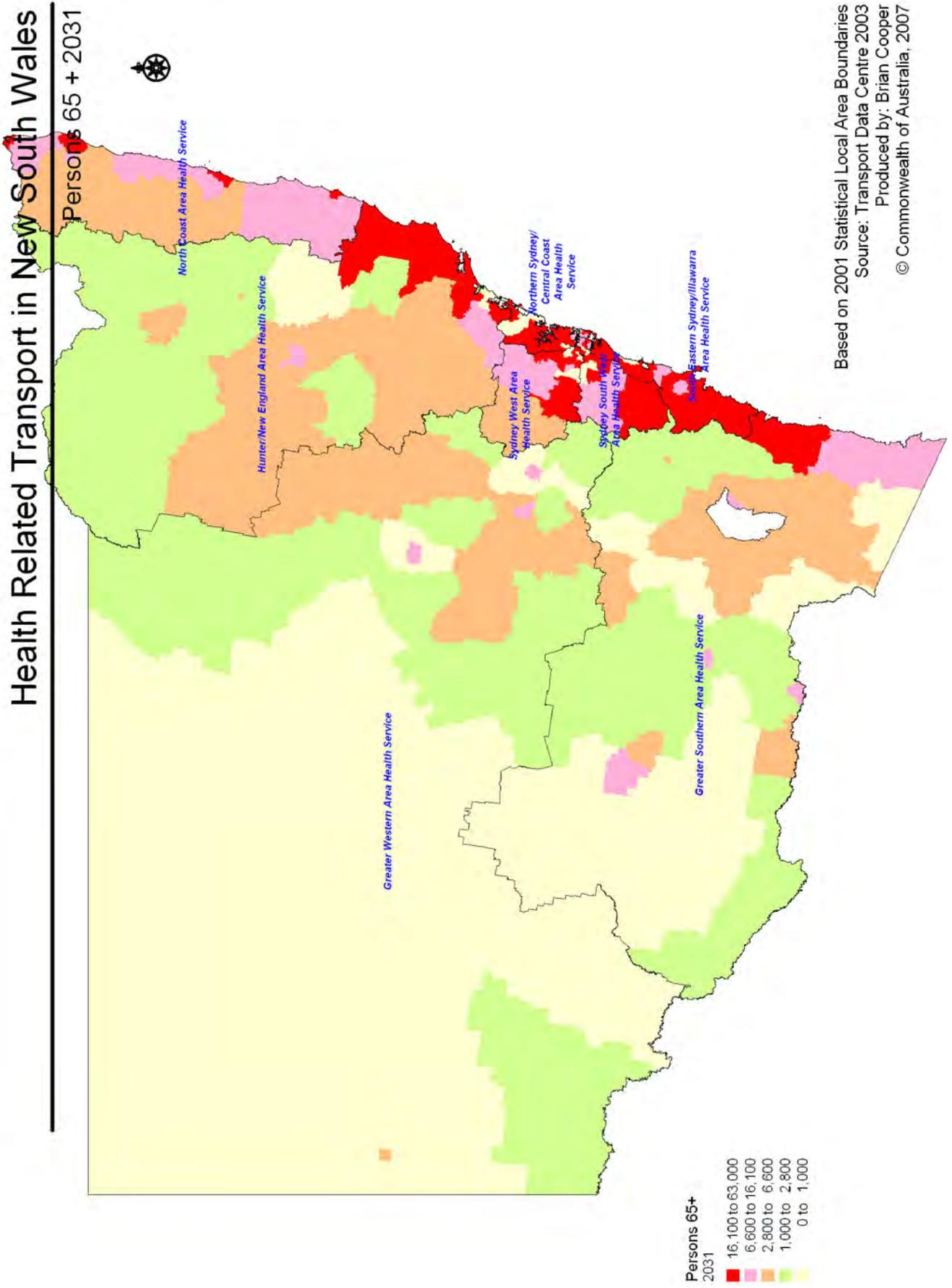


Figure 2. Projected population aged over 65 years in NSW, 2031



“For many people getting access to a doctor has become a much more difficult task than it might have been in the past.”

2.6. The impact of changes to health service provision

Reform of health care services is an ongoing process for the NSW government, driven by public demand for improved quality in health care as well as fiscal constraints. Broadly speaking, some important changes to the way health care is provided over the past decade have had an impact on the demand for health related transport. These include the following:

The concentration of services in fewer hospitals

For many conditions, services are now more safely and effectively treated in larger centres; smaller centres often do not have the capacity to support specialist practices. Concentrating health services in fewer hospitals frequently means people have to travel further to access health care.¹

A move to early discharge and increasing day-only surgery

Early discharge policies and the use of day-only surgery for treatment of a wider range of conditions frequently means patients need more assistance upon discharge and while travelling, making some forms of transport unsuitable, like driving themselves or catching public transport. Again this has been noted in the House of Representatives Standing Committee on Health and Ageing report, which argued that “early discharge, attendance as outpatients, day treatment at doctors’ surgeries mean that older people must travel more frequently for health care, often under circumstances when they require support while travelling.”²

Increased demand for health related transport has also been driven by an increase in the number of procedures that can be undertaken on a day-only basis and the location of diagnostic and specialist health services in larger centres as technology develops.³

A reduction in home visits by doctors.

There is evidence that GPs are making fewer home visits, necessitating travel to doctors’ surgeries by people who may not have private transport or the ability to use regular public transport services. According to Medicare statistics, the number of home visits made by GPs (mainly to elderly females) fell by 40% from 1.76 million to 1.05 million, nationwide between 2001 and 2006.⁴

The role of the NSW Ambulance Service

A change in the role of the NSW Ambulance Service has also increased unmet demand for health related transport. In the early 1980s, the primary formal service provider of health related transport was the NSW Ambulance Service which was providing about 600,000 non-emergency trips per year at the time. Alterations to the Ambulance Transport Guidelines in the mid-1980s, from recommendations contained in a Ministerial Inquiry into the NSW Ambulance Service (the Gleeson Report),⁵ resulted in the number of non-emergency trips provided by the Ambulance service dropping by over 450,000 trips – a reduction of approximately 75%.⁶

These factors have increased the importance of facilitating transport to health services. Arguably, the changes in the way health services are delivered have placed an increasing importance of transport being considered as a key component of the health system. One medical practitioner has described transport as a form of health service because of its critical role in getting people to the health service they require:

You bring people to the doctor; you do not necessarily bring the doctor to the people. It is cheaper, so transport is actually a health service provision.⁷

2.7. Regional differences in health and transport

Consideration of geographic variations in disease incidence and mortality are important for planning health services, addressing responsible lifestyle and environmental factors, and setting priorities for screening and other early-detection initiatives. Across Australia, people living in rural and remote areas generally have worse health than those living in cities.⁸ Reasons for this include geographic isolation, socioeconomic disadvantage, shortage of health care providers, lower levels of access to health services, greater exposure to injury risks, and poor health among Aboriginal people. According to NSW Health almost one quarter of people living in rural or regional areas will face difficulty accessing health care when they need it.⁹

Both urban and non-urban areas have issues with health-related transport, but with different underlying causes. In rural areas, the long distances to health care services, particularly specialist services, cause major difficulties in the provision of health related transport compared to metropolitan areas.

A report by the NSW Premier's Department in 1999 suggested that in rural areas vehicle resources may be underutilised while the transport needs of the wider community remain unmet.¹⁰ For example, in rural areas, school bus services, which are often the only public transport, run at restricted times and not during school holidays. This view was echoed by another researcher of the time:

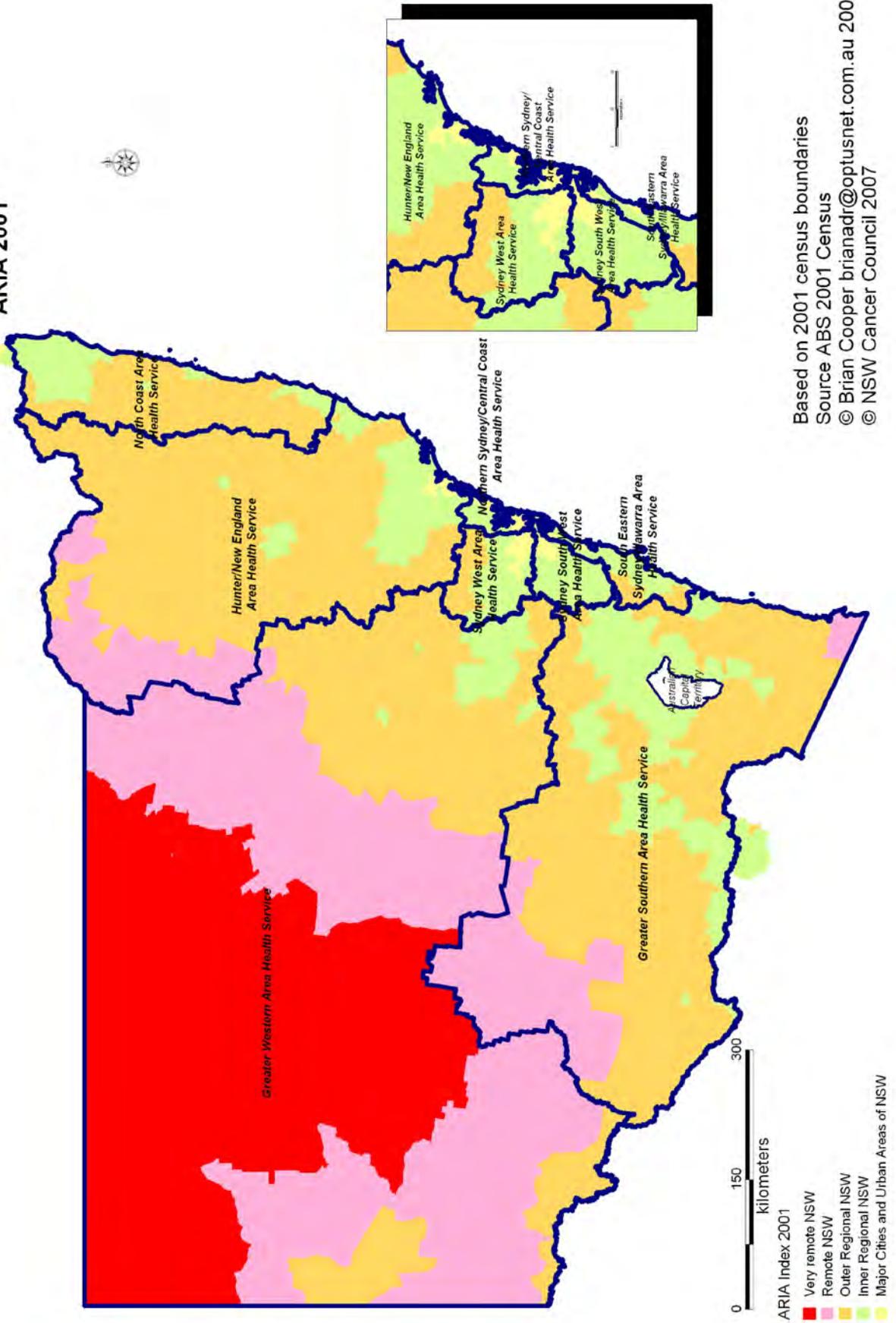
Guidelines for funding programs tend to be narrow, prescriptive and focused on a particular target group. Service provision based on strict program guidelines becomes increasingly unviable in small rural communities.¹¹

Problems in health-related transport faced in metropolitan areas, particularly the inner city, include that the supply of volunteer drivers is decreasing although the demand for health related transport is burgeoning. One major service has recently closed its doors to all new referrals yet requests for services continue to rise.¹²

Figure 3. ARIA index map of NSW

Health Related Transport NSW

ARIA 2001



2.8. Regional differences in cancer incidence and treatment

In Australia, one in two men and one in three women are expected to be diagnosed with cancer before the age of 85 years.¹ As the population ages the incidence of cancer increases, so more than half of all cancers are diagnosed in those aged 65 years and over. Cancer accounts for 29% of all deaths in Australia.²

In NSW, there were 34,092 new cases of cancer in 2004, affecting 19,160 males and 14,932 females. The most common cancers were prostate, colorectal, breast melanoma and lung. Together these accounted for 60% of all cancers.²⁵

Geographical variations have been observed in the incidence, treatment, mortality and survival of particular types of cancer by region. As noted in a previous NSW Cancer Institute report on cancer in New South Wales:

*Sometimes geographic variations in mortality reflect underlying incidence patterns, whereas on other occasions, they are influenced by differences in treatment outcomes or differences in quality of care.*²⁵

For example, the mortality rate from all cancers including prostate is significantly higher in the Hunter New England region, although the incidence of these cancers is the same or lower than that of the rest of NSW. Lower rates of screening tests and prostatectomy were found to contribute to the 21% excess mortality from prostate cancer in regional and rural areas compared to metropolitan areas across Australia.³ Lung cancer mortality rates are significantly higher in the Sydney South West Area Health Service region, however this could be influenced by the high incidence of these type of cancers in this area.²⁵ The observed variation in survival after diagnosis of colorectal cancer between Area Health Service regions was concluded to be a function of differences in cancer treatment in another large population-based study.⁴

A nation-wide assessment of cancer services which surveyed oncologists, chemotherapy nurses and other staff in regional hospitals which administer chemotherapy, found that 65% of respondents indicated that travel support was a problem for rural and regional patients.⁵ Another study, which adjusted for differences in incidence across geographic areas, found that people living in remote NSW diagnosed with cancer were 35% more likely to die as a result of their cancer within five years of diagnosis, compared to people living in metropolitan or inner regional areas.⁶ Problems with accessing health care caused by a shortage of healthcare providers and poor transport links also contribute to the poorer survival rates in rural and regional areas.^{26,30}

Geographic differences are compounded by low socio-economic status. Individuals of low socioeconomic status generally have a higher risk of avoidable death, and a higher number of ambulatory care hospitalisations,²⁰ both indications of poorer access to preventative health treatment.

Providing transport to health services for cancer treatment presents particular logistical and care challenges for transport providers compared to most other health related trips. Chemotherapy and radiology treatments involve an intensive period of treatments requiring trips to hospital three times per week for several weeks. People undergoing chemotherapy or radiology treatment are often very ill following treatment and require specialised care and support. Transport providers may therefore require specialised training to cater to people who have undergone cancer treatments. The difficulties experienced in accessing treatment for cancer and other health conditions, including those relating to transport to treatment centres, need to be considered as part of the quality and distribution of health care available across the state.

“43% of people in NSW over the age of 60 years needed assistance with transport.”

2.9. Indigenous people and health related transport

The most disadvantaged population group in terms of health status are Aboriginal people.⁷ On average, the life expectancy of an Aboriginal person is seventeen years shorter than other Australians. Aboriginal people comprise almost one-third of the population of very remote areas in NSW. Remoteness has a negative effect on health outcomes. Compared with people who live in major cities, people who live in remote or very remote areas:

- Have a life expectancy of 4 fewer years in remote areas and 11 fewer years in very remote areas
- Are more likely to die prematurely, and from causes classified as avoidable
- Report greater difficulties in getting health care when they need it
- Are more likely to be hospitalised for conditions for which hospitalisation can be avoided through prevention and early management.²⁰

It is likely that inadequate access to transport to health treatment is a key factor in poor health outcomes for Aboriginal and Torres Strait Islander people in NSW. Issues of access to transport are discussed in more detail in Chapter Four.

2.10. Research on health related transport needs

Several government reports from Australia and overseas have highlighted that the transport needs of the community are not being met. These reports are summarised below.

Australia's Welfare (AIHW)

The Australian Institute of Health and Welfare reported that transport is the area with the highest proportion of older people reporting that their need for assistance was completely unmet (11%). The Institute also noted that such figures “do not tell the full story” as those persons receiving some assistance may not be having their needs fully met.³¹

Survey of Disability, Ageing and Carers (ABS)

The ABS 2003 *Survey of Disability, Ageing and Carers* showed that 182,800 people (43%) in NSW over the age of 60 years needed assistance with transport. The percentage was lower among the 60 - 64 year age group but neared 50% for those over 75 years.⁸ Of these, 43,000 people had their needs partly met or not met at all.

Assistance was provided either formally (by funded services) or informally (by family or friends). According to the survey most assistance was overwhelmingly provided by informal providers (145,400 people compared to only 21,000 receiving assistance from formal providers). Of these about 30,000 were male partners, 20,000 female partners and 100,000 other relatives or friends. Significantly, 25,000 people did *not* receive the assistance they needed.³²

Other Australian Evidence

The 2001 non-emergency health related transport report⁹ reported that according to a survey of patients, 20% indicated that they had difficulty getting to or from health facilities in the three months prior to the survey.

In 2007, the Royal Automobile Club of Victoria undertook a survey of 100 recently retired drivers. The results showed that 5% of them do not visit the doctor or hospital and 31% found it hard to do so.¹⁰ It also appeared from this study and another undertaken in 1999¹¹ that difficulties in getting to health facilities is not just a rural phenomenon and that city people can experience as much difficulty getting to health facilities as people living in the country.

Interstate and overseas evidence

There is emerging evidence from the United Kingdom that there may be a strong link between transport and the non-attendance of hospital appointments. The researchers, from the Transport Studies Department of the University of East London claimed that missed hospital appointments are a problem costing the National Health Service millions of pounds each year. It has been reported that people failing to turn up for appointments costs the NHS in the region of £300 million (\$A750 million) per year.¹²

The UK researchers also said that missed appointments are evident across all areas and although health professionals tend to consider apathy the main cause, the reasons for non-attendance can be masked by other issues such as childcare responsibilities and poor weather and that transport rather than apathy was a significant factor.¹³

Another UK research report found that 31% of non-drivers and 17% of those with a car have problems getting to their local hospital. Over 1.4 million people said that they had missed, turned down or chose not to seek medical help during the previous 12 months because of transport problems.¹⁴

In the USA, participants in a survey of 100 families in Ohio with a history of missed appointments said that transport problems were a barrier to getting to appointments.¹⁵ Evidence from the United States suggests that longer driving distances from home to treatment services is associated with poorer glycaemic control in diabetes.¹⁶

Transport to therapy services

Previous studies have found that providing services to transport people to therapy services, such as cancer therapy and physiotherapy, appears to be particularly difficult for some CT groups. Therapy transport is a big commitment for CT providers, *"an incredible strain"* as one stakeholder put it. People need to get to city hospitals from the urban fringe for services such as oncology. Getting to Penrith from the Hawkesbury was described as *"a disaster"* by one interviewee.¹⁷

Other groups appear to select which treatments they will take passengers to. The Cancer Council has described some the problems this can have for patients:

*Just recently we had a very distressed woman ring the office trying to find a way to get to her radiotherapy for 6 weeks. She was feeling too sick to make the trek of bus, train and then walk to the centre from the station etc and was acutely anxious about possibly missing her treatment because of this and money for transport was also an issue. Our staff spent quite some time contacting Health, community transport and other agencies, without any luck, even though there was some understanding from the Health Transport Unit, but community transport (in this area) were not able to transport anyone who needs treatment.*¹⁸

There has also been a suggestion that some CT groups do not see therapy services as health related transport at all:

*Some therapy services such as hydrotherapy and physiotherapy are not seen as medical transport by some CT providers and the people miss out. This can delay their recovery. People have to depend on friends and relatives or church voluntary driver.*⁴¹

While there is little research in Australia on the association between transport, access to health services and health outcomes to draw direct conclusions from, the poorer health of people living in rural and remote areas, along with fewer health services in these regions, suggests that transport may be an important.

- 1 NSW Ministry of Transport. Local and Community Transport Programs. www.transport.nsw.gov.au/lact/programs.html. (Accessed on 22.3.2007).
- 2 Sussman, T. A History of Community Transport. Sydney. (Unpublished).
- 3 Edgar, K. 1985. Paper presented at the Australian Passenger Transport Conference, Sydney.
- 4 Transport Planning and Management. 2001. Non-Emergency Health-Related Transport – Facilitating access to health services in NSW. Submission to the NSW Government Action Plan for Health. North Sydney: NSW Health, p33.
- 5 An example in eastern Sydney shows that in one group individual transport accounts for 18% of all trips yet consumes 38% of paid driver time, 34% of volunteer driver time, 35% of paid administration time and 74% of volunteer administration time.
- 6 HACC target population is estimated by applying the sum of the moderate, severe and profound disability rates. Taken from the most recent Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC), to the relevant population projection.
- 7 NSW Ministry of Transport. Local and Community Transport Programs. www.transport.nsw.gov.au/lact/programs.html. (Accessed on 1.12.06).
- 8 Information from the Sydney Metro Transport Development Project, Randwick Waverley Community Transport Group. (Personal communication).
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- 12 NSW Government. 2006. State Plan: A new direction for NSW. Sydney: Premier's Department.
- 13 Department of Health and Ageing. 2007. Submission: Senate Community Affairs Committee inquiry into the operation and effectiveness of patient assisted travel schemes.
- 14 House of Representatives Standing Committee on Health and Ageing. 2005. Future Ageing: Report on a draft report of the 40th Parliament: Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years. Canberra: Commonwealth of Australia, p56. Personal support for people requiring access to health services is often only available from relatives or community transport services. The 2002 General Social Survey conducted by the Australian Bureau of Statistics (ABS) found that transport was the most common form of assistance provided to other relatives living outside the household, by driving them or letting them borrow the car. See Australian Bureau of Statistics (ABS). 2002. General Social Survey, Summary Results. Canberra: ABS. Catalogue No. 4159.0
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- 17 Gleeson, J. 1983. An Inquiry into all aspects of the NSW Ambulance Service. Sydney: NSW Department of Health.
- 18 Stone, C. and Mant, J. 1991. Health Related Transport Review. Prepared by Phillips Fox for the Community Transport Organisation, Sydney.
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- 20 NSW Health. 2006. Health of the people of NSW 2006: Report of the Chief Health Officer. Sydney: NSW Department of Health.
- 21 NSW Department of Health. 2005. 2004 Report on Adult Health from the NSW Population Health Survey. NSW Public Health Bulletin 2005: 16 (S-1).
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- 23 Rai, J. 1997. Issues in the Provision of Welfare/Human Services in Rural and Remote Communities in NSW: Discussion paper written for the North Coast Management Group of the Premier's Co-ordination Project. Sydney: Government of NSW.
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- 31 Australian Institute of Health and Welfare (AIHW). 2005. Australia's Welfare 2005. AIHW: Canberra.
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- 34 RACV. 2006. Transport and Mobility: Challenges, innovations and improvements. Melbourne: Royal Automobile Club of Victoria.
- 35 NSW Health. 1999a. NSW Older People's Health Survey. Sydney: NSW Department of Health. The survey involved 8,881 interviews with non-proxy respondents and 537 proxy respondents over 65 years of age. The survey had a response rate of 70.7%.
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- 37 Hamilton K. and Gourley M. 2002. Missed hospital appointments and transport, London: University of East London, p 32
- 38 UK Social Exclusion Unit. 2003. Making the Connections: Final Report on Transport and Social Exclusion. London: Office of the Deputy Prime Minister.
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3. Results

In order to estimate the amount of health related transport provided by CT groups in NSW, we surveyed 38 groups throughout the state. Each group was asked to provide data on all health related transport trips submitted over a two week period based on their travel data collection records. To expand on the quantitative information, interviews were conducted with another 12 CT providers and of these 12 groups, nine also provided some quantification of their services. In total, 50 CT groups contributed data to this study; this represents 42% of all formally funded CT providers in NSW.

3.1. Number of health related trips

A total of **2,247** outward trips (trips to destinations) were made during the one week survey period; an average of 59 trips per group. Most of the passengers also made a return trip, so it is estimated the number of passenger trips provided by the survey respondents over the period is approximately 4,250.

Extrapolating from the travel data collected in the course of this study and accounting for public holidays and summer closures, it can be estimated that all funded CT groups provide approximately **680,000** health related passenger trips in NSW over a year.¹

3.2. Service provision models

Amongst the survey respondents, services were provided using a mix of paid and unpaid staff. Generally rural groups depended more on volunteer drivers, while groups on the urban fringe and outer suburbs used a mix of paid and unpaid staff. Groups in the inner city mostly used paid staff (Table 3).

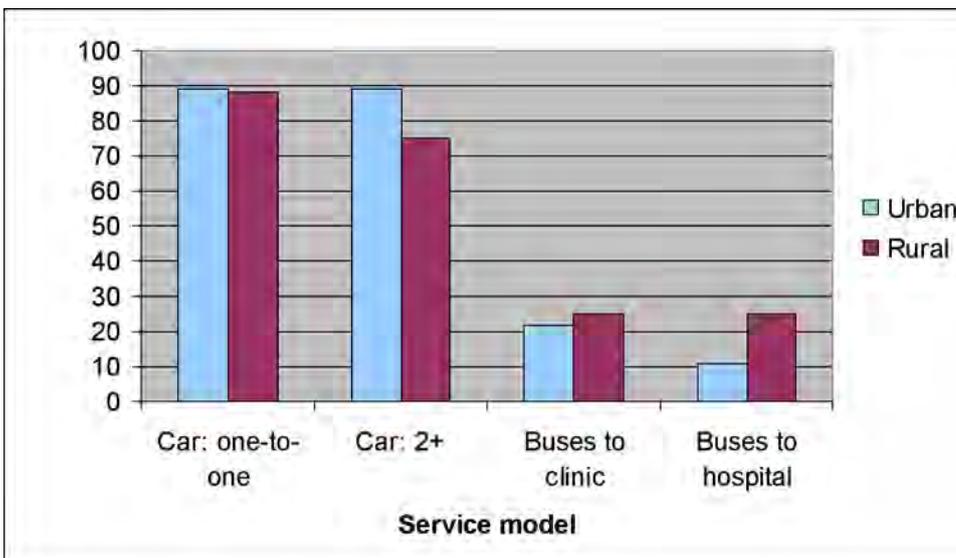
Most health related transport is provided on an individual basis with doubling-up of passengers achieved when possible. Some groups used minibuses to provide group transport to health facilities, particularly to therapy services such as hydrotherapy. This approach is becoming more common in areas of higher population density.

This study found CT groups use a range of service provision models for health-related transport, with 92% reporting that they provide health-related trips on a one-to-one basis. Other options include matching two or more passengers in one car going in the same direction (used by 83% of groups), and using buses to serve particular clinic or hospital (used by 22% of groups). There is also a significant use of taxi vouchers schemes in two country centres and in one urban fringe area surveyed.

Table 3. Provision of health related trips by paid and volunteer drivers

| ASGC* | AHS | Health Facilities Visited | Trips per week | | | | |
|-----------------------|--------------------------------|--------------------------------|----------------|-------------|-------------------|-------------|------------|
| | | | Paid Drivers | | Volunteer drivers | | TOTAL |
| Major City | Sydney West | All | 51 | 91% | 5 | 9% | 56 |
| Major City | North Sydney/ Central Coast | All | 73 | 60% | 48 | 40% | 121 |
| Inner Regional | Greater Western | All | 9 | 23% | 31 | 78% | 40 |
| Inner Regional | Hunter/ New England | Limited cancer | 0 | 0% | 183 | 100% | 183 |
| Inner Regional | Northern Sydney/ Central Coast | Not cancer, not renal dialysis | 375 | 100% | 0 | 0% | 375 |
| Urban Total | | | 508 | 66% | 267 | 34% | 775 |
| Outer Regional | North Coast | All | 4 | 2% | 209 | 98% | 213 |
| Outer Regional | Greater Southern | All | 0 | 0% | 7 | 100% | 7 |
| Outer Regional | Greater Western | All | 0 | 0% | 3 | 100% | 3 |
| Remote | Greater Western | All | 1 | 9% | 10 | 91% | 11 |
| Rural Total | | | 5 | 2% | 229 | 98% | 234 |

Figure 4. Service provision models for health related community transport*



*24 groups participated in this survey. Most groups used a combination of all models.

3.3. Proportion of trips to health destinations

Overall, trips to health destinations accounted for **28%** of all the transport provided by CT groups.

There was a degree of variability across all CT providers surveyed; the percentage of trips that groups provided to health facilities ranged from 12% to 54% of all trips provided. Non-health related trips include shopping trips, services to day care centres, outings, shuttle services and non-medical individual transport services.

There were differences between urban, urban fringe and rural groups in the number of health related trips provided as a proportion of all trips. An analysis of data from a selection of survey participants showed that among rural and urban fringe groups, 27% of trips were for health transport purposes. However, among urban groups 44% of trips were to health facilities. These findings are derived from a relatively small sample, but indicates that demand for health related travel is likely to be higher in urban areas.

3.4. Day of travel

According to the travel data survey, most health related trips were evenly spread between Mondays and Thursdays (19% – 22% on each day) with slightly fewer travelling on Fridays (16%). Only four trips were recorded during the weekends. Survey participants could not account for there being fewer Friday trips.

3.5. Users of health related community transport

As described above, clients of CT are constrained by the eligibility guidelines set down by funding programs, in particular the Home and Community Care Program. According to the travel data survey undertaken as part of this project, most passengers (78%) were 65 years of age or older. Two percent were younger than 35 years of age, 19% between 35 and 64 years of age, 62% were aged between 65 and 84 years and 16% were over 85 years of age. In other words, health related CT services appear to cater mainly for older people. The average age of passengers differed between the Area Health Services.

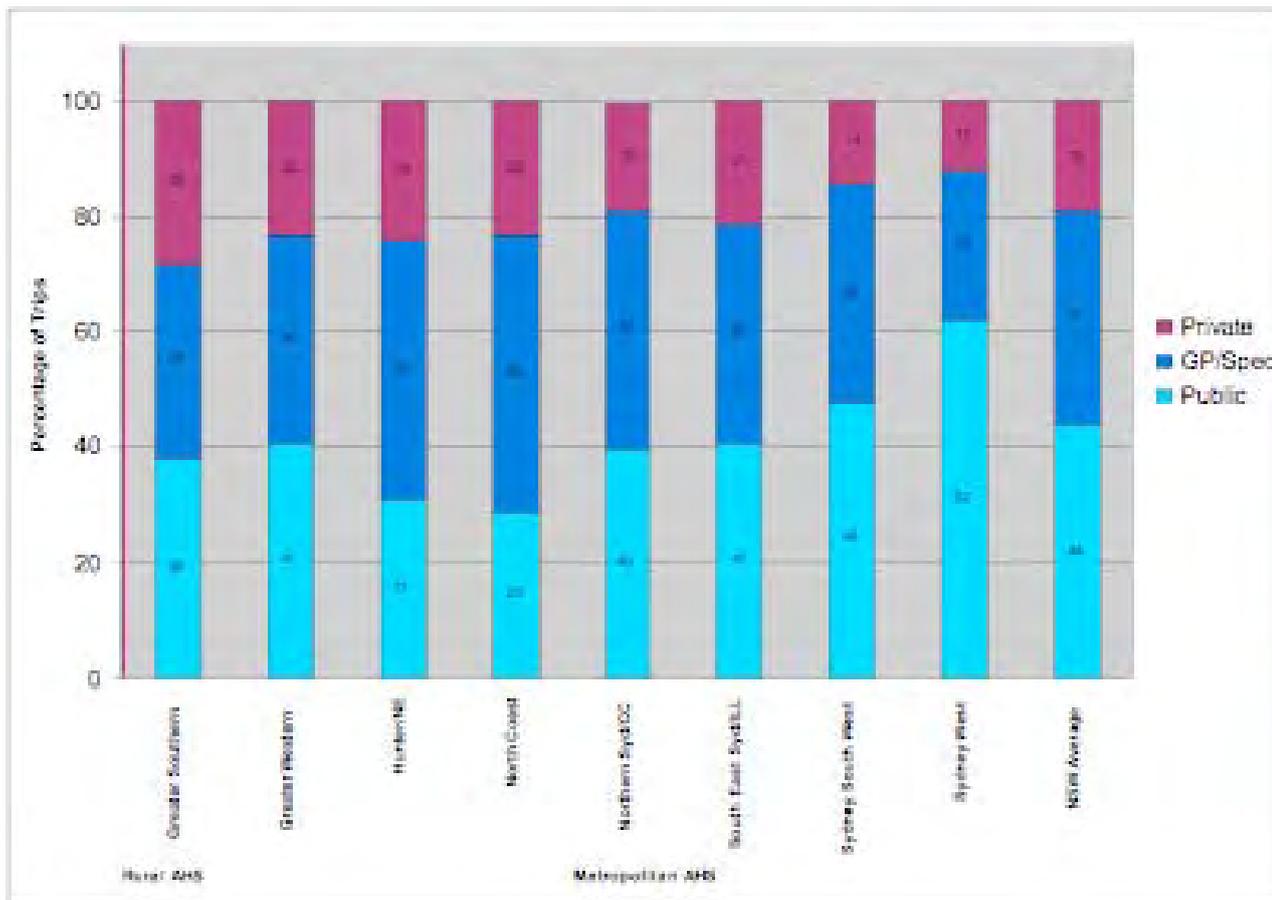
Women made 70% of all the health related community transport trips in this survey, and men 30%.

3.6. Health destinations

The majority of trips were to public health facilities, general practitioner or specialists (Figure 5). Of the 2,247 trips provided during the study period:

- 44% of all trips were to public health facilities
- 37% were to GPs or specialists
- 19% were to private health facilities.

Figure 5. Health destinations served by community transport in each Area Health Service.



3.7. Type of clinic visited

The most commonly visited clinics over the one-week study period were physiotherapy (156 trips), cancer-related clinics (151 trips) hydrotherapy (136 trips) and renal units (89 trips).

We estimated that over a period of a year CT groups provided over 50,000 passenger trips (one-way trips) to and from physiotherapy clinics and 50,000 trips to and from cancer related clinics. Over 45,000 passenger trips are provided to hydrotherapy clinics and over 30,000 to renal dialysis units (Table 4).

Table 4. Most visited clinics by community transport services.

| Clinic type | Passenger trips in 12 month period |
|----------------------|------------------------------------|
| Physiotherapy clinic | 53,891 |
| Cancer clinic | 52,164 |
| Hydrotherapy clinic | 46,982 |
| Renal unit | 30,745 |
| Dental clinic | 27,982 |
| Podiatry clinic | 27,636 |
| Eye clinic | 17,273 |
| Hospital admission | 9,327 |

Travel to some clinics was generally much further in country areas than in urban/semi-urban areas. This was true for cancer centres, dental clinics and for hospital admissions.

3.8. Distance travelled to health facilities

According to our survey of health related transport, passengers travelled an average of 21 kilometres to health facilities (distances quoted are direct “as the crow flies”).¹ There were, unsurprisingly, major differences in the average distances travelled within Area Health Services with the lowest being North Sydney/Central Coast AHS (8 kilometres on average) and the highest being Greater Southern (49 kilometres).

About 75% of trips were 15 km or less. However, the distances passengers travelled to particular types of clinics varied a great deal. For example, 90% of trips to podiatry and 80% of trips to physiotherapy, hydrotherapy and renal dialysis were 15 kilometres or less. On the other hand, the greatest average distances travelled by individuals to clinics were 64 km for hospital admissions, 38 km to oncology units and 30 km to renal units.

Importantly, around 135 trips by CT providers involved journeys over 100 km during the survey period to access a health service. In other words, it can be estimated that annually approximately 6% or 41,000 trips by CT providers to health treatment are over 100km in length.

Long distance travel may be more prevalent for some treatments than others. For example, 19% of renal patients travelled in excess of 100 kilometres each way. In four cases, within Area Health Services, the average distance to some forms of health treatment was over 100 km. These were:

- An average of 164 km to eye clinics in the Greater Southern region
- An average of 118 km for hospital admissions in the Hunter/New England region
- An average of 117 km for hospital admissions in the Greater Southern region
- An average of 108 km for renal dialysis in the Greater Southern region.

It should be noted that in some isolated areas distances people have to travel to get to health facilities can be very much longer. A survey undertaken in the far west of the state identified return trips as long as 1,500 kilometres to get to a medical appointment.¹

Of cancer patients, half lived within 15 km of their treatment centre and 40% between 16 and 50 km away from the clinic they attended.

There were large differences between the average distance travelled by men (27 kilometres) and women (18 kilometres). Men travelled further than women in all Area Health Service regions except the North Coast. The most pronounced differences were in Greater Southern Area Health Service where men travelled twice as far as women.

3.9. Methods of managing demand

When demand outstrips supply agencies normally find ways of either increasing the supply or of managing the demand.¹ Many CT groups are in the latter category. They use a variety of techniques to do this including:

- **Restricting access to passengers with high support needs.** This means placing a higher priority on transport clients with mobility impairment and chronic ill-health rather than people who require short term or preventative treatment.¹
- **Restricting access to passengers who do not have high support needs.** This may be true of smaller groups with no access to paid, trained drivers or to accessible vehicles.
- **Excluding certain categories of destinations from the service network.** This may include destinations out of the local service area (because of the additional effort and resources required to make each such trip) or transport to therapy services (because of the heavy investment in time and resources for individual passengers).

- **Imposing restrictions on how often a passenger can use a service.** This can include imposing a limit on the number of trips that can be taken in a given period; implementing a period on/period off policy (e.g. where a passenger can access services for six weeks then is denied services for six weeks); or restricting the number of services to certain venues.
- **Encouraging clients to access alternative forms of transport.** This can include encouraging the client to use transport provided by family, accessible bus services or transport provided by another agency.
- **Restricting access to services to certain times of the day or week.** Few CT groups, for example, provide services during the weekend (often due to the additional cost of employing staff at these times or because volunteers may be unavailable). This may pose problems for transport to some health destinations (for example 50% of people attending renal dialysis are treated on a three day cycle that includes Saturday).
- **The use of standby lists.** Passengers on a standby list in which case they receive a service if there is a cancellation by another passenger at an appropriate time. ²

In order to test the use of such measures, 23 CT organisations participated in an unmet needs survey that comprised 7 urban groups and 16 rural groups. They indicated that they used a range of demand management measures (Table 5).

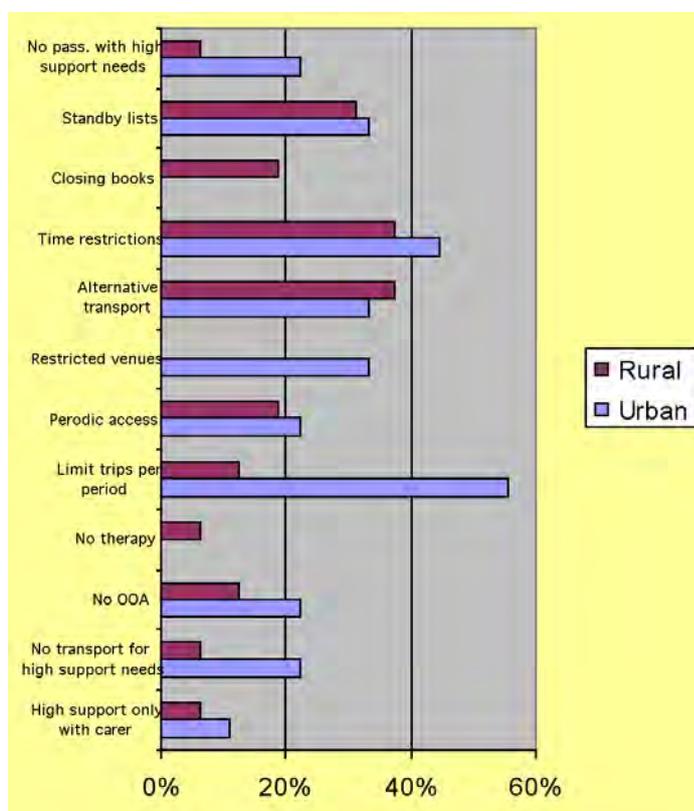
Table 5. Demand management measures used by community transport groups

| Method | Number of groups which use measure | Proportion of total CT groups* |
|---|------------------------------------|--------------------------------|
| Seek alternative transport | 9 | 39% |
| Put clients on standby list | 8 | 35% |
| Limit number of trips in a given period | 7 | 30% |
| Periodic access to transport | 5 | 22% |
| Restrict out-of-area transport | 4 | 17% |
| Transport clients with high support needs only with carer | 3 | 13% |
| No transport for clients with high support needs | 3 | 13% |
| Close the books periodically | 3 | 13% |
| No transport to therapy or clinics | 1 | 4% |

*23 groups surveyed

Urban groups were 50% more likely to use a wider range of demand management measures (3.3 measures per urban group compared to 2.1 measures per rural group). In terms of the types of measures used, urban groups made more use of limiting trips per period, time restrictions and not providing out-of-area transport. Rural groups on the other hand made more use of periodic access, standby lists and closing their books

Figure 6. Types of demand management measures used in rural and urban community transport groups.



3.10. Unmet need/demand

As was noted above, being eligible for a service does not guarantee that a service request will be satisfied. It is not usually known if a person who is refused a service is able to find an alternative elsewhere. Regular refusals will also suppress demand as people's expectations diminish. As a result it is very difficult to estimate the true extent of unmet need for health related transport services in New South Wales.

As part of this project 16 CT groups provided data on unmet requests for transport – occasions when the agency was unable to provide a service for one reason or another.

Results from the unmet needs survey showed that people in the city were five times more likely to be refused a service than people in regional areas. Among the four rural agencies that provided data unmet requests, an average of **3%** of requests for transport to health treatment were refused.¹ However, among the eight urban agencies providing data on unmet requests, an average of **15%** of requests were refused.

Due to the larger number of requests for health transport, and a greater proportion of refusals, CT providers in urban areas refused a greater number of trips to health destinations everyday. Agencies in the city refused on average just over 6 trips per day while country agencies refused an average of 1.3 trips per day. Based on the results of the unmet needs survey, and weighting the results to ensure a representative urban/rural sample, it is estimated that across NSW, CT providers refuse approximately **90,000 requests** for transport to health treatment per year.

Most people who had requests refused had referred themselves to the community transport service (64%), while 15% were referred by a health service.

Facilities where requests for health related transport were unmet

The destinations people were refused a trip to by community transport, included public hospitals (39% of refusals), GPs (17%) and medical specialists (15%).

The high number of refusals for transport to GPs is interesting as they tend to be local and relatively easy to provide trips to. However, people interviewed recently in western Sydney said that older people have difficulty in getting to health facilities including hospitals, community health, specialists rooms and even to their local GP. One interviewee described it as “a nightmare” for some people.²

Reasons for refusals

Most requests for health related transport were refused because the CT group did not have the capacity to provide the service. Capacity constraints accounted for 75% of refusals: 62% of total refusals were because no seat was available and 13% were because there was no volunteer driver available. During workshops for the Sydney Metro Transport Development Project participants made the point that there is a need to ration services because of demand exceeding supply.³

Short notice was another significant reason for a service being turned down (9% of requests). During consultations that took place during the development of a Community Transport Plan in Western Sydney, participants made the point that difficulties in accessing health related transport from the local Community Transport service were “exacerbated by doctors giving little notice of appointments. This can be very difficult if you have to book ahead with Community Transport in order to secure a service.”

Responses to the interviews indicated that no person is refused a service because of an inability to pay. Usually where affordability is an issue for people seeking transport, arrangements are made with them to pay either reduced fares or over time.

Referrals made when requests were unmet

People were most often referred to a taxi service (58%) or were asked to go on standby (14%) if the community transport service was unable to provide a trip.

Inconsistencies in the provision of health transport

Through interviews conducted with CT providers in this report, it became apparent that there is inconsistent provision of health related transport across the state. The capacity of a group to provide health related transport is affected by a number of things including:

- **Geography:** The physical location of a service may affect its ability to provide health related transport, particularly if there are long distances between the service area (where passengers live) and the services they require. In some examples sheer distance is a problem, in others it is the lack of direct routes because of geographic features such as mountain ranges and rivers.
- **Location:** If a service is located in an area that has few health services (e.g. some rural towns do not have a GP), passengers will have to be transported long distances to attend medical appointments. This makes the provision of services more expensive and more demanding on volunteer drivers who may have to spend all day or even two days providing one trip.
- **Resources:** The resources available to each CT group varies. This may be a function of catchment population size or some other function of the resource distribution formula used by the funding bodies. The distribution of Transport for Health funding in particular is very patchy with some groups having no specific funding for health related transport at all.

- **Supply of volunteers:** This is also a resource issue. Many rural groups have no paid driving staff or a very limited budget for drivers and are mostly or totally dependent on volunteers. Many of these volunteers are elderly and in some communities it can be difficult to find volunteers who are prepared to transport passengers long distances.
- **Demographic issues:** In some areas there are higher concentrations of people who are likely to require CT services than others. For example, there has been strong migration of older people to coastal areas over the past twenty years many of whom are now having mobility difficulties and who require formal health related transport assistance.
- **High-needs clients:** Some services lack the capacity to provide CT for patients with special needs, for example cancer patients who have undergone chemotherapy or radiotherapy and may be at high risk of vomiting or other post-treatment complications. CT groups catering to high-needs clients may require specialised vehicles, insurance and training to cater to these clients.

3.11. Client contributions

Client contributions towards the cost of their community transport trip vary from area to area for a number of different reasons, including differences in operating costs and distances travelled. A survey of eight CT groups undertaken as part of this study found the average income from fares to range between 12% and 21% of the total income of the agency.

Fares will also vary according to whether the passenger travels on a service on their own or goes in a group. The NSW Cancer Council pointed this out in their submission to NSW Health discussion paper for the Transport for Health Policy Framework. They quote an example whereby if a person travels from Tumut to Wagga Wagga with other people the cost will be \$18.00 but if they travel on their own they will have to cover the entire cost and pay \$35.00.

Fares may also vary within one agency's operational area. One community transport provider surveyed in this research, for example, has a flat fare structure within the local government area of Penrith but, because of the longer distances, has a distance-based fare for Blue Mountains residents. Fares are of particular importance for people who attend therapy services as they may have to travel every day of the week in the case of oncology or a return journey three times *ad infinitum* in the case of patients on renal dialysis.

Some non-community transport services, such as Patient Transport are free. This could be a potential source of friction if services begin to share seats and resources:

It has been reported that in some cases patients request a service because they know it is free of charge. This may represent a problem in circumstances where there is coordination of services or sharing of passengers and different patients are paying a varying amount for a similar service.¹

- 1 The 38 groups who participated in collecting the travel data were selected to be typical of each region and represented 32% of all formally funded community transport groups throughout the state. The approximation of 680,000 is arrived at by extrapolating out the results to represent a whole-of-NSW figure. This compares with figures from the Community Transport Organisation. According to a survey of their members, 89 groups (71% of all groups) provided 1.5 million trips to all types of destinations; 28% of these were to health facilities. From these figures we can derive an annual figure of 590,000 trips to health facilities.
- 2 It might be thought that the difference between road based distances and “as the crow flies” distances may differ between city and country areas. A sample that the authors undertook of 50 rural trips and 50 urban trips showed no consistent pattern of differences. Some country trips along major highways showed the road based distance to be close to the direct distance, however, other road based journeys, were over twice as long as direct distances, mainly because of geographic features. Therefore, for the purposes of this report distances quoted are the direct distances. The road based distances may be significantly longer but this will vary case by case.
- 3 Transport Planning and Management. 2001. *A survey of non-emergency health related transport in the Upper Western Sector of the Far West Area Health Service*. Sydney: NSW Department of Health.
- 4 When there are heavy demands on a community transport service the length of time a passenger has to book ahead also increases. The book-ahead time can vary a great deal and is typically between 3 days and 3 weeks although the period can be much longer. For some passengers, not being able to book the transport that they require may result in them not attempting to book again in the future. This leads to growth in latent demand which cannot be quantified.
- 5 Sydney Metro Community Transport. 2006. Response to the NSW Health *Fit for the Future Questionnaire*.
- 6 In a study of unmet transport needs among 5 urban community transport groups the treatment of passengers who were refused a service was monitored for three weeks in June and again in October this year. In June no passengers were put on standby whereas in October this happened to 108 passengers. Information from the Sydney Metro Transport Development Project, Randwick Waverley Community Transport.
- 7 Based on the number of trips refused, not the number of requests. One request may be for more than one trip.
- 8 Transport Planning and Management. 2005. *A Framework for an Integrated Transport System or Network in the Wentworth Region*. Prepared for the NSW Ministry of Transport, Parramatta NSW. (Unpublished).
- 9 Transport Planning and Management. 2006. *Health Related Transport – Issues Identified by Community Transport Providers*. Sydney Metro Transport Development Project. (In Press)
- 10 Transport Planning and Management. 2005c. Transport Solutions for Renal Dialysis Services in Sydney West Area Health Service. Sydney: Sydney West Area Health Service, p 45.

4. Health related transport: An Aboriginal perspective

“Indigenous people appear to be the most disadvantaged in terms of access to suitable transport services to attend medical appointments.”

Indigenous people are arguably the most disadvantaged in terms of access to suitable transport services to attend medical appointments. Poor access to health treatment plays a role in poor health outcomes. Yet, despite these factors, there is little formal literature on the relationship of transport to health service access for Aboriginal and Torres Strait Islander people.

This section explores these issues and some of the possible remedies to this situation. Information for this section was primarily sourced from interviews, undertaken as part of this project, with staff from eight agencies that provide transport to Aboriginal people.¹ In order to obtain another perspective on the issue of health related transport, staff from eight Aboriginal Health Services around the state were also interviewed.² The interviews were conducted by two Aboriginal people who have both worked in the CT industry as transport development workers. Additional information was sourced from a conference on Aboriginal transport organised by the Community Transport Organisation, a state-wide Health Related Transport Forum³ held in 2004 and the NSW Aboriginal Transport Network.⁴

4.1. Issues in Aboriginal transport

There are a number of issues that affect Aboriginal people's ability to get to health services including access to private transport, location, cost and the inflexibility of programs and services.

Driver's licences

Aboriginal people tend to have fewer private transport options. Interviewees raised examples of communities where there is very poor access to motor vehicles: for example an Aboriginal community of 70 people where there are only two cars and one person with a licence; and in another community of 400 people, only four people had a driving licence.

Gaining a driving licence can be very difficult for some Aboriginal people. Problems include:

- People having outstanding fines and not being allowed to apply for a licence
- New testing procedures using computers that people are not familiar with
- Being unable to undertake 50 hours driving practice.

It is important to note that driver's license issues are interconnected with other social barriers impacting on Aboriginal people. For example, barriers to accessing education will also prevent some Aboriginal people from obtaining a license.

The issue of driver's licenses has been addressed with some success in driver training schemes for Aboriginal people. For example the Northern Rivers program recognises a number of factors that contribute to unlicensed driving including the lack of awareness of how to obtain a birth certificate, lack of funds to pay for driver knowledge handbooks or driving lessons, limited literacy and computer literacy levels and the lack of access to vehicles to learn to drive and licensed drivers willing to provide 50 hours driving practice (as is required by the Graduated Licensing Scheme in NSW).

The program provides access to a computer-based driver knowledge test in local Aboriginal agencies offices, literacy and computer skills training, free driving lessons, licence testing in local Aboriginal community sites, access to supervised driving practice and assistance with applications to the NSW State Debt Recovery Office for "time to pay" to allow disqualified drivers to regain licences.⁵

Cost of transport and other services

Affordability and cost are an issue as some Aboriginal people do not have the money to pay transport fares. Interviewees also mentioned the expectation among some Aboriginal people that community services should be free-of-charge. This can be a problem for some service providers for whom contributions and donations have become a significant and necessary part of their income. Different processes for the same service can cause resentment as a result of a lack of cultural awareness: for example non-Aboriginal volunteers may question why Aboriginal passengers are not charged a fare.

Geographic isolation

Distance is an important issue in some regions. Aboriginal people in isolated communities may have to travel over 700 kilometres to access services. Health workers interviewed for this project indicated that in some country areas there is a need for Aboriginal people to travel as far as Sydney, Melbourne and Adelaide.

At Coomealla, Aboriginal people have to attend appointments as far away as Adelaide and Melbourne by bus. Interviewers were told of the situation at Brewarrina where a local gynaecologist passed away and has not been replaced, which meant that people then had to travel 370 kilometres to Dubbo to access this service.

Geographic isolation, in turn, creates operational problems for CT services. For example, a driver based in the far north-west of the state has to be able to get to Dubbo and back in one day during daylight because of the problems of kangaroos and other wildlife on the roads at dawn and dusk and at night. This means that the medical appointment must be scheduled between 11 and 12 o'clock otherwise the driver cannot return in time.

In other areas Aboriginal communities are located away from the local towns, often on the sites of old Mission settlements, and there is often no public transport to link the two. Many people walk from where they live to town. This emphasis on walking creates a barrier for some older people, people with disabilities and those that are unwell with mobility difficulties. Gaining ready access to fresh food is also seen as a health issue and this is very difficult in some remote or isolated communities where few people drive and there is no public transport.

Accommodation

In many cases geographic isolation and distance from health facilities means that Aboriginal people seeking treatment often have to arrange to stay overnight at their destination. A lack of affordable accommodation can create financial problems for some people. For example, a person may be undergoing chemotherapy but not be classified as ill enough for a hospital bed but cannot travel home. They then have to pay for accommodation such as a motel room which they may not be able to afford. This becomes a bigger problem if they are accompanied by family members. Many Aboriginal people have no money for motels if they have no relatives in town to stay with.

In the north west of the state, transport to day-surgery usually means two nights accommodation for the patient because the procedure usually takes place in the morning with a post-operative consultation later in the afternoon. In Dubbo a respite house is available but patients need to book well in advance to secure a bed.

Therefore the accommodation cannot be used when appointments are made with little notice. In some cases transport problems are so intractable that people who require regular treatment have to move closer to the treatment centre. This raises the issues of the availability of suitable accommodation and the additional cost to the families involved.⁶

Access to transport resources

The need for flexible use of funds and other resources was a common theme throughout the consultations and the reports reviewed as part of this project. Although there may be

resources available, the use of those resources is often inflexible which makes access by Aboriginal people difficult. For example, many transport resources are locked away after office hours but the need for urgent transport in Aboriginal communities often happens in the evening or at weekends.

Interviewees observed that eligibility to use services can be an issue. Interviewees noted that program eligibility criteria can be seen as yet another barrier to service access in communities where disadvantage among a high proportion of the population is endemic.

It can be difficult to understand why a bus service is reserved for frail older people when there are other people in the community who cannot get to vital services. For example, some Aboriginal Medical Services will only transport their own clients. It was also claimed that some CT services are not able to work in Aboriginal communities. Participants also said that there is a lack of information on the NSW Ambulance Service and that Aboriginal people need to know that they can call an Ambulance in emergencies. Such artificial barriers can also lead to the underutilisation of resources which raises the cost of service delivery on a per trip basis.

Forum participants also pointed out that Area Health Services have significant transport resources that could be used to address Aboriginal transport issues.

Isolated Patients' Travel and Accommodation Scheme

A number of the workers that interviewed in this project raised concerns about the Isolated Patients' Travel and Accommodation Scheme (IPTAAS). There appear to be two problems – the confusing paperwork which is difficult to complete by someone with low literacy levels and the fact that claims can only be made retrospectively (i.e. subsidies are not paid "up front"). We were told that many Aboriginal people just do not attempt to get support from the scheme because of these difficulties.

In addition, IPTAAS reimbursement can take up to three months, which creates a barrier for low wage earners. It was also suggested that there is a lack of trust in the system and that there is no system at all for those people who do not have a bank account as all payments are made by electronic transfer or cheque. Some interviewees were of the opinion that CT services should be treated as public transport services for the purposes of IPTAAS and that reimbursement for the full cost of using the service should be available to applicants.

Accompanied passengers

Most of the people interviewed were of the opinion that many Aboriginal people prefer to travel in the company of family members. It was also pointed out that many older Aboriginal people look after their grandchildren and cannot find alternative arrangements for them if they need to go to a medical appointment. Some Aboriginal clients need someone to go with them to advocate for them at their appointments. At Walgett Community Transport the coordinator hand-picks drivers who can communicate well and manage such situations.

These factors can create difficulties in relation to transport, particularly where transport operators are unable to make services flexible. For example in some cases Aboriginal people have to pay additional fares to cover family member travel, adding to expenses involved with attending health appointments.

Communication and Information

It is often presumed that all CT passengers have access to a telephone to book services and most booking procedures are based on this notion. This is not the case in some Aboriginal communities. Not only may individuals not have a telephone but the local public telephones may be out of order or have been removed.

It was reported that lack of access to cars, employment and decent food can affect people's morale and make them less likely to follow-up a transport service to get to an appointment. As one transport worker told us, "it is not always about transport, it is getting them to see that it is important that they go". For this reason it is important that the process of booking and using a transport service is as straightforward as possible. In addition, information about transport services, subsidies and programs is not readily available in many Aboriginal communities.

4.2. How Aboriginal people travel to health appointments

Poor access to either private transport or public transport services impacts on the forms of transport used by Indigenous people to access health appointments, with an emphasis on family and friends, walking and local services to get to health treatment.

Walking and hitch-hiking

Walking is also a very common way of getting around among Aboriginal people, including to medical appointments. In many cases, the high prevalence of walking by Indigenous people "is closely associated with lack of access to economic and social services, transport infrastructure."⁷

In some cases, Aboriginal people will walk long distances to attend medical appointments. Interviewees confirmed that a primary form of transport in some areas is hitch-hiking, even to dialysis. A report that examined transport in Aboriginal communities in the Northern Rivers pointed out that:

The most intractable problem appeared to be that of people who need to attend health facilities located at regional centres for regular treatment, particularly renal dialysis. We were told of one woman in an isolated community who has to attend treatment in Lismore three days per week, she has transport arranged for one day and has to hitch-hike on the other two days.

The isolated community in question is 86 kilometres away from the dialysis centre.

The role of family and friends

In many Aboriginal communities there is a strong reliance on family and friends for health transport.⁸ Family and friends provide a safe and trusting environment for people seeking health services, particularly during times of health crisis. One interviewee noted that Aboriginal people are often most comfortable travelling to health appointments with family members because of the difficulties interacting with people they do not know.

A lack of cultural appropriateness of services will further impact on the willingness of Aboriginal communities to access local services provided by CT operators. Further, the poor availability of public and CT services to some communities will increase the importance of the role of family and friends in providing transport. The reliance on family and friends to provide transport can create financial and social strain for some communities. As discussed below, in many Indigenous communities there is frequently a low number of licences and registered vehicles available; as a result drivers with vehicles will often take on a significant degree of responsibility in ensuring community members attend health appointments. Interviewees in this research project noted that car pooling, for example, can often become a burden for the few community members that own vehicles.

Use of public transport

A large number of Aboriginal people do not use public transport, either as a result of poor availability, or an unwillingness to use existing services.⁹ Interviewees said that some Aboriginal people do not feel welcome or comfortable using mainstream transport services. Others thought that people feel intimidated about travelling on a general public service and some have difficulties with reading which we can presume presents problems with following timetables and signage.

Cost can also be a factor, even where concession fares are available. For example the rail CountryLink bus service from Walgett to Dubbo leaves at 9 a.m. on Monday, Wednesday and Friday and returns at 6.30 p.m. on Tuesday, Thursday and Saturday. In other words, using the bus to get to Dubbo may only cost pensioners a concessionary fare of \$2.50, but it requires an overnight stay which few people from the area can afford.

Interviewees pointed out that in some areas in NSW public transport did not exist or was inadequate. As a result other, more expensive forms of transport were used. According to the service provider interviews, Aboriginal people use taxis in some areas despite the high cost, because of a lack of other options. But access can still be a problem for those who are willing to pay: for example interviewees noted that taxi drivers sometimes will not take Aboriginal people or want to see their money before providing a service.

Poor access to public transport increases the use of other modes of transport, such as walking, private motor vehicles and other services, even where these are inappropriate: for example in one community interviewees noted that Aboriginal people were being taken to health appointments by the police.

Use of community transport

A lack of culturally appropriate services was cited as the main barrier facing Aboriginal people in accessing CT. Interviews suggested that CT groups are not always good at dealing with Aboriginal communities: indeed a number of interview respondents used the word "uncomfortable" to describe how Aboriginal people feel about using a CT service.

The transport workers who were interviewed noted that it is not always recognised that there are cultural differences between Aboriginal communities and non-Aboriginal communities. They highlighted a need for more discussion with Aboriginal people about transport issues and that service providers need to accept that there may be at-the-door cancellations, an expectation that services may be free and that people attending appointments are likely to want to take family members along.

The need to ensure that non Aboriginal drivers received cultural awareness training was highlighted. It has been suggested that some drivers have a fear of Aboriginal people and that there is a need for additional driver training or contact with Aboriginal communities. The need for CT providers to actively recruit Indigenous workers was also raised by interviewees.

Volunteers are used in many country areas to transport people to medical appointments, however it can be very difficult to obtain Aboriginal volunteer drivers and, as pointed out by interviewees, Aboriginal people do not always fit in with a structured service that has policies, procedures and accountability mechanisms in place. In other areas, however, the use of Aboriginal volunteer drivers seems to work well.

A lack of involvement by Aboriginal people in planning for services was seen as a key concern. One CT worker was of the opinion that non-Indigenous people often think they know what Aboriginal people need without asking them and that agencies in the community with funding for Aboriginal transport may be making decisions based on opinion rather than on actual need.

A number of interviewees raised the problem of cost / affordability. It was noted that many Aboriginal people receive low incomes and rely on income support or low wages. Although, under the HACC program guidelines, no client can be refused a service because of an inability to pay, client contributions appear to be a barrier for some people. A recent survey of Aboriginal community care providers found that affordability was a barrier for 60% of clients.¹⁰

It should be noted that in some parts of NSW there is evidence that access to services has improved. For example, many communities have access to a community bus for health transport, such as a bus at Weilmoringle in the far north of NSW that is used regularly to take people to Bourke and Brewarrina for appointments. Regions with access to Aboriginal Transport Development Workers have a greater capacity to improve services for Indigenous people.

At Muli Muli in the Northern Rivers region a bus has been provided by Northern Rivers Community Transport. It is managed and driven by a local resident and is used for a variety of purposes including getting people to Lismore and as far away as the Gold Coast for medical appointments.

4.3. Health service providers and community transport

All of the Aboriginal health agencies interviewed said that they sometimes provide transport to health appointments. This may happen formally or informally. One agency has strict policies in place as to the circumstances when workers are allowed to provide transport. Five agencies provided figures on the volume of trips provided which ranged from 900 to 1,600 trips per year.

Health workers interviewed in this project expressed concern about the difficulties many Aboriginal people face in getting to doctors appointments, hospital appointments and to medical treatment. This means that health workers are often called upon to deliver transport services:

“It appears that many health workers spend a great deal of time providing transport for some of their clients in lieu of any other option. While there was a general agreement that this is not, nor should it be, the primary task of health workers, there was a recognition that some Aboriginal people require specific encouragement and support to attend health facilities, particularly mainstream ones. It was felt that, at the very least, a service that is to effectively provide transport to enable some Aboriginal people to attend health facilities, needs to be provided by Aboriginal people who understand the issues involved.”⁶

The provision of transport can be disruptive to the primary role of health services, particularly where additional resources are not available for this purpose. Health workers were being “burned out” by having to provide transport. In one case the health agency’s CEO has provided transport for clients on a number of occasions because there was nobody else to do it.

However, the provision of transport by health workers is not seen as totally negative. Two agencies said that while driving, health workers can promote health services as they chat to their passengers. At Walgett the AMS has Health Related Transport Program funding for cars and drivers and this is reported to be effective for both Aboriginal and non-Aboriginal patients. The Bourke Aboriginal Health Service also takes Aboriginal and some non-Aboriginal people to Dubbo for appointments.

Other concerns mentioned during the interviews with Aboriginal health workers included people feeling intimidated in unfamiliar surroundings, problems related to literacy and appointments being very early or late in the day, which causes transport problems. It was also raised that on discharge from hospital there are often no arrangements for transport and that the travel needs of people with mental health issues and drug problems are not adequately catered for.

4.4. Issues for Aboriginal transport industry workers

In addition to the issues raised by interviewees in relation to access to services, a number of issues were raised in relation to consolidating and improving the skills and information available to existing and future Aboriginal workers involved in delivering transport services.

Improving Skills

Workers in all Aboriginal transport services (including health services) should have access to suitable training. Identified areas for future training included fleet management, submission writing, computer literacy, project management and budgeting. Many Aboriginal workers involved in transport feel disconnected from each other, and do not have access to opportunities to share skills and ideas. Koori transport workers need opportunities to meet and learn from each other. This is particularly important for new workers who have limited opportunities to learn skills or share concerns about their workplaces with other Aboriginal workers.

Mentoring programs are one way to ensure that industry skills are shared and promote the development of new workers. A mentoring and support network for new Aboriginal transport workers, that incorporated existing workers, senior CT workers, transport planners and workers in other key professions such as information technology, would be a useful step. It should be noted that Aboriginal transport development workers currently meet regularly as part of the NSW Aboriginal Transport Network. The group provides some mentoring and support to workers, although is retrained by resources and the ability of members to balance network responsibilities and the role they play in local communities facilitating transport access.

Employment

Interviewees made a number of suggestions about how CT groups could go about providing transport to Aboriginal people. CT groups employing Aboriginal drivers could encourage people to use services. Once Aboriginal people have been accepted in a service and feel comfortable using it the use of Aboriginal drivers may not be so important. An Aboriginal person taking the bookings will encourage Aboriginal people to use a service. Participants at the Aboriginal Transport Conference said that it makes a difference having an Aboriginal person to deal with. Four CT groups that have employed Aboriginal transport development workers or coordinators have achieved a very large increase in the number of Aboriginal people using CT services. Consequently, workers have also recently been employed in all CT groups throughout the North Coast region.

The employment of more Aboriginal people in the transport industry – real jobs rather than work-for-the-dole arrangements - is seen by Aboriginal people as being of great benefit to not only the workers but in encouraging Aboriginal people to use transport services. It would make sense for funding agencies such as the Ministry of Transport, Department of Disability Ageing and Home Care and NSW Health to work with community services to develop an Aboriginal Transport employment strategy with a view to increasing the number of Aboriginal people employed on a permanent basis in the CT and related industries.

4.5. Improving health related transport for Aboriginal people

It was thought generally by those interviewed that there are insufficient resources available for Aboriginal transport and that a larger proportion of Transport for Health funds should be allocated for transport for Aboriginal people, particularly those in isolated areas. It was noted at the Aboriginal transport conference that in an area such as the Hunter region there is no specific funding for Aboriginal transport programs.

Responses from interviewees reveal a complex set of problems that will not necessarily be solved by increased funding, but require a whole-of-government response to tackling Aboriginal transport disadvantage in NSW. Improvements by CT and health providers in their business methods will also improve access to services for Aboriginal people.

A proposed strategy to improve access by Indigenous people to health services is outlined in Chapter 5 of this report.

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- 1 The agencies surveyed have not been named in this report for confidentiality reasons.
 - 2 Health staff were interviewed from eight health agencies in the Hunter, Greater Western, and South East Sydney/Illawarra Area Health Services.
 - 3 NCOSS and Mountains Community Transport. 2002. Notes from a Health Related Transport Statewide Forum. NCOSS: Sydney.
 - 4 Additional information was sourced from Transport Planning and Management. 2002. Richmond Valley Aboriginal Transport Project: Final Stage 1 Report" Prepared for the Northern Rivers Social Development Council , Lismore NSW.
 - 5 Information from the Australian Crime and Violence Prevention Awards Booklet. The Driver Licensing Scheme won this award in 2005. For more information go to: www.drivingproject.org
 - 6 Transport Planning and Management. 2002. Richmond Valley Aboriginal Transport Project: Final Stage 1 Report. Prepared for the Northern Rivers Social Development Council, Lismore NSW.
 - 7 See Holcombe, "Indigenous Australians and Transport – What can NATSISS tell us?" Assessing the Evidence on Socioeconomic Outcomes: a focus on the 2002 NATSISS. http://epress.anu.edu.au/caepr_series/no_26/mobile_devices/ch15.html.
 - 8 In interviews with Aboriginal health workers the most common forms of transport used were friends and family, Aboriginal Medical Services and community transport.
 - 9 See Holcombe, "Indigenous Australians and Transport – What can NATSISS tell us?" Holcombe observes: "In remote areas, 63.3% of respondents indicated that they did not use public transport, as no service was available, compared to 16.3% in non-remote areas... In non-remote areas, the total number of respondents who did not use public transport is 65.1%, which may appear surprising given the apparent availability levels."
 - 10 NSW Aboriginal Community Care Gathering Committee. 2006. Leading Our Way in Community Care Conference Report, p 28.

5. Solutions

“Community transport groups provide over 680,000 health related trips per year in NSW.”

The increased demand for community transport due to population demographics and the changing nature of health service provision has meant that CT providers are struggling to provide all our CT needs. This has meant that each year, over 90,000 requests for health-related transport are refused, the great proportion of which are to public hospitals, general practitioners and therapy clinics. Several underlying issues in healthcare planning and provision have led to excess demands being placed on the CT industry. In the context of the above findings, as well as drawing on previous transport reports and consultation with industry experts, we present several solutions that will address these issues and lead to a decrease in the number of people who are unable to access health services.

5.1. The NSW Government State Plan

The solutions proposed within this report are relevant to goals and priorities within the State Plan and will contribute towards achievement of targets. The recommendations below include a reference to how the proposed solutions relate to the goals and priorities in the NSW Government State Plan.¹ An outline of how the recommendations in this report fit the State Plan priorities is included in Appendix I.

5.2. Increase funding for non-emergency health related transport

The bulk of the issues identified in this report are a result of there being insufficient resources for CT groups to adequately provide health related transport. Issues such as out-of-area travel, the high cost of providing services to very high needs clients, and a lack of out-of-hours services will only be addressed successfully if additional resources are found to expand the operation of services.

At the moment the vast majority of funding for CT comes from the federal/state Home and Community Care (HACC) program. According to a snapshot of services compiled by the Community Transport Organisation, 75% of CT funding comes from this source, while 5% of funding for CT services is derived from the NSW Transport for Health program.¹

Although health transport accounts for 28% of all trips provided, as per the finding of this report, the proportionate cost of health transport to the industry is much higher. The provision of health related transport tends to be more expensive on a unit cost basis than most other forms of transport because of the increased administration and resources involved. It can be reasonably estimated that the provision of a passenger trip by individual transport (as occurs for the majority of health related transport) takes more than twice as many resources as does a passenger trip using group transport.²

This report estimates, using the breakdown of funding sources as per the NSW Community Transport Organisation survey, that the total cost of community transport relating to health transport in NSW is \$14.8 million, or 42.5% of the total funding for CT services, including the contributions of the Transport for Health program and Department of Veterans' Affairs.

This report has suggested that NSW Health funding for non emergency community transport is unlikely to exceed \$3 million per annum. It is difficult to estimate the contribution of the NSW Transport for Health program to health transport services, since the level of funding for non emergency health transport services within the program has never been publicly released. Nevertheless based on the above data, and taking into account historical funding for non emergency services, the contribution of the Transport for Health to these services in 2006/ 07 may be reasonably estimated at approximately \$1.5 million. In other words, the Transport for Health program only provided a little over 10% of the funding for the health transport delivered by CT services in NSW.

Given that the HACC program only caters for a specific target group of frail older people and people with a disability, an increase in funding for health related transport should come from the Transport for Health program, rather than the HACC program. This would ensure that all those who require health-related transport would be eligible to receive assistance. Because of the increasing growth in the number of people over 85 years of age, over half of whom are likely to have mobility difficulties and therefore have problems getting to medical appointments, it follows that a substantial amount of additional funding will be required for health related transport over the next 25 years.

Recommendation One

Increase NSW Health funding for non-emergency transport services from the current amount of less than \$3 million, to \$10 million per annum.

NSW State Plan: S1, S2, F1, F2, F3, F5

5.3. Allocate resources so health transport is available to all

Transport for Health resources are poorly distributed, impacting on the ability of some CT groups to deliver services. The capacity of a group to provide health related transport is affected by geography and location, resources, the supply of volunteers, demographic issues and planning for high-needs clients. These issues can be addressed through more robust planning processes and a strong commitment to ensuring equitable outcomes in the provision of health transport.

Recommendation Two

That the distribution of growth Transport for Health funds to community transport groups be more equitably distributed across the state, taking into account population profiles, health indicators, the location of health facilities and the relevant costs of providing transport.

NSW State Plan: S1, S2, F1, F2, F3, F5

5.4. Prioritise access of Aboriginal people to health transport

Poor access to transport has a flow-on effect in terms of the ability to access health treatment, and is a contributing factor to poor health outcomes for Aboriginal people. Improving access to health transport by Aboriginal people requires a firm commitment from government, health providers and CT providers. This report recommends that the NSW Government develop a strategic plan to address the access issues currently faced by Aboriginal communities in getting to health treatment.

Based on the evidence from this report, a strategy to improve access of Aboriginal people to health related transport should include commitments to the following:

1. Improve health transport resources available to Aboriginal people

Government agencies must monitor existing funded services to ensure that Indigenous people are accessing transport to health destinations. Where Aboriginal people face barriers to accessing services, there is a need to ensure that existing services are responsive to community needs and where necessary target resources towards specialised services that address the problem.

2. Improve planning and coordination

The Area Health Service's Transport for Health Plans should include Aboriginal Health Transport Plans, to be developed in conjunction with Aboriginal Transport workers and services. Such plans should include consideration of how isolated communities can access fresh food and pharmacy items.

3. Improve access to motor vehicles and licenses

Extend driver license education programs across NSW to increase opportunities for Aboriginal people to gain a license.

4. Address geographic isolation

- Provide sessional health services or consultations at locations closer to isolated Aboriginal communities at times that facilitate same-day travel to these services by patients.
- Use HACC and Transport for Health funding available for Aboriginal Transport Workers or CT groups to establish group transport services to link out of town communities to health and other facilities in town.
- Explore the potential of using funding from HACC and the Transport for Health to cover accommodation for trips to medical appointments that require an overnight stay.
- Examine opportunities for Area Health Services to subsidise accommodation for Aboriginal people who may need to stay away from home for extended periods of time to undergo medical treatment. Such funding should also recognise that the patient may have accompanying carers or family.
- Evaluate the advantages of locating CT vehicles in Aboriginal communities and providing logistic and administrative support for staff drawn from the community to manage and operate those resources.

5. Reform the Isolated Patients Travel and Accommodation Scheme

- Reform administration of IPTAAS in NSW to minimise paperwork and allow administration by local services.
- Reform payment processes through IPTAAS so that travel and accommodation expenses can be estimated and paid in advance.

6. Improve the cultural appropriateness of CT services

- Encourage CT organisations to employ Indigenous staff, in particular Aboriginal drivers.
- Ensure all staff in CT organisations attend cultural awareness training.
- Involve Aboriginal people in service planning and examine issues such as the suitability of vehicles and the cost of services.
- Employ Aboriginal Transport Development Workers to improve access by Aboriginal people to services.
- Support existing workers in transport and health services through networking, training and mentoring opportunities.

7. Improve information on public and community transport

The NSW Ministry of Transport should develop culturally appropriate resources for each regional area to include information about Aboriginal operated transport, community transport, patient transport, ambulance services, public transport and subsidies and concessions. All such information should be presented in a culturally appropriate way

Recommendation Three

That the NSW Government develop a strategy to address access to health transport by Aboriginal people that includes consideration of: resources and funding for services, planning and coordination, access to motor vehicles and licenses, geographic isolation, patient travel assistance and accommodation schemes, cultural appropriateness of existing services, and information on public and community transport services.

NSW State Plan: F1

5.5. Increase the role of public transport

Planning for health related transport should take place within the wider context of community and public transport services. Health related transport is not just the preserve of patient transport and community transport operators. There is a need for planners to recognise the potential of other transport operators to develop flexible transport services that can serve major health facilities. Consideration should be given to providing public transport companies financial incentives to serve major health facilities, as outlined below.

Flexible bus services

There is scope for transport operators to develop more flexible public bus services which pick up passengers at or near their homes and deliver them at their destinations. As the Parliamentary Standing Committee on Health and Ageing noted:

Health-related transport is one area where door-to-door service would be ideal. Early discharge, attendance as outpatients, day treatment at doctors' surgeries mean that older people must travel more frequently for health care, often under circumstances when they require support while traveling.³

This type of approach is becoming more common in Europe, particularly with the development of new technologies promoted through a variety of European Commission-funded projects. Examples of these systems which incorporate automated booking and scheduling, in-vehicle terminals for driver communication and automated vehicle location systems include Ring in Belgium, Personal Bus in Italy and MobiRouter in Finland.⁴

FlexRoute is operated at fixed intervals between two opposite end-terminals in an urban area (e.g. major activity centers) and has a flexible route between these nodes. Pick-up is at the door for users with STS (Special Transportation Service) permits, and with a short specified walking distance (e.g. < 150 metres) for other users.⁵

While door-to-door services have long been provided by the CT industry in Australia the bus industry is now taking an interest in this form of transport. Two Australian bus companies have pioneered this approach. In Melbourne, the Invicta Company have been running the Telebus service since 1977. Instead of running fixed routes the company has divided its service area into 9 smaller areas.

TeleBus passengers can use the service in two ways. Firstly, they may board or leave the bus at one of the fixed stops in the area, and pay the normal MET fare. Alternatively, they may telephone and request to be picked up from home, or may ask the driver to be dropped off at home. In either case, passengers pay a small surcharge for this personalised service.⁶

Also in Victoria, a bus company in the Hume region receives a subsidy from the HACC program to deviate from a fixed route to pick up a number of HACC clients near to where they live.

In Western Sydney, Baxter's Bus Lines has operated Flexi Bus for the past eight years. The service uses a low floor easy access midi bus. Passengers book ahead and are picked up from their homes and taken to one of four destinations including Westmead Hospital. Later in the day a return journey is provided. This service is mainly used by older people and people with mobility difficulties. The service shares passengers with the local CT group and absorbs some of the demand for individual transport services.

The further development of flexible public transport services will bring significant benefits to people who currently have difficulty in getting to and from health appointments. A number of NSW bus companies have expressed an interest in introducing such systems including Veolia which provides services in South West Sydney and which provides demand responsive transport in France using their Creabus system. In outer western Sydney both the Blue Mountains Bus Company and Westbus are involved in the development of an Australian demand responsive transport system.⁷

Demand responsive transport

A variation on flexible routes is to take bus services to where people live and where they want to go – demand responsive transport:

...a customer telephones a call centre from their home and requests a single or return trip to go to a nearby town, interchange or local facility. The call centre communicates with the driver of the bus, and the passenger is fitted on to a service round. These may be regular (for example hourly) or entirely according to demand. A pick up point and time are agreed and the bus collects the passenger within a 'time window' of, say 10 minutes, rather like a taxi. The bus is shared with other passengers with similar requests within a given zone. So the journey may take longer than a taxi, but the advantages are that the service can be of high quality, almost door to door and be available on a regular basis.⁸

There are a number of examples of this type of service in Australia. All services are offered on easy access buses. Appropriate driving staff are also selected to operate the services. The scope for these types of service to provide transport to health facilities for passengers who cannot use fixed route services, and to take pressure off CT operators is substantial.

At this point it is not clear how such services fit within the provisions of the *NSW Passenger Transport Act 1990*. It can be argued that they are not a regular route service and they are certainly not a taxi service. It is also not clear how they might fit with the present bus contracting regime which is very much based on fixed route services with payments to operators being based on the number of kilometres an operator achieves over a fixed period of time.

Recommendation Four

That the NSW Ministry of Transport work with NSW health to support bus operators to develop demand responsive flexible bus services that serve hospitals and other health facilities.

NSW State Plan: S2, S6, F1, F2, F3, F5

Sub-contracting

There is scope for CT groups to sub-contract work to other sectors of the transport industry. There is, for example, a longstanding tradition of CT groups using taxis to supplement their direct services. Cab-charge dockets are generally used to enable passengers to get home from late appointments after the local CT service has closed for the day or to arrange individual transport for wheelchair users. However, they can have wider uses:

For members of the scheme, taxi vouchers provide the means to travel to any destination at a time to suit them. This opportunity to travel is available to users over a much wider timeframe than that provided by existing, more conventional transport services. It is only limited by the resources available to the scheme. The vouchers provide members the opportunity to travel in safety to the destination of their choice, at a time of their choosing and with the confidence that they can get home safely afterwards. Journeys to hospital appointments, for example, become less stressful because the travel can be arranged to suit the time of the appointment. As a result the patient arrives at the appointment on time feeling more relaxed because the travel element of the trip has been organised.⁹

In some areas such as the Central Coast and South West Sydney wide-scale taxi voucher schemes are now operated by CT groups. While such services may not be suitable for passengers with high care needs they provide a useful complement to CT services in certain circumstances such as assisting people to attend medical appointments at the weekend, early in the morning and in the evening and for wheelchair users who cannot transfer to a standard car or bus seat.

It should be noted, that there is also scope for bus operators to subcontract work to community transport, where low patronage threatens the viability of running a bus service.

Share-ride taxi and minibus services

The use of share-ride taxi services, although once prevalent¹⁰, is no longer common in the delivery of health related transport. This seems at odds with the increasing use of group taxi services to take people shopping and for other purposes, such as in the Council Cab model. Even large scale movement of passengers can be effectively achieved by using taxi services.

An example of an innovative use of taxi transport is “Crossroads,” a day care and respite service on the Gold Coast, brings in 200 clients each week to one of their services entirely by taxi. This has been so successful they have been able to dispose of one of their minibuses. In order to do this effectively they deal with taxi owners, rather than the taxi network, and arrange the scheduling themselves. In effect they are running a CT operation but using Maxi and standard taxis as their fleet. As they do not own the fleet they are not responsible for its standing costs when it is not being used (six days out of seven).

5.6. Include transport as part of all health planning

Many of the problems experienced in the delivery of health related transport services can be traced back to a lack of coordinated planning of services and service support. This has been partly addressed by the publication of the Transport for Health Policy Directive,¹¹ but there is significant scope for improving health transport planning, particularly the need to take into account related services, such as non-health related CT, accessible bus and rail services and the development of flexible public bus services. Further, health transport planning must be holistic, and take into account health facility hours of operation, coordination with appointment times and a range of other issues.

Recommendation Five

That NSW Health work with local and non-government service providers and other government agencies to develop a regional planning process for health transport.

NSW State Plan: S1, S2, S6, F1, F2, F3, F5

Operational planning

In the past, CT groups have tended to operate in isolation partly because their funding agreements specifically defined a local service area of operation. As such, HACC program funding was only allocated to one group for each service area. In recent years a regional funding system has improved cross-locality connectivity, but many groups still operate in an exclusive area. There remain relatively few incentives or guidance for CT groups to plan with each other for the delivery of efficient and effective services.

Health related transport, however, is not exclusive to CT. There are a number of different agencies involved including Area Health Services, the Ambulance Service and many small funded and unfunded volunteer groups. Regional planning – possibly through regional health transport planning forums – would assist local human service providers, and Area Health Services to coordinate the delivery of health transport services.

At another level there is an urgent need for funding bodies and program administrators to meet to develop a common strategic approach to health related transport. At a minimum this process should involve Area Health Services, the Department of Ageing Disability and Home Care and the Ministry of Transport. Encouragingly, initial meetings of this type have been held in some areas. This, however, needs to be formalised and implemented across the state.

Recommendation Six

That systems be put in place by Health Transport Units and community transport operators to aggregate demand so that more effective use can be made of available transport resources and services.

NSW State Plan: S1, S2, S6, F5

Planning for hospital reception and discharge

CT groups and patient transport services should be more closely involved in planning for hospital discharges. Discharge planners need to identify and flag possible issues relating to patients getting home from hospital and their transport needs in terms of returning for follow up treatment and/or monitoring. These issues need to be raised with transport agencies to ensure that appropriate transport arrangements are in place before discharge takes place. This approach will not only assist individual patients but will assist in the development of solutions to access block in hospitals. Those responsible for hospital discharges should attend the new Health Transport Forums.

Recommendation Seven

That NSW Health review discharge planning procedures to ensure that patient transport needs are prioritised at discharge and for future health treatment.

NSW State Plan: S2, F1, F3, F5

Transit Lounges and Parking

A number of problems were identified during this study in relation to picking up /setting down and reception of patient at health facilities. A number of CT providers and The Cancer Council NSW believe that transit lounges should be reintroduced in all major health facilities, along with provisions for more efficient parking and reception procedures. Transit lounges are of particular importance to rural and regional patients, including Indigenous patients who may be travelling from remote areas. Such lounges should have places for patients to wait, purchase refreshments, and access toilet facilities as well as provide a greeting place for the patient to be met by hospital staff and taken to their appointment place.

A report prepared for Western Sydney Area Health Service outlined such an arrangement:

The lounge would be the connection point between transport services and the internal ward orderly service. Orderly staff would meet patients at the lounge (if they cannot make their own way to the ward or clinic they are attending) thus reducing the need for transport staff or ambulance staff to spend time escorting patients around the hospital site. In the case of the use of ambulance services this could represent a significant financial saving to the Area Health Service. When patients are ready to leave they would make their way to the lounge (or be escorted there) where they would be able to wait in comfort for their transport service to arrive. This will also make it easier for drivers to locate patients when picking them up from the facility.

A logical extension of this concept would be to locate the facility reception and patient appointment unit in the same area as the transit lounge. This would mean that patients and visitors would have more ready access to facility information and the appointments system.¹²

Transit lounges are already established or are being planned at the Mater Hospital in Hunter/ New England, Tamworth Community Centre, Kent House in Armidale,¹³ Royal Prince Alfred in Sydney and the Coffs Harbour Health Campus. In making the announcement for the Coffs Harbour transit lounge, the then NSW Minister for Health, John Hatzistergos said the concept was a new direction in the way patients are treated in busy referral hospitals around the state.

The transit lounge allows people who are ready for discharge to be located in a non-ward area, while still receiving nursing care and supervision... This means we can free up ward beds, using them for patients awaiting admission through the Emergency Department or for patients coming out of surgery.¹⁴

Transit lounges should be complemented by arrangements for short term parking near hospital entrances for CT, Area Health and Ambulance Patient Transport services. City-based CT workers claimed that at many Sydney hospitals parking is very difficult to find and it is often impossible to set-down relatively immobile passengers near to hospital entrances without parking on the footpath or otherwise illegally.¹⁵ In addition, the use of the transit lounges will reduce the amount of time drivers have to spend searching for and collecting passengers and will thus free-up parking spaces.

Recommendation Eight

That Area Health Services establish transit lounges at major health facilities and that major hospitals reserve areas near to hospital entrances for short-term parking reserved for use by community transport, Area Health transport and Ambulance transport services.

NSW State Plan: S2, S6, F1, F2, F3, F5

5.7. Collect data on transport needs

One of the consistent problems faced by transport planners in the CT area is a lack of consistent and accurate data. This means that funders and planners, if they do not undertake original research, are making decisions about resources and services without a full knowledge of what is being provided at the present or what the unmet community needs are.

Information currently collated by the Transport for Health program on every trip provided including age, gender ATSI status, living arrangements, government benefits, reason for transport, distance travelled, cost of trip, amount donated and travel time¹⁶ should be collated into a report at Area and State levels to aid future planning. This is a task which should be part of the development of Area Health Transport Plans with reporting being summarised every year. A consolidated report should be made available each year through the Department of Health. This information should be accessible by the Ministry of Transport, HACC planners and CT groups throughout the State.

Recommendation Nine

That all Transport for Health data be made publicly available.

NSW State Plan: S1, S2, S6, F1, F2, F3, F5

For the purposes of this project information was collected about unmet requests for transport. Although this does not provide a full picture about unmet need the information does allow planners to highlight stress points in the service system, and demonstrates that unmet needs is a significant problem for health transport in this state.

Recommendation Ten

That a periodic unmet transport needs data collection among funded community transport operators should be undertaken regularly by the Ministry of Transport.

NSW State Plan: S2, F1, F3, F5

5.8. Conclusion

This research into the nature and extent of non-emergency health related transport has demonstrated the critical role that CT providers play in enabling significant numbers of people throughout New South Wales to access essential health care services. Despite the invaluable contribution to the health and wellbeing of the population by CT services, there are wide variations between groups and between locations, in terms of the funding for health related transport and what health services can be accessed by them. In many rural areas the availability of health related transport is totally reliant on volunteer drivers who are driving many hundreds of kilometres to assist their clients.

With the introduction of the NSW Health Transport for Health policy directive, there is an opportunity to realign policy, funding and operational arrangements to create a more equitable and consistent approach to providing health related transport by CT groups across the state. Reforms recommended in this report aim to ensure CT groups are enabled and resourced to respond to current and future growth and change in demand for health related transport. This will ensure equitable access to health treatment for all residents of NSW, regardless of their level of need, ethnic background, ability to pay or place of residence.

- 1 NSW Government. 2006. *State Plan: A new direction for NSW*. Sydney: Premier's Department.
- 2 Community Transport Organisation. 2006. *Community Transport Organisation Annual Report 2005 – 06*. Sydney: CTO.
- 3 An example in eastern Sydney shows that in one group individual transport accounts for 18% of all trips yet consumes 38% of paid driver time, 34% of volunteer driver time, 35% of paid administration time and 74% of volunteer administration time.
- 4 House of Representatives Standing Committee on Health and Ageing. 2005. *Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years*. Canberra: Commonwealth of Australia.
- 5 Ambrosino, G., Nelson, J.D. and Romanazzo, M. Eds. 2004. *Demand Responsive Transport Services: Towards the Flexible Mobility Agency*. Rome: ENEA Italian National Agency for New Technologies.
- 6 Schwartz, S. 2000. *Demand Responsive Public Transport*. Brisbane: Smogbusters.
- 7 Information from the Invicta website: www.invictabus.com.au/telebus.html
- 8 *SmartCity Transport, Demand Responsive Transport Demonstration*. 2006 produced by Great Community Transport, Lawson: Great Community Transport.
- 9 Information from MTRU Transport Planning Consultants. www.drtbody.co.uk (Accessed 12.12.06)
- 10 The Countryside Agency. 2004. *The Taxi Voucher Toolkit*. West Yorkshire: Countryside Agency Publications.
- 11 For example, share ride taxi services used to operate in both Leichhardt and Cessnock.
- 12 NSW Health. 2006. *Transport for Health: Policy Directive*. Sydney: NSW Department of Health.
- 13 Transport Planning and Management. 2005c. *Transport Solutions for Renal Dialysis Services in Sydney West Area Health Service*. Sydney: Sydney West Area Health Service, p 43.
- 14 Information from brochures produced by Tamworth Community Centre and the Armidale partners.
- 15 NSW Government. 2006. *New transit lounge for Coffs Harbour health campus*. Media Release.
- 16 Transport Planning and Management. 2006. *Health Related Transport – Issues Identified by Community Transport Providers*. Sydney Metro Transport Development Project. (In Press)
- 17 NSW Health. 1999a. *Health Related Transport Instruction Manual*. Sydney: NSW Department of Health.

Appendix I. Relationship of community transport recommendations to NSW Government State Plan

| Recommendation Summary | State Plan Goals | Priority Areas | Contribution to Targets |
|--|--|------------------------|--|
| 1. Increase funding for non emergency health related transport. Enhanced funding will increase access to non emergency health care. | Healthy Communities, Strengthening Aboriginal Communities, Opportunity and Support for the Most Vulnerable, Early Intervention to Tackle Disadvantage. | S1, S2, F1, F2, F3, F5 | Improved survival rates through greater access to health care; reduce unnecessary hospital admissions, including for Aboriginal people; remove transport to treatment barriers for people with mental illness. |
| 2. Redress current inequities in distribution of health funds. This will create greater consistency in delivery of health transport services, and in ensuring consistent outcomes from health treatment. | Healthy Communities, Strengthening Aboriginal Communities, Opportunity and Support for the Most Vulnerable, Early Intervention to Tackle Disadvantage. | S1, S2, F1, F2, F3, F5 | Improved survival rates through greater access to health care; reduce unnecessary hospital admissions, including for Aboriginal people; remove transport to treatment barriers for people with mental illness. |
| 3. Develop processes to aggregate demand for health related transport. This will improve utilisation of existing transport services and resources and improve access to health services. | Healthy Communities, A High Quality Transport System, Early Intervention to Tackle Disadvantage. | S1, S2, S6, F4, F5 | Improved access to quality healthcare, Improved survival rates through greater access to health care, increasing share of peak hour journeys on a safe and reliable public transport system, embedding the principle of prevention and early intervention into Government service delivery in NSW, reduced avoidable hospital admission. |
| 4. Develop an Aboriginal Health Transport Strategy | Strengthening Aboriginal Communities | F1 | Reduce unnecessary hospital admissions for Aboriginal people. |
| 5. Develop flexible public bus services to health destinations. Increase use of public transport to health destinations. | Healthy Communities, a High Quality Transport System, Strengthening Aboriginal Communities, Opportunity and Support for the Most Vulnerable, Early Intervention to Tackle Disadvantage | S2, S6, F1, F2, F3, F5 | Increase transport options and reduce unnecessary hospital admissions, including for Aboriginal people; remove transport to treatment barriers for people with mental illness. |

| | | | |
|--|---|-----------------------------------|--|
| <p>6. Develop regional planning processes for health transport. Allow input from all stakeholders in order to improve effectiveness of health transport planning.</p> | <p>Healthy Communities, a High Quality Transport System, Strengthening Aboriginal Communities, Opportunity and Support for the Most Vulnerable, Early Intervention to Tackle Disadvantage</p> | <p>S1, S2, S6, F1, F2, F3, F5</p> | <p>Improved survival rates through greater access to health care; reduce unnecessary hospital admissions, including for Aboriginal people; remove transport to treatment barriers for people with mental illness.</p> |
| <p>7. Review discharge planning processes. Ensure that access to transport is taken into consideration in discharge planning.</p> | <p>Healthy Communities, Strengthening Aboriginal Communities, Early Intervention to Tackle Disadvantage</p> | <p>S2, F1, F3, F5</p> | <p>Reduce unnecessary hospital admissions, including for Aboriginal people; remove transport to treatment barriers for people with mental illness</p> |
| <p>8. Establish transit lounges in major health facilities. Create pick up and short term parking infrastructure for providers of health transport.</p> | <p>Healthy Communities, a High Quality Transport System, Strengthening Aboriginal Communities, Opportunity and Support for the Most Vulnerable, Early Intervention to Tackle Disadvantage</p> | <p>S2, S6, F1, F2, F3, F5</p> | <p>Improve transport connectivity and thereby reduce unnecessary hospital admissions, including for Aboriginal people; remove transport to treatment barriers for people with mental illness</p> |
| <p>9. Data on Transport for Health to be publicly available. Make planning for health transport more effective by sharing information between government agencies and non government providers.</p> | <p>Healthy Communities, a High Quality Transport System, Strengthening Aboriginal Communities, Opportunity and Support for the Most Vulnerable, Early Intervention to Tackle Disadvantage</p> | <p>S1, S2, S6, F1, F2, F3, F5</p> | <p>Share planning information and improve survival rates through greater access to health care; reduce unnecessary hospital admissions, including for Aboriginal people; remove transport to treatment barriers for people with mental illness</p> |
| <p>10. Collect data on unmet community transport needs. Create a measure of the effectiveness of government funded services in meeting demand.</p> | <p>Healthy Communities, Strengthening Aboriginal Communities, Early Intervention to Tackle Disadvantage</p> | <p>S2, F1, F3, F5</p> | <p>Reduce unnecessary hospital admissions, including for Aboriginal people; remove transport to treatment barriers for people with mental illness</p> |