

***Non-Emergency Health-Related  
Transport – Facilitating access to  
health services in NSW.***

***Discussion Paper***

Prepared for

**The Rural Health Implementation Coordination Group  
of the NSW Government Action Plan for Health**

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Prepared by Transport Planning and Management and Applied Economics for the Rural Health Implementation Coordination Group of the NSW Government Action Plan for Health.



## Section 1: Executive Summary

### 1.1 Aims of the report

This report discusses the public provision of non-emergency transport to and from public health facilities for transport disadvantaged persons in New South Wales. A transport disadvantaged person is someone with little or no access to private transport and without easy access to public transport. Emergency patients are the responsibility of the NSW Ambulance Service and are outside the scope of this report.

Currently, most publicly financed trips to and from public health facilities in NSW are provided by publicly funded community transport groups, Area Health Services or the NSW Ambulance Service. The main aim of this report is to examine how this framework for providing these trips can be better managed to improve services to the transport disadvantaged within the current Government policy settings.

### 1.2 Key issues

During the course of the study a number of issues were identified that have an effect on people's ability to get to and from health facilities.

Most people travel to and from health facilities in private cars or by public transport. Some of these people depend heavily on carers for transport. Many carers are older people and some have disabilities themselves.

Those who have the most difficulty do not have access to private transport and cannot use public transport for one reason or another. This is particularly true of people with disabilities and older people but includes people with temporary mobility problems or who are significantly ill.

A significant number of people depend on community transport, particularly in country areas.

The need for additional transport support is being partly driven by the centralisation of health services, increasing use of day surgery, the decreasing availability of carers and the growth in the number of people with disabilities and older people living in the community.

Patients and those who purchase transport services, have a limited choice of transport suppliers because of the restrictive regulations that govern passenger transport and non-emergency ambulance transport.

Greater utilisation of existing transport resources could be made if there was more flexibility with patients' appointment times. Early appointments and late finishes for day surgery, for example, can make the arrangement of transport difficult for both patients and transport providers.

Hospital discharge practices do not always take transport issues into consideration despite transport having been identified as one of the key impediments to effective discharge planning.

There is a need for greater cooperation between health facilities and the providers of transport services. This cooperation exists in some areas but needs to be formalised across the State.

The availability and skill levels of volunteer drivers is of concern and needs to be addressed if this resource is to be relied on in the future.

Some people have difficulty in finding information about non-mainstream transport services.

### 1.3 Proposed approaches to key issues

In order to address these issues and to ensure that health services run efficiently and the health status of transport disadvantaged patients is not compromised, Area Health Services need to recognise the importance of ensuring the availability of appropriate and adequate non-emergency transport services. Therefore, the following should be considered:

1. That transport and access issues be incorporated into Area Health Service planning processes including Population Health Plans and in relation to initiatives included in the Health Care in the Community Re-investment Strategy.
2. That improved data collection processes be introduced to identify and monitor unmet health-related transport need in the community.
3. That each Area Health Service establish a Health Transport Unit to take responsibility for non-emergency transport. The Units' function will be:
  - to act as a budget holder for transport funding;
  - to gather evidence on unmet health transport need;
  - to develop a Health Transport Plan for each Area Health Service;
  - to provide information on transport services and to act as a clearinghouse for transport requests;
  - to assist with identifying appropriate services for individual types of passengers;
  - to assist with the synchronisation of appointments so that better use can be made of transport resources;
  - to act as a training resource for transport suppliers; and
  - to support the Health Care Transport Networks.
4. That each Area Health Service establish a Health Care Transport Network. The purpose of the Network will be to bring together health facilities, transport suppliers, planners and community representatives in order to:
  - identify the scope and scale of health-related transport need;
  - prioritise where resources should be applied;
  - provide advice on identifying appropriate services for individual types of passenger;
  - provide a formal interface between the health system and transport suppliers;
  - provide advice on the training needs of transport suppliers;
  - encourage consistency in transport supply and fees to passengers; and
  - plan for the transport implications of changes to health services.
5. That the primary funding vehicles for addressing transport to and from health facilities be the Health-Related Transport Program (HRTP) and Area Health Services.
6. That the primary budget holders for the Health-Related Transport Program be the Area Health Services.
7. That HRTP funding be primarily used to purchase transport from non-Area Health Service suppliers, principally community transport, to address the needs of patients with limited or no access to private transport and who cannot easily use public transport to get to and from health facilities.
8. That mainstream transport suppliers be encouraged or be subsidised to provide more flexible transport services that meet the needs of patients who currently have difficulty in getting to health facilities because of problems with transport.

9. That H RTP funding also be used to provide support for the Health Care Transport Networks and for the provision of training for the staff of the suppliers of non-emergency transport.
10. That the identification of appropriate transport for patients be written into discharge policies, that transport be included in patients' discharge plans and that discharge planners be part of the Health Care Transport Networks.

#### 1.4 Potential benefits of this approach

Stakeholder	Benefit
Patients	<ul style="list-style-type: none"> <li>• Ability to travel to and from health facilities more easily, thereby missing fewer appointments and maintaining better health.</li> <li>• Improved quality of transport services in terms of timeliness and care considerations.</li> <li>• Access to more appropriate transport services.</li> <li>• Improved information about transport services and more obvious points of access to transport services.</li> <li>• Improved discharge practices that take transport issues into account.</li> <li>• Patients' transport needs included in wider health planning processes.</li> </ul>
Area Health Services	<ul style="list-style-type: none"> <li>• Better understanding of transport need and its effects on the provision of health care.</li> <li>• Patients miss or postpone fewer appointments leading to more efficient use of resources and staff time.</li> <li>• Benefits achieved from centralisation of services and increased use of day surgery will be less likely to be compromised by inability of patients to travel to appointments.</li> <li>• Direct control over resources to address health transport disadvantage.</li> <li>• Improved transport support for bed management processes.</li> <li>• Improved transport options for discharge planning.</li> <li>• More efficient and appropriate transport purchasing decisions made.</li> <li>• Better understanding of transport costs incurred.</li> <li>• Improved accountability for money spent on the purchase or provision of transport for patients.</li> <li>• Improved liaison with transport operators, other planners and the community in terms of developing better cooperative practices.</li> </ul>
Department of Health	<ul style="list-style-type: none"> <li>• Responsibility for transport to and from health facilities identified.</li> <li>• Better targeted, more equitable and more efficient use of Health-Related Transport Program resources.</li> <li>• Improved accountability for Health-Related Transport Program funds.</li> <li>• Improved health outcomes for some patients.</li> <li>• More efficient overall use of health resources.</li> </ul>

<b>Stakeholder</b>	<b>Benefit</b>
Transport funders	<ul style="list-style-type: none"><li>• More efficient use of transport funding.</li><li>• Improved outcomes for transport disadvantaged clients.</li><li>• Additional clients gaining access to health transport services.</li><li>• An opportunity to be involved in cross-departmental and cross-agency health transport planning through the Health Care Transport Networks.</li><li>• Improved knowledge of unmet transport need among program clients.</li></ul>
Transport operators	<ul style="list-style-type: none"><li>• The development of formal cooperative processes with Area Health Services to enable operators to provide more efficient services and services more attuned to passenger needs.</li><li>• Clearer contractual arrangements with Area Health Services.</li><li>• Clearer understanding of unmet need and where transport activity should be concentrated.</li><li>• Central point of information about transport services for passengers.</li><li>• Improved referral systems between operators.</li></ul>

## 2. Background to the study

### 2.1 History

Prior to 1982 the Ambulance Service was the major supplier of non-emergency transport to hospitals in New South Wales. An inquiry into the service in that year by the Health Commission<sup>1</sup>, resulted in a major reduction in the volume of non-emergency transport provided by the Service. Since then the transport of patients on a non-emergency basis has been undertaken by a wide variety of agencies within the context of a lack of central funding or coordination.

Since the mid 1980s a number of reports have suggested that some patients may be having difficulty in accessing medical facilities because of difficulties in gaining access to suitable non-emergency transport services<sup>2</sup>.

In recent years the Ambulance Service has again become involved in non-emergency or “routine” patient transport services. In addition, the Department of Health has instigated the Health-Related Transport Program which funds community transport operators to provide transport for patients on a non-emergency basis. In recognition of the role of community-based transport services in providing non-emergency transport, the Department has also developed “A Framework for the Development of Local Health-Related Transport Guidelines” in cooperation with the Community Transport Organisation. Some Area Health Services also provide transport to selected categories of patients. The volume and type of services, and the categories of patients transported varies significantly between areas.

### 2.2 Recent evidence of a problem

Last year the NSW Ministerial Advisory Committee on Health Services in Smaller Towns<sup>3</sup> noted that transport was one of the most common issues raised by communities during their consultations. Their report identified that a number of funding bodies provided resources for health-related transport which is, in turn, delivered by a large number of service providers. The committee suggested that there is both duplication of, and gaps in services, restrictive eligibility criteria, variations in interpretation of such criteria and a lack of coordination and consultation in planning processes. They also observed that the transport needs of patients are not consistently viewed as a high priority or core business by rural Area Health Services. The Committee have consequently recommended the following:

- that a comprehensive review of community transport at an Area Health Service level be undertaken to promote a strategic approach to health-related transport planning;
- that the NSW Government identify a single agency to coordinate, at a local level, the planning and delivery of transport services involving Federal, State and Local Government agencies, non-Government providers and volunteers.

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<sup>1</sup> Health Commission of NSW (1982) *Inquiry into the NSW Ambulance Service*.

<sup>2</sup> Wood R. (1990) *The Health Related Transport Study (Interim Report)*, Community Transport Organisation, Sydney and, E3 Group (1995) *A Study of the Provision of Health Related Transport in SW and SE Sydney Health Areas*.

<sup>3</sup> NSW Ministerial Advisory Committee on Health Services in Smaller Towns (2000) *Report to the Minister for Health: A Framework for Change*.

The NSW Health Council also dedicated a section of their March 2000 Report<sup>4</sup> to health transport issues. They also found that access to affordable and responsive transport is a significant problem for people in rural and remote NSW and that there is a need to ensure that transport is properly funded, better coordinated and does not impede access to appropriate clinical care. Community-based transport was identified as being essential to facilitate better access to primary health care services.

The issue of improving the coordination of community transport across the entire sector, falls outside the jurisdiction of NSW Health. NSW Health raised this issue with the Premier in later 2000, who agreed that a whole-of-Government approach for the delivery of community transport in the future would be developed. An Inter-agency Working Group has been established to develop a strategic policy framework.

The New South Wales Council of Social Service has also raised the issue of a lack of transport to health services in rural and remote parts of the State in a recent report<sup>5</sup>. The report indicated that there has been a “*dramatic increase in the number, length and complexity of journeys to access health services*”, and that there are growing demands on existing service providers.

It appears from the material that has been reviewed during the study that the present system could be perceived to have the following characteristics:

- it is not providing enough services to satisfy current demand;
- it is difficult for patients and health practitioners to understand and use;
- it is inconsistent in terms of access to services by patients;
- it is uncoordinated in an operational sense;
- it lacks overall objectives and direction; and
- it is not planned for in terms of inter-Departmental and agency coordination (particularly at a regional level).

This is not to say that the existing system has no redeeming features. A great many people do have access to appropriate transport services, there is an existing pool of dedicated staff and volunteers and there would appear to be a will, among many stakeholders, to find and implement a workable health-related transport system. Funding, planning and operational issues all need to be addressed by this study.

### **2.3 Problem statement**

An advisory group comprising representatives from the Department of Health, Area Health Services, Aboriginal Medical Services, transport providers and independent community members was convened to provide advice to NSW Health and the consultants throughout the study.

In early discussions about the study the advisory group defined the problem that the study was seeking to address. The key problem was identified as a lack of access to health services for those people who:

- do not own a car;
- have no one else to drive them;
- live in an area where public transport is not available; and/or
- are unable to access available public transport due to physical or financial constraints.

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<sup>4</sup> NSW Health Council (2000) *Report of the NSW Health Council: A Better Health System for NSW*.

<sup>5</sup> Bragg R. & Reedy L. (2001) *Transport to Access Health Services in Rural and Remote NSW*, New South Wales Council of Social Service

Other issues to be addressed by the study were:

- a lack of coordination between transport services and health services;
- no system for currently matching the needs of clients with transport service capacity;
- uncertainty in that transport services may be delayed or cancelled due to the large volunteer component in the system;
- inadequate discharge planning in relation to transport; and
- a lack of available consumer information on transport services availability.

It was agreed that services need to be:

- affordable;
- available within a realistic timeframe;
- able to provide an appropriate level of care, training and safety to meet the patients' needs; and
- able to provide a door-to-door continuum of care for patients.
- guaranteed a level of funding commensurate with the need for services and the costs of their operation.

## 2.4 Scope of the project

It was indicated to the consultants by the NSW Department of Health that the study report should reflect current Government policy settings with regard to public spending and the regulation of public passenger transport.

A second issue in defining the scope of the project was the development of a definition of the transport that was to be the subject of the study. After discussions within the Department of Health and at the Advisory Committee for this project the following definition was adopted:

*“the transport of non-urgent clients who require transport to or from recognised medical facilities. These are clients that need no clinical decisions or active management during the journey. They would not be expected to develop complications of their condition en route. They may continue to routinely manage self-managed clinical interventions such as home oxygen and regular medications but would not be expected to administer new interventions in transit.”*

The definition, however, begged further clarification of what constitutes a recognised medical facility. It was decided that recognised medical facilities should include hospitals, clinics, day care centres and other venues funded or operated by Area Health Services in New South Wales.

They do not include private medical facilities or clinics, general practitioners, medical specialists not based in public hospitals, aged care facilities or other health services not provided by Area Health Services. To include such facilities would require a whole-of-Government approach which would involve the Commonwealth Department of Health and Ageing which funds many of these services.

It was noted that community transport provides a wide range of transport services that have an impact on patients' health status in addition to transport to health facilities.

## **3. Methodology**

### **3.1 Introduction**

After a review of base information made available by the Department of Health, a methodology for the study was developed in cooperation with the study Advisory Group. The methodology consisted of a process of data collection, consultation, analysis and the development of a discussion paper.

### **3.2 Stages of the study**

The methodology was designed to take advantage of existing information and knowledge as far as possible and to gather additional data only where necessary. The study was undertaken in six stages. The stages were:

1. A review and analysis of base information including a description of existing services;
2. Consultations with key stakeholders;
3. Data collection;
4. Assessment of current and future needs to 2006;
5. The development of options, including related costings; and
6. The production of a Discussion Paper to assist with a review of the options.

### **3.3 Consultations on the methodology**

A round of initial consultations took place early in the project in order to gather background information that would assist with the development of a revised methodology. Interviews took place with the people listed in Attachment A.

The methodology was discussed at the April meeting of the Advisory Group. It was agreed that the study would examine a representative sample of areas across the state. Those areas are:

1. Hunter;
2. Mid North Coast;
3. South West Sydney (Liverpool and Macarthur Sectors);
4. Greater Murray (Albury to Deniliquin area); and
5. Far West (Upper Western Sector).

In areas 1 – 4 a survey of users of public health facilities and a survey of transport supply was undertaken. The supply survey provided a snapshot of two weeks activity. Alternative arrangements were made for the Far West because of the fragmentation of service delivery among a large number of providers, few of whom provide transport as a core activity.

Subsequently the St George region of South Eastern Sydney Area Health Service was invited to participate in the study in order to provide a better city/country balance. Transport suppliers in the Eastern Suburbs also agreed to participate in the study.

The methodology involved the collection of a range of information in addition to the survey data through meetings, correspondence and telephone calls and conferences. Information was requested from:

- senior health planners in all NSW Area Health Services;
- Divisions of General Practice;
- Heath Councils in the target areas for the study;
- transport budget holders in Area Health Services and the Ambulance Service; and

- financial data from selected health-related transport suppliers in the study regions.

### **3.4 Health Facility User Survey**

A questionnaire was designed and refined after discussions with the study Advisory Group and on additional advice from individual group members (see Attachment B for a list of those consulted).

The purpose of the survey was to identify what proportion of the population are having difficulty in attending public health facilities because of problems with transport, what the nature of those difficulties are and to develop a profile of those who are most likely to experience those difficulties.

Questionnaires were distributed to health service users by mail through Hunter Area Health and at public health facilities throughout the other areas except the Far West. Details of the distribution can be found in Attachment B.

Approval from the Ethics Committee in the Greater Murray was required and was granted on 1 June 2001.

1,918 questionnaires were returned and the results were entered onto a database for analysis.

### **3.5 Transport Supply Survey**

The purpose of this survey was to develop a picture of the extent to which transport suppliers in the study areas were involved in non-emergency health-related transport. The survey was also designed to test two hypotheses:

1. That the home to health facility market is mainly catered for by community based providers, the facility to facility market is split between AHS Patient Transport Services and the Ambulance Service, and the facility to home market is split between the Ambulance Service and community based providers.
2. That community based providers cater for passengers with low care needs, AHS Patient Transport Services cater for passengers with medium care needs, and the Ambulance Service caters for passengers with high care needs.

The questionnaire went through a series of drafts on advice from Advisory Group members and agencies that were to administer it. Fifty-one agencies were contacted personally to explain the project and to ensure their participation. This proved to be very time consuming but necessary. Feedback from many of these conversations was recorded and will be considered an additional source of data. A copy of the questionnaire is to be found in Attachment C.

The survey was distributed to a range of transport suppliers in each of the study areas. Returns were received from:

- the Ambulance Service;
- 24 Area Health Service transport providers;
- 14 Community Transport groups;
- 10 Neighbour Aid groups;
- 3 Volunteer groups;
- 1 Community Options Program; and
- 1 Home Care Service.

Details are to be found in Attachment C.

### **3.6 Far West region**

It was agreed, after consultations with health workers in the Upper Western Sector of the Far West AHS that the health facility users questionnaire would not be appropriate in that area. It was also recognised that because the transport supply in the area is very fragmented, the administration of the transport supply questionnaire would be very cumbersome.

After consultations with service providers and a two day visit to Bourke and Walgett during which a focus group was held with service users and a major meeting with transport providers, it was decided to ask transport providers to complete a log sheet over a two week period that would capture information about both the supply of transport and some personal details about passengers (see Attachment D).

### **3.7 Consultations with transport suppliers**

Consultations about supply issues have taken place with a range of service providers including:

- the NSW Ambulance Service;
- Patient Transport Services at St Vincent's Hospital (Darlinghurst), Liverpool Health Service, Macarthur Health Service, Hunter Area Health Service and Albury Base Hospital;
- the Illawarra Integrated Community Transport Planning Project;
- the Awabakal and Bourke Aboriginal Medical Services;
- the Community Transport Organisation; and
- a group of transport service providers at a meeting in the Upper Western Sector of the Far West Health Service.

Reports on the supply of health-related transport from the Northern Rivers, Hunter and Mid North Coast Area Health Services have been considered. Consultation has also taken place with the New England Area Health Service which has developed a computer based booking and costing system for patient transport.

#### **3.7.1 Contact with Community transport**

130 community transport groups funded through the Department of Transport were contacted with a view to identifying examples of coordination with Area Health Services and information on passenger classification systems. 27 replies were received. The results are to be found in Attachment E. One meeting has been held so far with the Community Transport Organisation to discuss the study.

#### **3.7.2 Contact with the NSW Ambulance Service**

Four meetings have taken place with the Ambulance Service and have involved discussions with the CEO, the Director of Finance and Data Services, the Directors of both the Rural and Metropolitan Ambulance Services and the Superintendent in charge of Second Tier Transport Development. Discussions have concentrated on the supply of transport services to Area Health Services, the expansion of second tier or routine transport, and financial issues.

### **3.8 Consultations with transport budget holders**

During our initial consultations with the five designated Area Health Services it became evident that transport purchasing decisions are typically dispersed among a large number of entities, particularly individual wards and clinics at hospitals.

A round of structured interviews was undertaken with senior managers and financial directors of Health Services and the Ambulance Service. This has enabled us to build an understanding of what transport alternatives are available, what the costs of those

alternatives are, who carries those costs and the quality aspects of the transport services used. The results are tabulated in Attachment F.

### **3.9 The regulatory environment**

The quality of transport purchasing decisions will depend, to an extent, on the choices available to the purchaser. It has been suggested that current regulatory arrangements for passenger transport services, under the provisions of the NSW Passenger Transport Act (1990), may act as a barrier to the development of alternative patient transport services. There has also been the suggestion that current patient transport services, as provided by Area Health Services, may require accreditation under the same legislation. These matters are currently being considered by the NSW Department of Transport through a Review of Regulation for Community and Courtesy Transport Services.

Two meetings were held with the Department of Transport to discuss the issue.

### **3.10 Consultations with other stakeholders**

A number of other stakeholders were consulted during the course of the study. These included Health Councils, Divisions of General Practice and Senior Health Planners.

#### ***3.10.1 Contact with Health Councils***

A letter was sent to the Health Councils in the study areas asking for their comments in relation to the difficulties some patients have in getting to public health facilities and whether these difficulties may be compromising their health treatment.

In addition, their opinions were canvassed on the nature of these difficulties and how they might be addressed.

Nine replies were received. A summary of their comments is to be found as part of Attachment G.

#### ***3.10.2 Contact with Divisions of General Practice***

A similar letter was sent to the 47 Divisions of General Practice around the state asking for their comments. Fifteen replied including 3 that ran a short survey of their members. The results are also to be found in Attachment G.

#### ***3.10.3 Contact with Senior Health Planners***

Senior health service planners were contacted in all Area Health Services with regard to their views on the difficulties some patients have in getting to public health facilities and how those difficulties might be addressed.

In the five study areas, health planners were also asked whether it would be possible to canvass the views of relevant health staff on the same issues.

Responses were received from nine Area Health Services. Some from the study areas canvassed the views of staff in individual clinics and/or towns. These amounted to an additional 35 responses. These are also summarised in Attachment G.

### **3.11 Assessment of current and future needs to 2006**

An assessment of current and future needs for health-related transport was undertaken, based on data collected as part of this study, data held by the NSW Department of Health, ABS survey data, and analyses of ABS data undertaken by the Australian Institute of Health and Welfare and the NSW Department of Ageing, Disability and Home Care.

### **3.12 Examination of transport costs**

One of the key considerations in making transport purchasing decisions is the cost of the available service options. It was therefore necessary to investigate the comparative marginal costs of different types of transport provision by means of a costing survey, a review of typical vehicle costs, a review of the cost of commercial ambulance services and an assessment of the cost of outputs from the Health-Related Transport Program. The results of these investigations are to be found in Section 5.5.

## Section 4. Need for Transport Services

### 4.1 Introduction

This chapter discusses the needs of transport disadvantaged persons for assistance to access public health facilities in NSW. As defined by the Department of Transport<sup>6</sup>, a transport disadvantaged person is a person with little or no access to private transport and without easy access to public transport.

This group of persons does not include:

- emergency patients with access to ambulance services;
- persons who drive their own vehicle;
- persons with friends or relatives to transport them;
- people with the means to pay for their own transport, including taxis;
- people with easy access to bus or rail services; and
- people transported by privately financed community based organisations.

It should be noted that this chapter is concerned with the need for transport, not with the demand for transport. The transport of disadvantaged persons with transport needs is a social service based on the needs of individuals. The concept of demand is based on (a) what people are willing to pay for services and (b) the existence of some form of price mechanism. Neither applies in this case.

However, in discussing need, it must be recognised that this concept is based on a judgement of what is an acceptable need judged by some kind of social norm. There is no objective measure of need. While individuals may assert that they have transport needs, some of these assertions, indeed perhaps many, will pass the test of need by a social norm; others will not. Accordingly, estimates of need must always be treated with caution.

A related difficulty is the lack of availability of data on needs, and specifically needs for transport to health facilities. Because the concept of need is inherently subjective, there are not many useful data on needs. One way to get around this problem is to base our estimates on the current volume of services to people with transport needs.

Presently community transport groups and Area Health Services provide 70% of the publicly provided transport for disadvantaged persons to public health facilities. Accordingly, data on these services should provide a base for the estimates of need. However, as discussed below, these agencies have limited data on the trips that they provide.

The following section discusses the present level of trips provided to transport disadvantaged persons. Sections 4.3 to 4.6 discuss the unmet need for transport services to public health facilities. Section 4.7 discusses the likely growth in need to 2006. The final section provides a short summary.

### 4.2 The Present Met Need for Transport to Public Health Facilities

To provide an overall market context, Table 4.1 shows the numbers of inpatients and outpatients at NSW health facilities. Excluding inpatients and emergency services, the health facilities provide about 18.5 million services a year.

Of the total services, approximately 70 per cent are provided by metropolitan AHSs and 30 per cent by rural AHSs. Of course, in order to estimate passenger trips to and from public health facilities, these numbers must be doubled.

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<sup>6</sup> NSW Department of Transport – Guidelines for the Accreditation of Community Transport Operators.

**Table 4.1: Health Care Services in NSW in 1998/99**

Services	Number	Total
<i>Inpatient separations (inc.babies)</i>	1,357,892	
Emergency services	2,428,264	
Total		3,786,156
<i>Non-inpatients</i>		
Outpatients	8,003,255	
Mental health services	1,772,281	
Rehabilitation and extended care	2,777,845	
Primary, community based services	5,942,793	
Total		18,496,174
Grand total		22,282,330

Source: NSW Health

The great majority of passenger trips to public health facilities are provided by people drawing on their own resources or on those of friends and relatives.

Publicly financed trips for transport disadvantaged persons are provided in the main by community transport groups funded through the joint Federal/State Home and Community Care program, the State funded Community Transport and Health-Related Transport programs and by Area Health Services.

Community transport groups provide over 1.2 million trips per annum to their client group, including social and shopping trips. According to data from the Department of Transport<sup>7</sup>, funded community transport groups provided 150,000 passenger trips last year to hospitals and medical facilities. They also provide transport to day care centres, some of which are operated by Area Health Services. According to our survey 25% of their trips were to day care facilities. Overall, community transport groups provide about 200,000 trips to and from health facilities per annum. Calculations based on our survey also indicated that other community based providers of transport, including Neighbour Aid groups and unfunded groups are likely to provide approximately 40,000 trips a year.

However, this figure appears to be too high for the budget constraint. Community transport groups do not know accurately (a) how much they spend on provision of transport services to health facilities or (b) the average cost of a trip. However, even allowing for the much higher costs of transport for disadvantaged persons to health facilities than for shopping (usually in a group) or on outings, it is unlikely that community transport groups spend over half their budgets on transport to health facilities. In these estimates we allow that they may spend \$5.0 million on this transport (see Table 4.2).

We also allow for an average transport cost of only \$21 per passenger trip. As can be seen from the analysis of transport costs in Chapter 5, this estimate is at the low end of the possible range of estimates. Accordingly, we estimate that community

<sup>7</sup> Summary of data returns for community transport services funded under the Home and Community Care Program, the Community Transport Program and the Area Assistance Scheme – NSW Department of Transport, 2001.

transport groups are currently providing about 240,000 passenger trips a year to and from public health facilities, including primary and community facilities.

Nor do the Area Health Services have accurate data on the number of passenger trips they provide to or from health facilities, the costs of these trips, or the costs per trip. One reason for this is that many different parts of health agencies provide these services. For example, within a hospital, these services are often provided by wards or clinics as well as by some part of the central administration.

A recent NSW Health survey indicated that AHSs currently spend an estimated \$9.9 million on passenger services for the transport disadvantaged from their own resources.<sup>8</sup> However, some of this expenditure is presumably allocated to transport between hospital facilities. For our estimates, we have assumed an expenditure of \$8.0 million a year for transport to and from health facilities (see Table 4.2). Drawing on our cost estimates in Chapter 5, we allow an average cost of \$40 per passenger trip. Using a round number, this indicates about 180,000 passenger trips per annum. Many of these trips are to a hospital's outpatient services.

The third category shown in Table 4.2 is the Health-Related Transport Program of \$0.8 million funded by NSW Health. Allowing an average cost of \$50 per passenger trip, this would provide about 16,000 passenger trips per annum.

According to our supply survey the Ambulance Service provides 7,000 trips to or from health facilities per fortnight on a non-emergency basis across the whole State. This equates to about 180,000 trips over a year.

Overall, an estimated 620,000 publicly-funded transport services are provided to transport disadvantaged persons per annum at an approximate total cost of about \$13.8 million (excluding Ambulance services). This is equivalent to about 3 per cent of all non-emergency trips to health care facilities in NSW.

**Table 4.2 Estimated services to transport disadvantaged persons per annum<sup>a</sup>**

Agency	Expenditure \$m	Cost per pass. Km (\$)	Avg.cost of pass. trip (\$)	Total Pass. trips
Community transport	5.0	0.65	21	240,000
AHS	8.0	1.90	40	181,000
HRTTP	0.8		50	16,000
Ambulance	n/a	n/a	n/a	182,000
Total	13.8			619,000

Source: Consultant estimates.

(a) To and from health facilities, excluding inter-facility trips.

### 4.3 Estimates of unmet need for transport to health facilities

As discussed above, there are many kinds of unmet need and the concept of unmet need is not readily measurable. Some people have a serious unmet need, others have a minor unmet need. In this analysis, people who cannot meet an appointment and have to cancel it and people who are delayed at a hospital for many hours after they are discharged, or whose discharges would be delayed, are considered to have a serious unmet need. Qualitative and quantitative evidence from a number of

<sup>8</sup> NSW Health Department, 2000, *Transport Survey, A stocktake of non-emergency services funded by the Area Health Services*.

sources is used to assess the numbers of people who have significant unmet needs in terms of travel to and from health facilities.

It should be noted that the availability of relevant data varies between population groups. Most of the useful information that is available relates to older people and people with disabilities. While these are likely to be core groups in terms of unmet transport need, there are others in the community who will have difficulty in travelling to health facilities. Such difficulties may arise because of personal characteristics such as temporary mobility problems, lack of income or no access to a car, geographic issues such as the location of the facilities that need to be accessed in relation to where people live, and systemic issues such as the adequacy or existence of public transport. The needs of many of these people cannot be adequately quantified but should not be ignored.

Apart from the research conducted as part of this study, there are a number of surveys that have been undertaken in recent years that have indicated that some people have difficulty getting to health facilities because of problems with transport. There is also evidence that some people's need for assistance with transport is not met at all.

## 4.4 Summary of relevant data from study research

### 4.4.1 Health Facility Users' Survey

This survey was undertaken in the six sample Area Health Services and involved inviting patients visiting health facilities to complete a questionnaire about how they travel to and from facilities and the type of difficulties they encountered<sup>9</sup>.

#### Extent of difficulty experienced

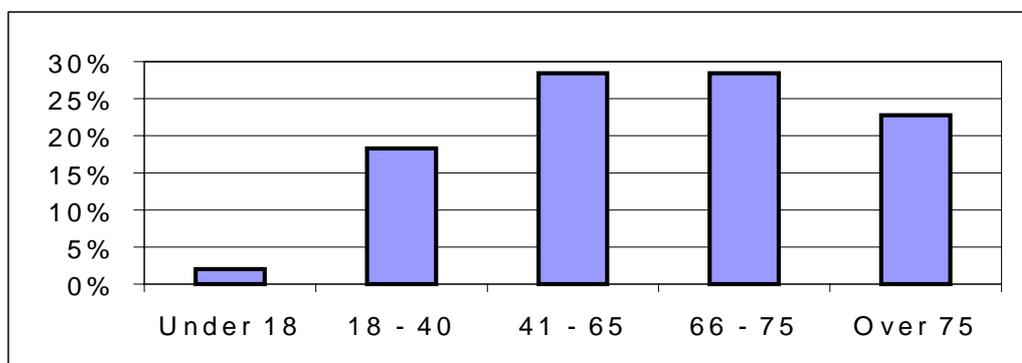
Of the 1,900 people who responded to the survey, 20% indicated that they had difficulty getting to health facilities in the preceding three months. Overall, there was not much difference between city and country respondents although this varied between regions.

#### Profile of those who had difficulty

Of those who indicated that they had experienced difficulty, most were pensioners. Half were people over the age of 65 and a quarter were on some sort of disability pension or allowance. Only 8% were wage earners or on a salary.

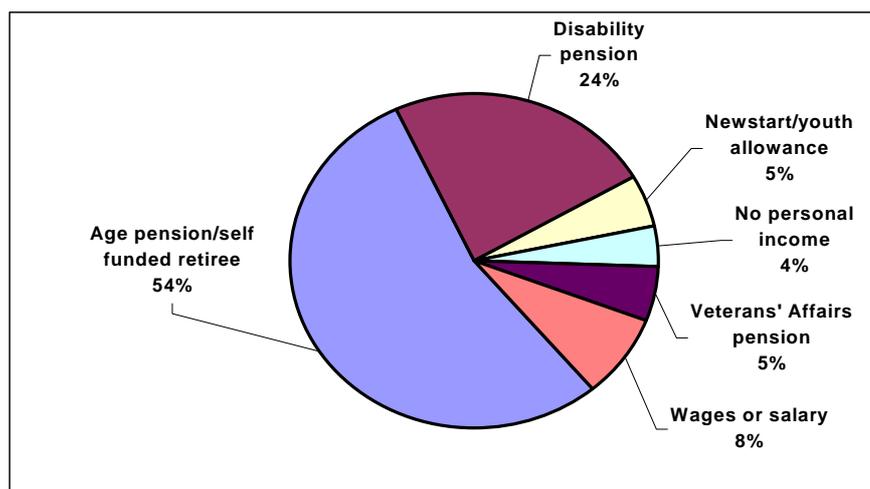
Just over half had a car in their household and 40% lived alone.

**Chart 4.1 Age groups of people who indicated difficulty in getting to health facilities**



Source: Consultants Health Facility User Survey.

<sup>9</sup> See Appendix B for survey information and results.

**Chart 4.2 Income source of people who indicated difficulty in getting to health facilities**

Source: Consultants Health Facility User Survey.

These results suggest that those groups in the population that tend to have fewer transport choices, people who drive less and who have difficulties in accessing or affording public transport, are most likely to have difficulty in getting to health facilities.

#### Nature of difficulties

The most common difficulty was recorded as not having access to a private car (30%). This is significant as the study showed that most people surveyed (75%) used private transport to get to health facilities on the day of the survey.

Problems with public transport were also reported including service times not being convenient (16%), feeling unsafe (8%) and bus stops or railway stations being too far away (14%).

12% of city respondents indicated that expense was a problem compared to 9% of respondents in country areas.

A carer not being available was indicated as a problem among 12% of respondents.

#### Difficulties getting to medical appointments

A number of questions were asked about getting to medical appointments. The number of appointments cancelled in the previous year because of difficulties with transport ranged from nearly one per respondent per year in Liverpool to one every two years per respondent in the Greater Murray. It was a similar picture with regard to the postponement of appointments. As the Health Service Planners pointed out, when patients fail to turn up or cancel appointments at short notice it can be too late to reschedule others to fill the gaps. Staff may therefore be underutilised and waiting lists not only remain, but increase. There is also an impact on the patient's recovery because of delayed care.

3% of respondents indicated that they often had problems getting to their General Practitioners because of difficulties with transport. 7% indicated that they sometimes had difficulty. The numbers were similar for getting to medical specialists.

#### **4.4.2 Consultations with stakeholders**

Part of the research for this study involved consulting with three main groups of stakeholders, General Practitioners, Health Service Planners and Health Councils representing Health Service consumers.

All of the stakeholders indicated that some people have difficulty in getting to and from Health Facilities although none could provide any hard data about the extent of the problem. In general, most difficulties appeared to be related to the availability of private transport.

General Practitioners were of the opinion that difficulties in getting to medical appointments are related to the availability of private transport. Groups that are particularly affected include: young people with no driving licence; people who no longer drive; people who do not own a car; people in single car families where the car is used by one family member during the day; and low income earning families facing high fuel charges.

It was also suggested that in some cases getting access to health services was dependent on having friends or relatives who are willing and able to assist with transport at the times required. This is consistent with the results of the Health Facilities User Survey which showed that nearly 40% of patients relied on friends or relatives for transport to and from health facilities.

Health Service Planners also indicated that some people were having difficulty finding suitable transport to get to health facilities. Again there was no hard data to support this view. They identified that people with particular problems finding transport to get to health appointments include indigenous people, residents of low level aged care facilities and those with limited access to a car or who do not drive.

It was also suggested that because of difficulties with transport, some people in country areas ignore deteriorating health and delay making an appointment until it is absolutely necessary.

The Health Council highlighted the lack of public transport in country areas, the high cost of taxi travel, the heavy dependence on community transport and friends and family for transport to health facilities. It was suggested that some people delay making health appointments so that they do not have to ask for assistance with transport too often.

## **4.5 Unmet transport need among people with disabilities**

The most useful information on the current need for assistance with transport is to be found in the ABS Survey of Disability, Ageing and Carers (1998). The survey included information about transport used, destinations reached by various modes and the assistance with transport needed by persons with disabilities aged between 5-59 years and people over the age of 60. This section refers to people with disabilities between the ages of 5 – 59.

### **4.5.1 The need for transport assistance**

If a person needs to be driven and/or cannot transit between locations without help or supervision they would be considered as having a need for transport assistance<sup>10</sup>. According to the survey, in NSW 75% of all people with a disability did not need assistance with transport although 40,800 did have some difficulty but did not require assistance. 285,000 people with a disability did need assistance, of these 53,300 always needed assistance and 75,000 sometimes needed assistance. The need for transport assistance among people with a disability was more pronounced in females (17%) than among males (9%).

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<sup>10</sup> NSW Department of Ageing, Disability and Home Care, *Disability and the Use of Transport*, p 2, yet to be published.

102,300 people with disabilities between the age of 5-59 years had their need for transport assistance completely met, 18,500 had their needs only partly met and 7,600 had none of their needs for transport assistance met.

#### **4.5.2 Type of assistance received**

Of people with disabilities who needed assistance with transport, 6% received no assistance, 84% received informal assistance<sup>11</sup>, 3.6% received formal assistance<sup>12</sup>, and 6.6 % received assistance from both sources.

#### **4.5.3 Formal assistance**

Of people with core activity restrictions<sup>13</sup> aged over 5 and living in households, 10% used public transport for the last journey during the previous fortnight compared to 76% who used private transport, 10% who walked or used other forms of transport, 4% who did not make a journey and 1% who were housebound<sup>14</sup>. Of the journeys taken on public transport 12% were used to visit a doctor.

In total, 370,000 people with disabilities reported difficulties in using public transport including 127,000 who could not use public transport at all<sup>15</sup>.

Specific difficulties included difficulty using steps (42%), a lack of seating or uncomfortable seating (26%), problems getting onto stops or stations (25%), fear or anxiety about using public transport (12%), difficulties with crowds, toilets, space and ventilation (9%), cognitive difficulties using public transport (9%) and difficulty using doors when boarding or alighting vehicles (8%).

Taxis are also widely used by people with disabilities. 36% of users of Wheelchair Accessible Taxis made at least one journey per week and 32% of journeys were for medical purposes<sup>16</sup>. About 10,300 people with severe, permanent mobility difficulties are registered as members of the Taxi Transport Subsidy Scheme<sup>17</sup>. Scheme members made 91,440 trips in the year 2000/01 at a rate of 8.8 trips per person<sup>18</sup>.

Another form of formal transport assistance which is particularly heavily used in country areas is community transport. Community transport groups funded through Government programs provide services to transport disadvantaged people, mainly frail older people and younger people with disabilities. In the 12 months to June 2000<sup>19</sup> they provided 150,000 passenger trips to GPs or medical specialists and a further 150,000 passenger trips to hospitals or other medical services.

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<sup>11</sup> "Informal assistance" is defined by the ABS as unpaid help or supervision that is provided to persons living in households. Informal assistance may be provided by family, friends or neighbours. Any assistance received from family or friends living in the same household was considered to be informal assistance regardless of whether or not the provider was paid. It does not include providers whose care is privately organised for profit.

<sup>12</sup> "Formal assistance" is defined by the ABS as help provided to persons by organisations or individuals representing organisations (whether profit making or non-profit making, government or private); or other persons (excluding family, friends or neighbours) who provide assistance on a regular, paid basis and who were not associated with any organisation.

<sup>13</sup> Core activities are self care, mobility and communication – source, ABS.

<sup>14</sup> ABS 1998 Survey of Disability, Ageing and Carers, Summary Tables, No. 13.

<sup>15</sup> Includes all people with disabilities over the age of 5 years.

<sup>16</sup> Transport Data Centre, NSW Department of Transport (2000), *Survey of Usage of Wheelchair Accessible Taxis*.

<sup>17</sup> This scheme is administered by the NSW Department of Transport and provides a 50% discount on all taxi travel by members.

<sup>18</sup> Verbal advice from the NSW Department of Transport, Accessible Transport Branch.

<sup>19</sup> Data from the NSW Department of Transport, Accessible Transport Schemes Branch.

#### 4.5.4 Informal assistance

107,000 people with disabilities received assistance with transport from an informal source and 8,500 used both formal and informal support. 83,900 people (72%) had only one informal source of that assistance. Where informal assistance is provided by a person on an ongoing basis, that person is referred to as a “primary carer”.

The survey indicates that there are 162,000 primary carers in NSW of whom 73% are women. 21,500 primary carers are aged between 65 and 74 and 16,500 are aged 75 years or more. 51,000 primary carers stated that they spent more than 40 hours per week caring for the main recipient of care.

Of the carers who received assistance in their caring role, 32% (24,500) said that they need further assistance. Of those who do not receive assistance, 21% (18,200) said they needed assistance. In a recent survey 8.3% of carers stated in a response to an open-ended question that transport was the most helpful type of support that they could receive<sup>20</sup>. 41% of primary carers said that fall-back carers were not available to them<sup>21</sup>. Among carers over the age of 65, half have some degree of core activity restriction themselves<sup>22</sup>.

Given that a significant number of primary carers are aged over 75, have disabilities themselves and may not have the support they need, the sustainability of such forms of assistance at existing levels must be brought into question.

#### 4.5.5 Unmet need for transport to health services

It is not possible to estimate with any accuracy the current level of unmet need for travel to health facilities. There are some data, however, that can be considered.

As noted above, if a person needs to be driven and/or cannot transit between locations without help or supervision they would be considered as having a need for transport assistance.

According to the 1998 ABS data 7,600 people with disabilities in NSW under the age of 59, did not have any of their needs for transport assistance met and 18,500 had their needs for transport assistance partly met. The survey also included information on the frequency of need for transport assistance.

**Table 4.3 The frequency of need for transport assistance of people with disabilities between the ages of 5 – 59 whose need for transport is not met.**

Frequency	%	No. of persons
Less than once per week	36.7%	2789
At least once a week but not daily	51.6%	3922
At least daily	11.7%	889
Total	100.0%	7600

Source: ABS Disability, Ageing and Carers Survey (1998)

<sup>20</sup> Carers Association of Australia (1999) *National Survey of Carer Health and Wellbeing*. Table 21.

<sup>21</sup> ABS 1998 Survey of Disability, Ageing and Carers, Summary Tables, Table 26.

<sup>22</sup> Australian Institute of Health and Welfare (1999) *Older Australian at a Glance*, Canberra, Catalogue No. AGE 12.

**Table 4.4 The frequency of need for transport assistance of people with disabilities between the ages of 5 – 59 whose need for assistance with transport is partly met.**

Frequency	%	No. of persons
Less than once per week	36.7%	6789
At least once a week but not daily	51.6%	9546
At least daily	11.7%	2164
Total	100.0%	18499

Source: ABS Disability, Ageing and Carers Survey (1998)

19% of survey respondents indicated that the last trip they undertook by private vehicle was to a medical practitioner or medical specialist<sup>23</sup>.

While it is not possible to quantify the level of unmet need for transport assistance it would appear that there are a significant number of people with disabilities in the community who do not receive the assistance they require.

## 4.6 Unmet transport need among older people

In 1999 the NSW Health Department undertook a survey of older people's health needs<sup>24</sup>. The survey included a number of questions about transport including mode of transport used in the preceding four weeks and whether the respondents had problems getting to and from health services.

### 4.6.1 Mode used

There were significant differences between the sexes in the transport modes used. Men used a car as driver nearly twice as often as women (85% - 44%). Women were more likely to be a passenger in a car (78% - 49%). Women were more likely to use buses (40% - 29%), taxis (18% - 12%) and community transport (7% - 2.5%).

### 4.6.2 Transport to health services

Overall, 4.6% of the respondents indicated that they had difficulty in getting to and from health services. This would represent 37,500 older people in NSW. The percentage of respondents who indicated they had such problems varied widely between Health Areas from 1.8% in the Far West to 7% in Central Sydney. In general, people appeared to be slightly more likely to have problems in getting to and from health facilities in the city compared to regional areas. This reflects the results of our own survey of users of health facilities.

### 4.6.3 ABS 1998 Survey of Disability, Ageing and Carers

According to this survey, in NSW 182,000 people over 60 years of age needed assistance with transport. 57% of these always need assistance. Most older people (82%) who needed assistance with transport received the assistance they required but 12,900 (7%) had their needs only partly met and 18,400 people in this category (10%) did not have their needs met at all<sup>25</sup>. This totals 31,300 older people who require extra transport assistance, a figure which is similar to the 37,500 who

<sup>23</sup> ABS (1998) *Survey of Disability, Ageing and Carers*, NSW Summary Tables, Table 13

<sup>24</sup> NSW Health Department (1999) *NSW Older People's Health Survey*, Epidemiology and Surveillance Branch. 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%.

<sup>25</sup> NSW Department of Ageing, Disability and Home Care, *Disability and the Use of Transport*, yet to be published.

indicated a problem with getting to health services in the Older People's Health Survey (see above).

Even among those who were not categorised as having a disability, 25,000 had need of transport assistance and 5,500 did not receive any of the transport assistance they needed<sup>26</sup>. The frequency of need for transport assistance by older people, is slightly different from those of people with disabilities.

**Table 4.5 The frequency of need for transport assistance by people over 60 who do not have their need for assistance met.**

Frequency	%	No of persons
Less than once per week	37.3%	6863
At least once a week but not daily	51.4%	9457
At least daily	11.4%	2097
Total	100.1%	18417

Source: ABS Disability, Ageing and Carers Survey (1998)

**Table 4.6 The frequency of need for transport assistance by people over 60 whose needs for assistance are partly met.**

Frequency	%	No of persons
Less than once per week	37.3%	4811
At least once a week but not daily	51.4%	6630
At least daily	11.4%	1470
Total	100.1%	12911

Source: ABS Disability, Ageing and Carers Survey (1998)

Again it is not possible to quantify the level of unmet need for transport assistance, however, it would appear that there are a significant number of older people in the community who do not receive the assistance with transport that they require.

#### **4.6.4 Summary of unmet need for transport assistance**

According to the data in the Disability, Ageing and Carers Survey and the Older People's Health Survey, it appears that there is a level of unmet need for transport assistance among people with disabilities between the ages of 5 and 59 and people over the age of 60. It is not possible to quantify the extent of unmet need accurately. However, the number of people with disabilities and older people who have an unmet need for transport assistance is significant.

Other categories of people who may also require assistance with transport are not included in this table because of an absence of any hard data. There is anecdotal evidence that residents of low care aged care facilities have a high need to attend health facilities but suffer significant transport disadvantage.

Other groups who are experiencing difficulty include people with temporary medical conditions or who are in a course of treatment that prevents them from driving (including those returning from day surgery), people who cannot afford the transport on offer and people with no access to private transport and who live in areas with unsuitable or no public transport.

<sup>26</sup> *ibid.*

**Table 4.7 Unmet and partly met need for assistance with transport among people with disabilities and people over the age of 60.**

Category of people	Number
People with disabilities (5-59) whose needs for transport assistance not met.	7,600
People over 60 whose needs for transport assistance are not met.	18,400
Total of people with disabilities and older people whose needs for transport assistance are not met.	26,000
People with disabilities (5-59) whose needs for transport assistance partly met.	18,500
People over 60 whose needs for transport assistance are partly met.	12,900
Total of people with disabilities and older people whose needs for transport assistance are partly met.	31,400
Total people with disabilities and older people who have unmet need for transport assistance.	57,400

Source: ABS Disability, Ageing and Carers Survey (1998)

One guide may be the Health Facilities User Survey undertaken as part of this project. Respondents were asked to indicate their sources of income. The sources of income of those who indicated that they had experienced transport difficulties in getting to health facilities were as follows:

- Disability pensions, aged pension or self-funded retiree income - 86%.
- Other sources of income - 14%.

On this evidence it would appear that people with disabilities and older people represent the great majority of people who have unmet needs for assistance with transport to health facilities. Of the remainder, 75% were salary or wage earners who are likely to have a greater range of transport options available compared to people with disabilities or older people. This leaves 4% who may have an unmet need for transport assistance within the rest of the population. However, these figures are based on a very small population sample and cannot be considered reliable.

Overall, it appears from our user survey that not only did 20% of respondents to the survey indicate having had a difficulty getting to health facilities. 0.6% of patients have to cancel appointments because of a lack of suitable transport. Given that time is of the essence for about half of the non-emergency non-inpatient services shown in Table 4.1, this suggests that people have a serious unmet need for transport assistance on about 30,000 occasions a year.

As we have stressed, the concept of unmet need is quite elastic. From our review of the general data on the transport needs of people, as well as our own surveys, we judge that unmet need for transport assistance in getting to health facilities may total around 250,000 occasions of service a year. In many of these cases, transport services are provided but not to a socially adequate standard.

#### **4.7. Projected need for assistance with transport to 2006**

As discussed in the previous section, the two population groups that appear to have the most need for assistance with transport are people with disabilities and older people. The Health Facilities User Survey indicated that 86% of people who had difficulty getting to health facilities were from these two groups. Whilst it is recognised that there may be significant needs for transport assistance among other members of the community, difficulties in clearly identifying and quantifying these groups make a projection of future need more problematic.

In terms of the two core groups, people with disabilities under the age of 60 and older people, it is estimated that the need for additional transport assistance will rise by 14% for the former and 16% for the latter.

Increase in the need for transport assistance among other sectors of the population is likely to rise in line with the general increase in population, currently 1% per year. This will equate to a 5% rise to the year 2006. Increasing use of sophisticated technology at centralised sites and the general tendency of the use of services to rise in line with Gross Domestic Product is also likely to increase demand for transport services by 2.5% over the next five years.

Overall demand for health-related transport is likely to rise 16 – 20% by the year 2006.

A more detailed analysis of utilisation trends in the two key disadvantaged groups is provided in section 4.8 and 4.9.

#### **4.8 People with disabilities**

Demand for assistance with transport by people with disabilities is likely to continue to increase over the next 5 years for a number of reasons. These include a projected increase in the number of people with profound or severe activity restrictions; continuing de-institutionalisation; and the ageing of carers.

##### ***4.8.1 Increase in numbers of people with profound or severe activity restrictions***

According to the Australian Institute of Health and Welfare (AIHW), the number of people with a disability and specific restrictions (handicap) as a proportion of the general population appeared to increase between 1981 and 1998 from 2.1% to 3.4%<sup>27</sup>. Projections of the percentage change in the number of people with a profound or severe core activity restriction suggest a 12% increase in this population over the next five years<sup>28</sup>. Greatest growth is likely to occur in the 45 – 64 age group (19.3%) compared to the other age ranges.

128,400 people with disabilities in NSW are currently in need of transport assistance<sup>29</sup>. A 12% increase in this number would amount to an additional 15,400 people.

##### ***4.8.2 Deinstitutionalisation***

There has been a trend towards deinstitutionalisation among people with a disability in Australia for the past twenty years. The percentage of people with disabilities in Australia with a profound or severe core activity restriction living in cared

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<sup>27</sup> AIHW (1999) *Australia's Welfare: Services and Assistance*, AIHW, Canberra, Table 7.5

<sup>28</sup> AIHW (2000) *Disability and Ageing: Australian Population Patterns and Implications*, Table 17.1

<sup>29</sup> DADHC (2001) *Disability and the use of transport*, Table "Need for Transport Assistance", p5.

accommodation fell from 9.9% to 2.6% between 1981 and 1998<sup>30</sup>. Australia wide, the number of people with a profound or severe core activity restriction aged under 65 and living in the community (i.e. in households) rose from 302,432 in 1988 to 596,094 in 1998<sup>31</sup>. This represents an increase of 97% over 10 years. The increase was most marked in the past five years (60%).

In NSW there are currently 308,500 people with profound or severe core activity restrictions, over the age of 5, living in private dwellings. According to the AIHW there will increase in number by 9.9% between 1997 and 2003<sup>32</sup>. This is likely to lead to increased dependence on family, friends and other informal sources of support.

#### **4.8.3 Ageing of carers of people with disabilities**

There is a very heavy dependence on informal support for transport assistance among people with disabilities. In NSW, 107,600 people with disabilities between the ages of 5 – 59 receive their only support from this source<sup>33</sup>. It is worth noting that the number of people receiving support from this source increased by 47% between 1993 and 1998 on an Australia wide basis.

While the increase in the general population of people aged between 45 – 64 may suggest that a larger pool of carers may become available, changes in family structure, living arrangements and other social and economic factors may decrease the number of family carers and the commitment of families to providing care<sup>34</sup>. Carers take on their role for a variety of reasons. In a recent survey 28% said that no other friends or family were available, 17% said that no other friends and family were willing, 23% said that they had no choice and 26% that alternative care was not available (some carers reported more than one reason)<sup>35</sup>. This suggests that for some, the caring role may not be one of choice but rather one of necessity.

Many of these carers are older people. In 1998 in NSW 21,500 primary carers of people with disabilities were aged between 65 –74. A further 16,500 were over 75.

Most carers in these age ranges are women – 76% among the over 65s. This is the age when many women cease to drive. Between the ages of 30 – 59, 89% of women hold driving licences, this percentage drops to 61% for those between the ages of 60 – 79 and to only 16% for those 80 and over. Their ability to provide transport assistance for those they care for is correspondingly reduced<sup>36</sup>.

A significant number of primary carers have disabilities themselves. Of primary carers in 1998 in Australia, 39% had a disability and of them 23% (9% of all primary carers) had severe or profound core activity restrictions<sup>37</sup>.

The availability of a sufficient number of carers to cope with the increasing volume of people with disabilities and older people who need assistance with transport appears unlikely to continue.

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<sup>30</sup> AIHW (2000) *Disability and Ageing: Australian Population Patterns and Implications*, p 183.

<sup>31</sup> AIHW (1999) *Australia's Welfare: Services and Assistance*, AIHW, Canberra Table 6.4.

<sup>32</sup> *ibid.* p 252.

<sup>33</sup> DADHC (2001) *Disability and the use of transport*, Table "Type of Transport Assistance Received" p 6.

<sup>34</sup> Schofield H & Block S (1998) *Disability and chronic illness: the role of the family carer*, *Medical Journal of Australia*, 169: 405-406.

<sup>35</sup> ABS Disability, Ageing and Carers Survey (1998) *Summary Tables NSW*, Table 25.

<sup>36</sup> ABS, *Basic Community Profile* and RTA, *Driver and Vehicle Statistics for NSW, 2000*

<sup>37</sup> AIHW (2000) *Disability and Ageing: Australian Population Patterns and Implications*, Table 16.3.

#### **4.8.4 Estimate of need for transport assistance by people with disabilities**

Three factors have been taken into account in arriving at an estimate of need for transport assistance by people with disabilities aged between 5 – 59.

1. Growth in the number of people in this population group.
2. Continuing restrictions on the number of places available in institutional care.
3. The ageing of carers.

As indicated above the likely growth in this population group is about 12% to the year 2006.

Given present Government policies on deinstitutionalisation it appears unlikely that a greater proportion of people than at present are going to enter residential care and reduce the level of need for transport assistance.

The ageing of carers has been flagged as a potential difficulty by the Australian Institute of Health and Welfare. The Institute note that 107,000 people with disabilities under the age of 60 depend entirely on carers for support. Of these carers 36% are over 65 and 39% have a disability themselves. A quarter of the latter group had core activity restrictions and represent the class of carers that are least likely to be able to sustain the caring role. They make up 9% of carers that provide transport assistance where no other assistance is available and 8% of carers who provide transport assistance overall.

If it is assumed that the supply of this group of carers is likely to reduce by 5% per year this would mean an overall reduction in carers of 0.4% per year. Over 5 years this would amount to a shortfall of 2% in informal carers which would need to be replaced by formal support.

Taking the growth in the population of people with a disability under the age of 60 (12%) and the shortfall in the future supply of carers (2%) the need for formal transport assistance will grow by 14% over the next 5 years.

### **4.9 Older people**

The number of older people requiring assistance with transport is also likely to increase over the next 5 years. The main reasons for this are the significant projected increase in the older population; very high rates of increase in the number of over 75s who are expected to require the greatest level of assistance; the move to care in the community for frail older people instead of residential care; and the likely decrease in the level of available family support.

The projected rate of increase in the population of over 60s in the 10 years between 1997 and 2007 is 23%. For the five years 2001-2006 it is estimated that the projected increase in this population group will be 12%. This should be increased by a further 4% for the reasons given below, indicating a total rise of 16%.

#### **4.9.1 Ageing and activity restriction**

From the data on the table below it appears that there is a correlation between age and the prevalence of core activity restrictions. Profound and severe activity restrictions describe people who are unable to perform a core activity or who need assistance to do so (profound) or sometimes need assistance (severe). Core activities encompass mobility, which includes using public transport.

**Table 4.8 Prevalence of profound or severe core activity restriction by sex and age group – percent of people aged 65 years and over.**

Males					Females				
65-69	70-74	75-79	80-84	85+	65-69	70-74	75-79	80-84	85+
7.8	11.8	19.0	24.2	56.0	9.2	15.1	24.9	35.5	68.8

Source: AIHW (1999) Australia's Welfare: Services and Assistance, Table 6.3

Activity restriction among this population appears to remain relatively low until the age of 75. At the age of 85 over half of this population will have activity restrictions.

#### **4.9.2 Increase in numbers of older people living in the community**

Over the next 5 years the number of people over the age of 75 will increase significantly all across the state, particularly in coastal areas. The table below shows the increase in four separate areas of the state.

1. Urban areas including Sydney, Wollongong and Newcastle;
2. Semi-urban areas including the Blue Mountains, Camden, Gosford, Wyong, Hawkesbury, Lake Macquarie, and Queanbeyan;
3. Coastal areas not included above; and
4. Rural areas not on the coast.

**Table 4.9 Increase in number of people aged 75 or over by NSW regions 1997-2007.**

	Urban	Semi-urban	Coastal	Rural
<b>1997</b>	190,324	39,585	44,536	60,818
<b>2007</b>	239,022	55,349	66,969	76,063
<b>Increase</b>	48,698	15,764	22,433	15,245
<b>% increase</b>	26%	40%	50%	25%

Source: ABS Unpublished data.

The highest rates of increase are in coastal communities and in the semi-urban areas on the fringes of the cities.

Percentage increases in the 85+ age group, among whom over 50% will have activity restrictions, are even more significant.

Part of the increase in coastal and semi-urban areas is likely to be fuelled by internal immigration from the cities and rural areas. Many of these people are unlikely to have retained the family support that they are likely to require given the heavy dependence of this age group on informal support. Between 2001 and 2006, the increase in this age group across NSW is likely to be 25%.

There has been debate about whether an increase in the older population will mean that there will be a related increase in the number of people requiring assistance with transport. On the one hand is the argument that while people are living longer, improvements in health care mean that morbidity<sup>38</sup> tends to increase only late in life. In other words people are older but healthier than they would have been at the same age years ago. An alternative argument is that increased longevity has resulted in

<sup>38</sup> Morbidity is the level and type of sickness within a population.

more people surviving with chronic health conditions thus increasing the prevalence of disability<sup>39</sup>.

**Table 4.10 Increase in number of people aged 85 or over in selected NSW regions 1997-2007.**

	Urban	Semi-urban	Coastal	Rural	All areas
<b>1997</b>	43,423	7,929	8,349	14,354	76,052
<b>2007</b>	62,987	13,691	15,350	18,919	112,954
<b>Increase</b>	19,564	5,762	7,001	4,565	36,892
<b>% increase</b>	45%	73%	84%	32%	49%

Source: ABS unpublished data.

In Australia it has been suggested that increased longevity has been accompanied by an increase in the years lived with a mild or moderate disability<sup>40</sup>. An AIHW study has also shown that the age-standardised rates of severe and profound core activity restrictions for people aged 65 and over do not seem to be declining<sup>41</sup>.

It would appear, therefore, that the increase in the number of older people will also increase the need for assistance with transport.

In previous years it might have been expected that most older people with profound or severe core activity restrictions would be cared in hostels or nursing homes. However, the supply of residential care places is dropping as a ratio of the population of over 65s with profound or severe core activity restrictions<sup>42</sup>. Government support for this sector of the population is, in part, being replaced by programs such as Home and Community Care and Commonwealth Aged Care Packages, designed to assist people at risk of institutionalisation to stay in their own homes.

#### **4.9.3 Informal support for older people who require assistance**

Despite the growth in formal support programs for older people, there is still a high dependence on informal support by frail and disabled older people. Of those older people who received assistance with transport in NSW in 1998, 93% received assistance from informal sources. 15,500 received assistance from a female spouse, 23,000 received assistance from a male spouse and 106,300 received assistance from other relatives or friends<sup>43</sup>.

Many older people who received informal support did so from other older people. Australia wide, 78% of carers of older people were co-resident with the person being cared for; 26% were over the age of 65 and 10% over 75<sup>44</sup>.

<sup>39</sup> AIHW (2000) *Disability and Ageing: Australian Population Patterns and Implications*, p 12.

<sup>40</sup> Mathers C (1995) *Expectations of disability and handicap in Australia* Paper presented to the 3<sup>rd</sup> National Rehabilitation Conference, Canberra May 1995 – quoted in AIHW (2000) *Disability and Ageing: Australian Population Patterns and Implications*.

<sup>41</sup> AIHW (1999) *Australia's Welfare: Services and Assistance*, p168.

<sup>42</sup> Ibid. p 191.

<sup>43</sup> ABS *Disability, Ageing and Carers Survey, Summary Tables NSW 1998*, Table 19.

<sup>44</sup> AIHW (1999) *Australia's Welfare: Services and Assistance*, Canberra, Table 6.7.

#### **4.9.4 Estimate of need for transport assistance by older people**

Three factors have been taken into account in arriving at an estimate of need for transport assistance by older people.

1. Growth in the number of people in this population group particularly among the “old old” (those over 85).
2. Continuing restrictions on the number of places available in high needs residential care.
3. The ageing of carers.

As indicated above, the likely growth in this population group is about 12% to the year 2006. The growth in the number of people over the age of 85 is about double that figure at 25%.

It appears unlikely that a greater proportion of people than at present are going to enter high needs residential care and reduce the level of need for transport assistance as the supply of beds is not keeping pace with the number of older people with core activity restrictions.

The ageing of carers has been flagged as a potential difficulty by the Australian Institute of Health and Welfare. According to the ABS, 144,800 older people in NSW depend on carers for support. 78% of these were co-resident and 10% of co-resident carers are over 75 years old. This equates to 8% of all carers who provide assistance with transport.

Given the large increases forecast in the number of “old old” (25%) among whom the prevalence of core activity restriction is much higher than the rest of the population (over 50%), it can be presumed that overall, the caring task will become more demanding and fewer carers will be able to cope. If the assumption is made that the supply of co-resident carers over 75 years old is likely to reduce by 10% per year this would mean an overall reduction in carer numbers of 0.8% per year. Over 5 years this would amount to a shortfall of 4% in informal carers which would need to be replaced by formal support.

Taking the growth in the population of older people (12%) and the shortfall in the future supply of carers (4%) the need for formal transport assistance will grow by 16% over the next 5 years.

#### **4.10 Overall growth**

Most of the need for assistance with transport to health facilities appears to be among people with disabilities and older people.

There will be continuing growth in the need for assistance with transport in this sector of the population, particularly among those over the age of 85. This growth relates to increasing numbers in these population groups, fewer institutional places being available and a decrease in the level of informal support that will be available in the future.

The growth in need is likely to be 14% for people with disabilities and 16% for older people over the next five years.

It is impractical to construct an accurate estimate for the growth in need among other sectors of the population. However, there are a number of factors at play including:

- technological advances in health care which are likely to increase in incidence of day surgery;
- the tendency of the delivery of services to increase with the steady rise in Gross Domestic Product;

- the high cost of many of these technologies which will mean that these services are unlikely to be delivered at a local level and the need for patients to travel to regional centres and the bigger city hospitals for treatment is likely to increase; and
- population growth estimates for NSW of approximately 1% per year.

On this basis there would be an overall increase in the demand for formal transport services from the general population of about 0.5% per year or about 2.5% over the next five years.

#### **4.11 Summary**

In summary, we estimate that approximately 620,000 publicly funded transport trips are provided to transport disadvantaged persons per year. This is equivalent to about 3% of all non-emergency trips to health care facilities in NSW. Of these trips, about 40% are provided by community transport groups, 30% by Area Health Services and 30% by the Ambulance Service.

It should be noted that unmet need is an elastic concept. Some people may not receive the service they need, others may receive an inappropriate service or a service of unacceptable quality. This report estimates, conservatively, that there is a high unmet need for at least 30,000 trips per year when transport is not available at all. Significant unmet needs may exist in one form or another for a total of 250,000 trips per year.

Overall, taking into account the expected growth in the number of persons with disabilities and older people, the declining availability of carers, the increasing provision of outpatient services and day surgery, and the rise in the overall provision of health services, the need for transport services for transport disadvantaged people is likely to increase by 16 – 20% over the next five years to 2006.

## Section 5. Transport Supply

### 5.1 Overview

There are three distinct forms of non-emergency transport: home to health facility; health facility to home and between health facilities.

In addition, patients that travel to and from health facilities are divided between those who travel regularly for treatment and those who travel is occasional or irregular. Patients also have different care needs while in transit. This affects the type of transport they require.

The supply of passenger transport services is governed by Government regulation. Transport operators that wish to collect a fare or other consideration are required to seek accreditation under the Passenger Transport Act. Only a limited range of accreditation types are available at this time. Ambulance services are currently legislatively restricted to the present suppliers under the provisions of the Ambulance Services Act. The NSW Health Department has reviewed the inclusion of commercial transport providers in the ambulance service network and it was not supported as a viable option at the time of review.

### 5.2 Types of transport

#### 5.2.1 Transport to facilities

- According to our survey of users of health facilities<sup>45</sup> it appears that most people travel to public health facilities by private arrangements. These include using a private car as driver or passenger (76%), walking (4%) and cycling (less than 1%).
- Some people may use public transport, mainly bus and rail services (8%) and taxis (3%).
- A significant number of patients are brought into health facilities by community transport operators and other non-Government organisations (6%).
- Area Health Services concentrate on bringing patients in from home to day care centres, to services such as dialysis or cancer therapy and to rehabilitation services. Overall the user survey showed that the use of Area Health patient transport services was low at 1%. It varied between regions with highest use in the Greater Murray.
- There are some non-emergency Ambulance Services from home to facilities. The user survey showed low usage of Ambulance services to get to health facilities in the five target areas (1%) with the highest usage being in the Greater Murray.
- Aboriginal Medical Services staff also provide a very significant amount of transport to health facilities for aboriginal people.

The transport supply survey undertaken as part of this study<sup>46</sup> showed that nearly 30% of all trips to health facilities provided by Area Health Services and community transport groups were to day and respite care facilities. 16% were to oncology or renal units and 11% to other therapy.

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<sup>45</sup> The figures on transport usage in this section of the report are from a survey of users of health services undertaken as part of this study unless indicated otherwise. More detailed analysis of this survey is to be found at Attachment B.

<sup>46</sup> More details of the survey results can be found in Attachment C. The survey did not include the transport provided by the Ambulance Service.

**Table 5.1 Purpose of trips provided by AHSs and community transport (percentages and numbers)**

Purpose of Trip	Percentage	Number
Day/respice care	28.6%	2590
Oncology/renal	16.1%	1458
Other therapy	10.9%	987
Rehabilitation	9.7%	878
Outpatient clinic	9.7%	878
Specialist	9.0%	815
Hospital discharge	6.5%	589
Pre-admission	5.1%	462
Radiography	2.9%	263
Hospital admission	1.4%	127
Dentist	0.1%	9
Total	100.0%	9056

Source: Consultants' Supply Survey.

Other significant destinations were rehabilitation and outpatients (each 10%), medical specialists (9%), hospital discharges (7%) and pre-admission clinics (5%).

**Table 5.2 Purpose of trips provided by AHSs and community transport (percentages)**

AHS	Purpose	CT
93%	Hospital discharge	7%
88%	Oncology/renal	12%
81%	Pre-admission	19%
77%	Rehabilitation	23%
64%	Radiography	36%
59%	Outpatient clinic	41%
55%	Day/respice care	45%
33%	Hospital admission	67%
13%	Specialist	87%
9%	Other therapy	91%
0%	Dentist	100%

Source: Consultants' Supply Survey.

Area Health Services were most heavily involved in oncology and renal transport, pre-admission appointments and rehabilitation.

Community transport mostly serviced other therapy, medical specialists and hospital admissions. Transport to day and respice care was split with Area Health Services carrying 55% and community transport 45%.

The same survey showed that community transport provided more transport to health facilities than Area Health Services (59% - 41%) but not to the same extent as indicated in the health facility user survey. Given the low number of respondents to the questions in the latter survey the 59%-41% split appears to be the more robust figure.

The important point is that community transport groups play a major role in taking people to health facilities. According to the transport supply survey the proportion of trips provided by community transport groups compared to Area Health Services was higher in country areas (96%) than in city areas (41%).

Overall it appears that about 5-10% of visitors to health facilities cannot get to health facilities independently and require assistance from the Ambulance Service, Area Health Services or community transport groups.

### **5.2.2 Transport from facilities**

- As with transport to health facilities most patients travelling home from health facilities make private arrangements: 53% drove themselves, 47% travelled as passengers and 3% walked.
- 12% use public transport with 8% using buses or trains and 4% making use of taxis.
- Community Transport operators conveyed 5% of respondents home.
- Area Health Services provide transport services to home to 1% of the sample.
- Less than 1% of respondents travelled by Ambulance.
- Aboriginal Medical Service staff also provide an important transport service to home in some areas of the State.

As with travel to health facilities, our survey of Area Health Service and community transport suppliers also found that community transport provided more transport from health facilities to home than Area Health Services (56% - 44%) but not to the same extent as indicated in the health facility user survey. Again the transport supply survey figures may be more robust.

Community transport groups appear to provide a significant proportion of these trips, particularly in country areas. According to the transport supply survey, compared to Area Health Services, community transport groups provided more trips home from health facilities in country areas (92%) compared to the city (40%). However, 93% of hospital discharges were transported by Area Health Services transport compared to 7% by community transport.

### **5.2.3 Transport between facilities**

There are only two significant suppliers in this market:

- The Ambulance Service who carry patients on contract to Area Health Services, in particular patients with medium to high care needs. Services are also provided out of hours when other transport is not available.
- Area Health Services who provide Patient Transport Services on both a formal and informal basis. Services concentrate on patients with medium care needs and those who require stretcher transport but no active monitoring in transit.

Community transport groups are rarely involved in this type of transport.

## **5.3. Suppliers of Health-Related Transport Services**

Transport is provided by a combination of private means, public transport or publicly funded or subsidised transport services. Most people make private arrangements to get to health facilities. Other options include public transport, community transport, Ambulance Services, patient transport provided by Area Health Services and Aboriginal Medical Services.

### **5.3.1 Private arrangements**

Most private transport involves the use of private cars either driven by the patient themselves or driven by a friend, neighbour or member of the family. A few people also walk or cycle to health facilities. The private car is the most flexible and convenient type of transport for most people. The supply survey identified that most people (75%) travel to and from health facilities in this way with 53% driving themselves and 47% being passengers. Among people with disabilities and some older people there is a heavy dependence on relatives and friends for assistance with transport, rather than public or community transport, Area Health Services or the Ambulance Service.

### **5.3.2 Ambulance Services**

Non-emergency transport represents 25-30% of the work of the Ambulance Service. Over 4,500 trips per week are provided across NSW on a non-emergency, non-urgent basis. Most of this transport is provided on contract to Area Health Services or on behalf of Health Funds. The Ambulance Service also carries a range of patients free of charge, including Health Care Card holders. Transport is generally approved by a health fund, doctor or other health professional.

Services are provided using ambulances or routine transport vehicles. All field staff are trained either as Ambulance Officers or Patient Transport Officers.

Scheduling for urban services takes place across four areas. At the moment emergency and routine services are scheduled from the same system. Eventually there will be a separate system for non-emergency work. Most of this work is booked ahead of time so routes will be able to be designed the day before. At the moment there is no coordination between Area Health Service regions.

There are six Patient Transport Services in rural areas and no comprehensive coverage of the state. It has been described as a "patchwork".

The traditional market for non-emergency transport that has been served by the Ambulance Service has been reduced in recent times by the development of in-house Patient Transport services by Area Health Services.

Two factors will impact on the future role of the Ambulance Service in this market in the short term:

1. the proposed reduction in the price of non-emergency transport services by the Ambulance Service; and
2. the enhancement of "routine" or Patient Transport Services which may improve the current poor response times for non-emergency services.

#### Revised pricing structure

The Ambulance Service is currently considering a reduction in the price of non-emergency transport services charged to Area Health Services to a commercially competitive level. The changes in the pricing structure would mean a net transfer of resources from urban to country areas. This will come about due to the long distances currently travelled in providing non-emergency services in the country and the current volume of emergency transport provided in urban areas.

The change is designed to encourage Area Health Services to return to the Ambulance Service for non-emergency transport and to expand the Ambulance Service's share of this market.

### Expansion of Patient Transport Services (ie non-emergency transport)

The current Patient Transport supply in Sydney consists of 24 vehicles and 52 Patient Transport Officers. This will increase to 39 vehicles and 80 Patient Transport Officers by October.

The expansion of this system by the Ambulance Service will make it more attractive to Area Health Services as this initiative will assist the Service to address two major quality shortfalls in the existing arrangements – long waiting times for patients and an inability by Ambulance Service to provide accurate arrival times for non-emergency transport services.

It should be noted that the Patient Transport Service expansion will only take place in urban areas. Problems that relate to the inability of rural stations with low staff numbers being able to provide long distance transport and retain local emergency cover will require other, more radical structural changes.

### **5.3.3 Area Health Patient Transport Services**

These services take a number of different forms including:

- formal services provided using a fleet of modified vehicles and coordinated through a central booking office;
- minibus services designed to bring people in regularly to a treatment or day care centre; and
- informal use of pool cars to transport patients on an ad hoc basis.

The availability of Area Health Patient Transport varies a great deal from area to area as does the volume and nature of the services provided. The services are funded from internal Area Health Service budgets – often from more than one. The budgets may be held at Ward, Sector or Area level.

There has been recent growth in the volume of Area Health Service in-house patient transport services. This has mainly been a response to the high cost of purchasing non-emergency transport from the Ambulance Service and the indifferent quality of those services in terms of waiting times and being able to confirm arrival times. The cost, quality and utilisation rates of patient transport services would appear to be variable across the State. There is no consistency as to who operates the services both in terms of coordination and driving duties. Some services use computerised booking systems, others have only basic manual systems or informal ways of organising transport. A wide variety of staff drive patient transport vehicles including ground staff, ward orderlies, general administration assistants, enrolled nurses and drivers/general assistants. There is no standard for training or skill levels and these vary between services.

### **5.3.4 Community transport operators**

There are 130 Community Transport groups around the state, funded and accredited by the Department of Transport. Most of these groups provide transport to public health facilities which represented about 10% of their activity last year. Groups are funded through a variety of sources including:

- the Home and Community Care Program (for frail elderly and younger people with disabilities);
- the Community Transport Program (aimed at people who are transport disadvantaged);
- the Area Assistance Scheme (aimed at developing transport services in selected areas of the state);

- the Health-Related Transport Program (aimed at enabling more people to access the services they need to maintain their health);
- support from Local Government (varies from area to area); and
- income from the farebox and donations.

Access to services is determined by each individual group according to eligibility guidelines set down in funding agreements and operator accreditation conditions. In addition, there are a number of other small community based providers including Neighbour Aid groups funded through the Home and Community Care Program and others that operate on a largely unfunded volunteer basis. Services are provided by using a combination of paid and volunteer drivers, project owned and volunteer owned vehicles and coordination staff. Some training is provided, mainly to paid driving staff.

Community transport operators are the primary source of irregular patient transport and a significant provider of regular patient transport. They are well placed in the irregular patient transport market because of their existing work in and links with, local communities.

According to the transport supply survey undertaken as part of this study, travel to health facilities by community transport varied markedly across the five target areas with 24% of trips in the Hunter being provided in this way, 5% in the Greater Murray, 4% in St George, 2% on the Mid North Coast and less than 1% in Liverpool.

Many community transport services have advantages both in terms of their cost structures, due to the heavy use of non-paid labour and market position (many of their health-related transport passengers are already clients of their services).

It should be noted that the function of community transport goes beyond that of just being a supplier of transport. At the moment they have a passenger assessment function and act as gatekeepers for a variety of funding programs including the Health-Related Transport Program. The existence of this function raises their administrative costs and makes cost comparison with other suppliers problematical.

If and when additional operators enter the market, the role of community transport could develop into that of budget holder/purchaser or transport broker rather than just supplier. However, this is unlikely to happen in the short term.

The supply of community transport services is constrained by limitations on resources. In areas where the Department of Veterans Affairs has been willing to purchase transport from community transport operators, most groups have been able to increase their levels of service. Often this is achieved by the use of project owned vehicles and volunteer drivers. Presumably community transport groups would be able to increase the supply of transport to health facilities to some extent if additional funding were to be made available.

An important issue for community transport at the moment is the recruitment and retention of volunteer drivers and the availability of affordable and appropriate training resources.

It would appear that the supply of volunteers is patchy across the state. In some coastal areas there appears to be a satisfactory supply compared to some county towns where, typically, a small core of volunteers are shared by a variety of services and are becoming overstretched. In the inner city few, if any, volunteers are available and services use paid staff.

The lack of training among some community transport drivers has also been questioned in relation to the transport of passengers with significant care needs.

### **5.3.5 Public transport**

Public transport includes fixed transport in the form of route bus service, train travel or demand responsive transport represented by taxis or hire cars. The use of public transport varies according to the available supply. The health facilities user survey results showed the highest use of public transport in Liverpool and St George (20% of respondents), 13% of respondents in the Hunter, 4.5% on the Mid North Coast and 2% in Greater Murray.

#### Buses and trains

Bus and rail services provide most public transport trips. Criticisms of this form of transport include vehicle access problems of people with mobility limitations, its infrequency and poor connections in some areas, and the fact that they run on inflexible line haul routes that do not carry passengers directly from home to health facilities. Bus and rail services have in the past poorly catered for those with mobility difficulties, people who are frail or who have certain types of cognitive difficulties. Some improvements have been made to cater for people who are frail and those people with disabilities (eg. instillation of lifts on key stations, provision of disabled parking at major railway stations). Further improvements to the system are possible, particularly in relation to encouraging or requiring bus operators to run services to, or past, major health facilities. However, in terms of addressing the needs of the core market of people who have difficulty in accessing health facilities public transport has a limited role to play. It must also be recognised that in many rural areas public transport is skeletal, consisting only of school bus services that only operate one return journey per weekday and which are only available during term time. Some communities have no public transport at all.

It is worth noting the initiative taken by one western Sydney bus company which has developed a Flexiride Service<sup>47</sup>. This service, which is available to the general public, runs every weekday morning and afternoon in the Merrylands, Greystaines, Westmead, Parramatta area and uses a short wheelbase, low floor accessible bus. Passengers book ahead and the service picks them up at their own homes and takes them to a choice of four destinations, one of which is Westmead Hospital. Later in the day the bus returns and takes them home. The service is used in the main by older people, many of whom are frail and have mobility difficulties. A similar service has been in operation for the past 20 years in the outer suburbs of Melbourne<sup>48</sup>. Such services could represent another significant transport option for health-related transport. They operate without subsidy but could presumably extend their times and frequencies if provided with appropriate incentives.

#### Taxis

The taxi industry is widely used for short haul, short notice and out-of-hours health-related transport, particularly for hospital discharges, but also by the general public to get to health facilities. People with disabilities are heavy users of taxi services and a recent survey of Wheelchair Accessible Taxis showed that 32% of the trips they provide is to medical facilities<sup>49</sup>. In some circumstances taxis are used for long distance services but this is not common as this is a very expensive option (although cheaper than Ambulance services). Given that people who have difficulties in getting to health facilities tend to have low incomes (our research shows that most are pensioners), the main drawback to the use of taxis is their costs. This is due to the

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<sup>47</sup> This service was developed by Baxter's Bus service as a Transport Demonstration Project of the NSW Ageing and Disability Department.

<sup>48</sup> The Invicta Bus Service in Lilydale, Victoria.

<sup>49</sup> NSW Department of Transport (2000) *Survey of Usage of Wheelchair Accessible Taxis: Summary of Results*, Transport Data Centre, Report 2000/3.

fact that they are in the main, hired on an exclusive ride basis. There is scope for the development of multi-ride taxi services but few taxi companies have pursued this option although there is increasing scope for this type of travel as larger capacity taxi vehicles become available. Such services could be chartered by community transport operators or Area Health Services, given the identification of stable patterns of demand.

Another drawback for some people with mobility limitations or who have significant care needs is the fact that taxis generally only offer a kerb to kerb service. These groups generally do not make significant use of taxis unless accompanied by a carer.

### Hire Cars

Hire cars have the potential to provide a greater volume of health-related transport than is currently the case. Quality, in terms of passenger care, tends to be higher than is generally provided by taxi drivers because of the preponderance of owner drivers in the industry. The NSW Independent Pricing and Regulatory Tribunal recently commented in an interim report that the constraint on the supply of licences in this industry has stifled innovation and the development of new markets<sup>50</sup>.

Scope for negotiation on fees for taxis and hire cars requires further exploration.

### **5.3.6 Aboriginal Medical Services**

For many Aboriginal and Torres Strait Island communities health-related transport is mainly provided by Aboriginal Medical Services (AMS). Transport is often provided using health workers using AMS vehicles. Not all of these services are funded to provide transport although many do because suitable transport represents a major barrier to the attendance of some Aboriginal people at health services. In our consultations the provision of transport by some local AMSs was described as “crisis management”, given the high need for transport to health facilities and the absence of specific transport funding. The constant diversion of Health Workers from their core functions to act as drivers was also cited as being a major problem. Some Aboriginal Medical Services do receive funding for transport through the Health-Related Transport Program and through Area Health Services but this is not consistent throughout the State.

### **5.3.7 Air services**

A small amount of non-emergency transport is provided by the Ambulance Service's Air Ambulance. Patients on these services are triaged by trained Flight Nurses to ensure their suitability for this type of travel. Private air charter services are also sometimes used by Area Health Services. Some charter services may provide trained escorts (sometimes nursing staff). Patients are also sometimes transported on commercial flights.

This is an expensive form of transport and is used on a non-emergency basis mainly for interfacility transfers and to repatriate patients to home or to hospitals closer to where they live.

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<sup>50</sup> Independent Pricing and Regulatory Tribunal of NSW (1999) *Summary of Review of the Taxi Cab and Hire Car Industries: Interim Report*, Sydney, August 1999.

## **5.4 Summary of transport provision**

The bulk of transport to and from health facilities is undertaken in private vehicles with a heavy dependence by many people with disabilities and some older people on friends and family for assistance.

About 5 -10% of people depend on Area Health Services, community transport, Aboriginal Medical Services and the Ambulance Service for transport to and from health facilities.

## **5.5 The costs of transport supply**

### **5.5.1 Introduction**

Cost data are an essential input to an analysis of management efficiency and economic evaluation. Ideally, data would be available for both the short-run marginal cost and the average cost of each kind of passenger trip. Data on the short-run marginal cost of alternative modes are important to ensure efficient use of resources at any point in time. Average cost is a guide to where to expand or contract a service in the long run.

However the major providers of transport services to public health facilities have limited data on their real marginal and average transport costs. Community transport groups provide many kinds of vehicle and passenger trips. They have data on the marginal costs of providing some trips but not of others, for example trips involving the use of their own vehicles and some administration. They do not have data on the total cost of community transport services to health facilities or on the average cost per vehicle or per passenger.

Various agencies within Area Health Services, and often within facilities such as hospitals, employ many different personnel and vehicles, often in-house vehicles. Generally neither the organising agency nor the Area Health Service has data on marginal, total or average costs of passenger trips provided.

The prices charged by taxis and ambulances are of course known. However, taxi prices are well above the marginal costs of taxi trips, at least at certain times. They are also above the average real cost of taxi transport because the price has to cover the artificial cost of a license, which is created by regulation and is not a resource cost.

Ambulance charges are related to the average cost of the ambulance system, which is designed for over capacity in order to meet emergencies. They do not reflect the marginal cost of transport by ambulance.

In order to remedy some of these data gaps, Transport Planning and Management organised a transport costing survey and analysed the costs incurred by community transport groups operating with funds from the Health-Related Transport Program (HRTTP). Other results were received from the New England Area Health Service. The survey and the analysis of the HRTTP are reported below along with an interpretation of the results.

### **5.5.2 The Transport Cost Survey**

The transport cost questionnaire is shown in Attachment I. The questionnaire sought to obtain data on the total cost of running a vehicle over a given period, the kilometres run, and the average passenger load per trip (excluding carers and escorts). The cost comprised fuel, repair and maintenance, modification costs, insurance and registration, depreciation or lease costs, and other costs. Respondents were also asked to estimate relevant administration overheads. The costs do not include interest payments or imputed costs.

The transport costing questionnaire was sent to 4 community transport groups and 5 AHSs. Responses were received from three community transport groups and three AHSs. Because the response was limited, the answers must be treated cautiously.

Table 5.1 summarises the results for the three community transport groups that responded. Table 5.2 shows the results for the three AHS that responded. In each case the final column shows the average cost of the three respondents, with each one weighted equally. Note that for the community transport groups, the average cost is based on a community transport-owned or leased vehicle, a paid driver and some administration overheads. Administration costs may include some patient assessment time.

As shown in Table 5.3, the average community transport cost is \$1.50 per vehicle km and \$0.75 per passenger km, because an average occupancy rate of two is claimed. The vehicle cost per km comprises \$0.71 for labour costs, \$0.29 for vehicle costs and \$0.30 for administration costs.

As shown in Table 5.4 the average AHS cost is \$1.92 per vehicle km and \$1.89 per passenger km, with an average occupancy rate only marginally over one. The vehicle cost per km comprises \$0.83 for labour costs (excluding penalty rates at weekends), \$0.87 for vehicle costs and \$0.21 for administration costs. The reported vehicle costs are high because they include some high capital costs. These may overstate the true depreciation. On the other hand, the labour costs involved in transportation may be understated.

In 1999/2000, the New England AHS spent \$222,000 on transport costs covering 90,000 km with two vehicles (a car and a van). Thus the average cost was \$2.47 per vehicle km. Passenger km are not known. Labour transport costs totalled \$150,000 or \$1.67 per vehicle km. Vehicle costs were \$0.41 per vehicle km. Administration (a clerk) and telephone costs were \$0.39 per vehicle km. Given the comprehensive nature of these figures, they may be a better indication of costs than the average of the survey results for the other AHSs.

### **5.5.3 Analysis of Health-Related Transport Program**

Table 5.5 shows data collected and analysed for ten community transport groups funded from the Health-Related Transport Program, including three metropolitan community transport groups and seven non-metropolitan community transport groups.

The cost per vehicle km is in fact funding per vehicle km. If the funds were not fully spent, the cost is overestimated. On the other hand, if the funds were overspent, the true cost would be underestimated. The data are therefore included principally for illustrative purposes. We do not draw on them in the analysis below.

**Table 5.3 Survey of Transport Costs of Community Transport Groups**

Source: Consultants' Estimates based on Costing Survey.

Agency	Semi-urban				Urban				Rural		Average CTG	
Vehicle make	Toyota Coromuter		Toyota Carry Swagon		Toyota Carry wagon				4x Ford Au Falcons			
Ownership period of vehicle	5 years		6 years									
Period for cost calculations	1 year		1 year		50 weeks		50 weeks		6 months			
Kilometres/year	38,911		37,597		35,000		30,000		40,000		42,302	
	Cost/Period	Cost/Km	Cost/Period	Cost/Km	Cost/Period	Cost/Km	Cost/Period	Cost/Km	Cost/Period	Cost/Km	Cost/Period	Cost/Km
Fuel cost	\$4,269	\$0.11	\$3,234	\$0.09	\$4,301	\$0.13	\$2,693	\$0.13	\$3,066	\$0.08	\$4,126	\$0.10
Repairs & maintenance	\$1,522	\$0.04	\$1,872	\$0.05	\$718	\$0.02	\$672	\$0.03	\$197	\$0.00	\$1,036	\$0.02
Modification costs		\$0.00	\$0.00	\$0.00	\$390	\$0.01	\$390	\$0.02		\$0.00	\$156	\$0.00
Insurance & registration	\$1,346	\$0.03	\$978	\$0.03	\$828	\$0.02	\$791	\$0.04	\$644	\$0.02	\$1,046	\$0.02
Loss of capital value or lease	\$15,000	\$0.39	\$3,981	\$0.11	\$3,000	\$0.09	\$3,000	\$0.15	\$1,840	\$0.05	\$5,732	\$0.14
Other costs	\$500	\$0.01	\$300	\$0.01	\$46	\$0.00	\$46	\$0.00	\$38	\$0.00	\$173	\$0.00
<b>Total vehicle costs</b>	<b>\$22,437</b>	<b>\$0.58</b>	<b>\$10,265</b>	<b>\$0.27</b>	<b>\$9,283</b>	<b>\$0.27</b>	<b>\$7,593</b>	<b>\$0.38</b>	<b>\$5,786</b>	<b>\$0.14</b>	<b>\$12,270</b>	<b>\$0.29</b>
Average passenger load/trip	4		2		1		1		2		2.0	
Vehicle cost/Key/ passenger	\$0.15		\$0.14		\$0.27		\$0.38		\$0.07		\$0.15	
<b>Labour costs</b>												
Award	Driver MBD&CA				Driver MBD&C				Volunteer Drivers			
Hourly base rate	\$17.70				\$16.00				\$16.90			
On costs	23%				19%				20%			
Penalty rate sat												
Penalty rate sun												
Annual salary incl on costs									\$30,145.68			
Driver cost/KL									\$0.71			
Driver cost/ Passenger/KL									\$0.36			
Service administration costs	\$34,500											
As % total transport cost	40%				37%				80%			
Administration cost/ passenger/Km									\$0.25			
Total cost / Km									\$1.49			
Total cost/ passenger/Km									\$0.75			
<b>Contracting services</b>												
Volunteer using own car												
Charge/Km	\$0.40								\$0.45			
Hire vehicles from other HACC projects \$/Km									\$0.45 / \$0.35			
									\$0.40			

**Table 5.4 Survey of Transport Costs in Area Health Services**

Agency	City Area Health Service (AHS)				City AHS				Rural AHS		Average AHS	
Vehicle make	2x Ford Transit Van		2x Chevy Swagon		2x Ford Transit Van & 1x VW Van				Ford Transit			
Ownership period of vehicle									Leased 2 years			
Period for cost calculations	1 year		1 year		1 year				1 year			
Kilometres	16,770		36,499		62,483				26,607		35,590 Km/year	
	Cost/Period	Cost/Km	Cost/Period	Cost/Km	Cost/Period	Cost/Km	Cost/Period	Cost/Km	Cost/Period	Cost/Km	Cost/Period	Cost/Km
Fuel cost	\$2,726	\$0.16	\$4,266.00	\$0.12	\$7,367	\$0.12			\$2,506	\$0.09	\$4,216	\$0.12
Repairs & maintenance	\$260	\$0.02	\$290.00	\$0.01	\$5,745	\$0.09			\$397	\$0.01	\$1,673	\$0.05
Modification costs	\$18,000	\$1.07		\$0.00		\$0.00			\$0.00	\$0.00	\$4,500	\$0.13
Insurance & registration	\$1,522	\$0.09	\$1,240.00	\$0.03	\$5,121	\$0.08			\$48	\$0.00	\$1,983	\$0.06
Loss of capital value or lease	\$8,440	\$0.50	\$7,944.00	\$0.22	\$39,157	\$0.63			\$19,428	\$0.73	\$18,744	\$0.53
Other costs		\$0.00		\$0.00	\$46	\$0.00			\$38	\$0.00	\$21	\$0.00
<b>Total vehicle costs</b>	<b>\$38,956</b>	<b>\$1.85</b>	<b>\$13,740</b>	<b>\$0.38</b>	<b>\$57,426</b>	<b>\$0.92</b>			<b>\$23,417</b>	<b>\$0.88</b>	<b>\$21,127</b>	<b>\$0.67</b>
Average passenger load/trip	1								1.06		1.02	
Vehicle cost/ Km/Passenger		\$1.85								\$0.81	\$0.86	
Labour costs												
Award	Driver/ Gen.Asst	Enrolled Nurse	Administration		Transport Driver	Reg Nurse/TA	Transport Coord		Hospital Asst/Grd 4			
Hourly base rate	\$15.40	\$15.65	\$15.82		\$14.62	\$23.80	\$15.00		\$17.06		\$16.77	
On costs	8%	8%	8%		28%	28%	28%		26%		19%	
Penalty rate Sat					50%	50%	50%				50%	
Penalty rate Sun					75%	75%	75%				75%	
Annual Salary incl on costs											\$29,634.99	
Driver cost/Km											\$0.83	
Driver cost/ Passenger/Km											\$0.82	
Service administration costs												
As % total transport cost	15%				11%						13%	
Administration cost/ passenger/Km											\$0.21	
Total cost/Km											\$1.92	
Total cost/ Passenger/Km											\$1.89	
Contracting services												
Volunteer using own car												
Charge/Km												
Hire vehicles from other HACC projects \$/Km												

Source: Consultants' Estimates based on Costing Survey.

**Table 5.5 Health-Related Transport Program**

	Months	Annual funding	Funding for period	Klms	Avg trip length	Cost per klm	Pass. trips	Cost per trip
Inner city	3	25000	6250	948	4	6.59	224	28
Inner city	6	10000	5000	1210	10	4.13	123	41
Outer city	6	20000	10000	4116	42	2.43	98	102
Rural north coast	6	50000	25000	20148	162	1.24	124	202
Rural south west	6	5000	2500	2084	91	1.20	23	109
Rural central west	6	30000	15000	14722	237	1.02	62	242
Rural south east	6	18000	9000	25028	253	0.36	99	91
Rural central west	6	10000	5000	9780	279	0.51	27	185
Rural north west	6	35000	17500	7690	88	2.28	87	201
Regional centre	3	60000	15000	4884	36	3.07	135	111

Source: Consultants' analysis of Health-Related Transport Program data returns.

### 5.5.4 Summary of transport costs by mode

Table 5.6 provides a summary of the average unit cost structure for trips by community transport groups using a volunteer with their own vehicle, community transport groups using a paid driver with a community transport vehicle, area health services, taxis and ambulances. Some unit costs are provided for vehicle and passenger km.

**Table 5.6 Summary of Average Unit Prices for Transport Services**

Price Structure	Flagfall	Kilometre rate	Comment	Waiting Time / Hr	Booking Fee	Luggage rate	Night rate	Maxi taxis
Volunteer with own car & no Admin - vehicle/km		\$0.43	Average - range \$0.35 to \$0.45					
Volunteer with own car & Admin - vehicle/km		\$0.63	Average					
CTG car, paid driver & admin - vehicle/km		\$1.49	Average					
CTG car, paid driver & admin - passenger/km		\$0.75	Average					
AHS car, paid driver & admin - vehicle/km		\$1.92	Average					
AHS car, paid driver & admin - passenger/km		\$1.89	Average					
Taxi City	\$2.35	\$1.35	all distances	\$36.84	\$1.10	\$0.55	20%	50%
Taxi Country	\$2.85	\$1.35	first 12 km	\$36.84	\$0.65	\$0.55		
		\$1.95	over 12 km					
Ambulance - NSW Public current price	\$147.00	\$2.95	over 16 km					
Ambulance - NSW proposed non emergency fee	\$90.00	\$2.00	over 16 km					

Source: Consultants' Estimates based on Costing Survey.

Table 5.7 provides a summary of the average cost of trips of various lengths, allowing for time costs, for the same modes.

**Table 5.7 Summary of Costs for Various Transport Services**

Cost per Trip	10 km with 10min wait + booking fee		50 km with 15 min wait + booking fee		100 km with 20 min wait + booking fee		200 km with 30 min wait + booking fee	
	\$/ Km	Total	\$/ Km	Total	\$/ Km	Total	\$/ Km	Total
Volunteer with own car & no Admin - vehicle/km	\$0.43	\$4.25	\$0.43	\$21.25	\$0.43	\$42.50	\$0.43	\$85.00
Volunteer with own car & Admin - vehicle/km	\$0.63	\$6.33	\$0.63	\$31.66	\$0.63	\$63.32	\$0.63	\$126.64
CTG car, paid driver & admin - vehicle/km	\$1.49	\$14.94	\$1.49	\$74.69	\$1.49	\$149.39	\$1.49	\$298.78
CTG car, paid driver & admin - passenger/km	\$0.75	\$7.47	\$0.75	\$37.35	\$0.75	\$74.69	\$0.75	\$149.39
AHS car, paid driver & admin - vehicle/km	\$1.92	\$19.25	\$1.92	\$96.25	\$1.92	\$192.50	\$1.92	\$384.99
AHS car, paid driver & admin - passenger/km	\$1.89	\$18.87	\$1.89	\$94.36	\$1.89	\$188.72	\$1.89	\$377.44
Taxi City	\$2.31	\$23.09	\$1.60	\$80.16	\$1.51	\$150.73	\$1.46	\$291.87
Taxi Country	\$2.31	\$23.14	\$2.06	\$103.01	\$2.04	\$203.58	\$2.02	\$404.72
Ambulance - NSW Public current price	\$14.70	\$147.00	\$4.95	\$247.30	\$3.95	\$394.80	\$3.45	\$689.80
Ambulance - NSW proposed non emergency fee	\$9.00	\$90.00	\$3.16	\$158.00	\$2.58	\$258.00	\$2.29	\$458.00

Source: Consultants' Estimates based on Costing Survey.

Clearly the least cost mode is a volunteer using their own vehicle. The average price is \$0.43 per vehicle km. Actually, because the marginal cost of vehicle use is about \$0.18 per vehicle for medium sized vehicles<sup>51</sup>, volunteers are in effect paid about \$0.25 per vehicle km. Allowing for a community transport administration cost, the full cost for a volunteer with their own vehicle may be about \$0.63 per km.

As previously noted, the average cost of a community transport vehicle with paid driver and some administration cost is an estimated \$1.50 per vehicle km. This is over double the price of volunteer labour using their own vehicle.

Drawing on the various observations above, the average cost of an AHS transport service appears to be between \$1.92 and \$2.47 per vehicle km. Note that the former costs does not include any penalty time. This higher average cost, compared with community transport groups, is a result of both higher labour and vehicle costs. It may also be noted that AHS occupancy rates appear to be lower than community transport rates.

It is difficult to compare unit taxi rates directly with unit community transport or AHS rates because taxi fares include flagfall and waiting time rates. However, Table 5.5 indicates that taxi rates for 10 and 50 km trips are at the higher end of AHS costs and

<sup>51</sup> NRMA, *Vehicle Operating Costs* 2001.

are much higher than community transport costs. This would be expected because of the high capital cost of taxi ownership due to regulation and the high interest rates that the private sector bears.

The average price of ambulance services is considerably higher again with a high flagfall charge and a high charge per vehicle km. The ambulance service is a high quality emergency service with a high capacity. Therefore its average cost is bound to be high. However, its marginal cost per km is also likely to be relatively high because of the high cost of its vehicles and equipment and the high cost of its skilled labour.

### **5.5.5 Some Conclusions**

There are significant differences in both the average costs and the marginal costs of transport by different modes. The most economic mode, by some way, is use of a volunteer with their own vehicle. The next most economic mode analysed is use of a community transport vehicle and paid driver. The AHS cost structure is higher than the community transport structure and, at the top end, is close to taxi rates. The ambulance service has the highest cost structure and the highest rates.

Of course, these estimated average rates are the centres of a range of costs in each case. Sometimes an AHS service will be cheaper than a community transport service. Sometimes a taxi will be cheaper than an AHS service. Nevertheless the general ranking of modes by cost is clear.

Moreover, there is considerable discontinuity in the price structure. This is evident in the difference between the volunteer/ own vehicle service cost and the community transport paid driver / community transport vehicle service cost and between the latter cost and the AHS cost and the taxi price.

At first sight these discontinuities in the price structure might be thought to offer opportunities for transport rationalisation and cost savings. However, it is doubtful whether there is a significant supply of more volunteers. Our discussions with transport providers indicated that the supply of voluntary labour is highly constrained.

There might be some scope for an increased community transport role in provision of transport, for example by doing more contract work for AHSs. It appears that community transport groups provide more economic vehicles and labour. However, they may also supply a lower quality service than AHS in terms of timeliness and nursing skill. Thus the scope for cost savings by switching to community transport mode may be limited.

Another longer term possibility is some transport deregulation. The discontinuity in the cost structure is due in large part to the regulation of the transport market. There are numerous Government regulations on the conditions under which drivers may be employed, on the vehicles that can be used, and on the types of service that may be offered by the market.

In many areas there are people who are willing to provide a transport service with their own vehicle at a price of \$1.0 - \$1.50 per vehicle km., comprising a full labour cost of \$0.75 - \$1.25 per vehicle km and a high marginal vehicle operating cost of \$0.25 per vehicle km. However, they are not permitted to provide such a service.

## Section 6. Key issues identified in the study

### 6.1 The unmet need for transport to health facilities

It appears that some people are having difficulty in getting to and from health facilities. A survey of older people in NSW in 1999 indicated that 4.6% of older people have reported problems getting to and from health services. Our survey of users of health facilities came up with much higher figures indicating that between 13 and 40% of health service users in different regions have difficulty in getting to health facilities.

Estimates by the ABS based on their Survey of Ageing, Disability and Carers (1998) suggest that in NSW 7,600 people with disabilities do not have their needs for transport assistance met and that 18,500 only have their needs partly met. Among older people 18,500 did not have their needs for transport assistance met and 13,000 only had their needs partly met. However, it is not possible to estimate to what extent this affects people's ability to get to health facilities.

People in urban areas appeared to have roughly the same degree of difficulty as people in country areas. This was confirmed by our health facilities user survey and a NSW Health Department Survey of the Health Needs of Older People undertaken in 1999.

Although the number of people having difficulty getting to health facilities is relatively small, many of those consulted with, including health service planners, GPs and Health Councils, were of the opinion that for those patients that have difficulties the problem is very real and may affect their health care.

Additional need for transport assistance to get to health facilities is likely to grow by about 16 - 20% over the next 5 years.

### 6.2 Factors that drive demand

There are a number of factors that drive the demand for health-related transport. These include:

- Health facilities are now concentrated onto a smaller number of sites than in the past. This has resulted in patients having to travel longer distances than used to be the case. This is a particular problem in rural areas where trips of 4 - 5 hours to access health facilities in regional centres or Sydney are not uncommon.
- A continuing growth in the number of surgical procedures that are undertaken on a same-day basis. Patients who may have had surgery and post surgery treatment during one stay in hospital in the past may now be required to make multiple journeys to health facilities for follow-up appointments after day surgery.
- According to our survey of users of health facilities, over 75% of people who reported difficulties in getting to health facilities were either older people or people with disabilities. Population growth among these two groups is projected to be greater than for the general population over the next five years. This is supported by the ABS, who project the proportion of people with disabilities living in the community compared to institutional care continues to grow.
- People with disabilities, of all ages, who live in the community have a high dependence on carers for assistance with transport. Many of these carers are older women who are less likely to hold driving licences compared to the rest of the population. Many primary carers have disabilities themselves. In the coming years the community is unlikely to have a sufficient number of capable carers to cope with the growing number of older people and people with disabilities.

### 6.3 Problems with travel to and from health facilities

- Most of the people consulted thought that the people who have most difficulty getting to health facilities are those who do not drive or who do not have access to private transport.
- Some health planners suggested that the dependence on friends and neighbours for transport may be because some people have limited or no other transport options.
- Aboriginal people told us that they have particular difficulties in getting to health facilities for a number of reasons including geographic isolation; lower per capita income; lower rates of car ownership and a generally poorer health status that increases the need to attend health appointments. There is a high dependence on Aboriginal Medical Services for transport, a function that many services are not funded to undertake.
- The consultants were told that public transport is not suitable for many people. This was confirmed by data from the ABS Survey of Ageing, Disability and Carers. Reasons include problems with getting in and out of vehicles, a lack of seating or uncomfortable seating, long walks to and from bus stops and railway stations, problems with connections, routes that do not bypass health facilities. It was also pointed out to us that people who are ill or who have just received treatment are even less likely to be able to use buses and trains.
- Health Councils, rural health planners and GPs made the point that in many areas outside the cities public transport provides only a skeletal service and in some areas there is no public transport at all.
- Taxi transport can be a suitable form of transport for most people including those who would find travelling on a bus or train difficult or impossible. However, our consultations indicated that for many people taxi transport is too expensive, particularly in country areas.
- Health planners and some GPs told us that community transport services are valued by many people who use them but they may not be available due to excess demand or restrictive eligibility criteria. Cost can also be a discouraging factor.
- Health planners in the country and Health Councils indicated that many people depend heavily on the goodwill of friends and relatives for assistance to travel to health facilities, particularly older people and people with disabilities. This was also confirmed by the ABS Survey of Ageing, Disability and Carers and by an analysis by the Australian Institute of Health and Welfare. However, this support may not always be available, particularly if long distances or early appointment times are involved. The consultations revealed that some willing drivers may be unavailable during working hours which coincides with most appointment times. Others may have to take time off work in order to assist.

### 6.4 Transport between facilities

- The high cost of ambulance services to Area Health Services may be driving the development of in-house Patient Transport Services. The average cost of an ambulance trip in the city is currently approximately \$150 - in rural areas it is much higher.
- Some Area Health Patient Transport services that operate on the basis of a centralised booking system claim to have reduced the overall costs of patient transport and increased efficiency.

- However, the cost of Area Health Patient Transport services is difficult to assess because of a lack of data. This makes comparisons with the Ambulance Service or other potential commercial alternatives problematical.
- There can be long waiting times for non-urgent ambulance services. This can disrupt patient flows and bed management and can cause distress and discomfort to patients.
- Ambulance services are also reported to lack flexibility due to competing demands on service. Patients carried by the Ambulance Service on a non-urgent basis can wait a long time (over 4 hours appears is not uncommon) for transport to pick them up.
- However, there is still a dependence on the Ambulance Service for out of hours services as Area Health Services do not appear to offer much transport at these times hours except in a few areas.

### **6.5 Other issues that impact on people's ability to get to and from health facilities**

- Community transport groups told us that dispersed referral patterns to specialists or hospital clinics can fragment the demand for transport. As a result, many health-related transport trips are supplied on an individual rather than on a shared or group basis. This leads to underutilisation of transport resources and high costs per trip to both the supplier and passenger.
- Difficulties in arranging or re-arranging appointment times so that more than one person can be transported at one time, or so that patients can be taken to appointments on days when a transport service is available, were brought up by community transport groups.
- A number of community transport groups felt that some health services had little idea about the function or limitations of community transport and that something needs to be done to increase understanding and cooperation between the two.
- Much successful liaison at present takes place in an informal manner but is subject to the vagaries of interpersonal relationships and staff movement. This cooperation needs to be formalised.
- Hospital discharge planning does not always take into consideration transport issues. A recent survey by the Department of Health showed that transport remains one of the key impediments to effective discharge planning. Patients can be stranded or have to use inappropriate transport services.
- Patients who live far away from health facilities (and sometimes their families or carers) have to bear expenses for accommodation and meals as well as transport costs. This is particularly true of patients who are undergoing long term treatment such as renal dialysis, oncology or rehabilitation.
- Community transport groups also highlighted that it can be difficult to get people to early appointments for day surgery, particularly if the patient lives a long distance from the hospital or clinic. This can be a particular problem for volunteer based groups who can find it difficult to find volunteers willing to transport people very early in the morning. It was also pointed out that discharges after day surgery are sometimes after 5 pm which also complicates the provision of transport.
- Some community transport agencies said that they depend heavily on volunteers, the supply of which is reported to be shrinking in many non-coastal rural areas.

- Community transport groups questioned whether some volunteers should continue to provide transport for people with significant care needs.
- Finding out how to obtain transport is difficult for many people. If a clinic or health service provides a transport service patients attending that service may be told about the transport and be able to access it. Other patients may be aware of, or be existing clients of, community transport services and access transport services in this way. For others who cannot use public transport, there may be no obvious place to access information on health-related transport services.

## 6.6 Conclusions

The issues that need to be addressed fall into three categories, all of which need to be addressed in any proposed model or solution.

### 1. Operational issues

Transport providers have some scope to operate more effectively and efficiently. The primary way to reduce the cost of transport per passenger trip is to achieve greater utilisation of vehicle capacity. Incentives must be put in place to encourage this. The health system also to be more flexible in terms of consolidating appointment times for people travelling from similar areas to enable more group transport to be provided. The provision of multi-passenger services may, however, degrade service quality if it increases waiting and travel times. This needs to be taken into account for some passengers.

### 2. Management issues

The responsibility for the management, planning, coordination and delivery of health-related transport issues at a regional and local level is fragmented and ineffective in many cases. A lead agency need to be identified that can take on these roles.

There is a need to improve the liaison between transport providers and health facilities in order to enhance patient access to suitable services and assist in achieving higher vehicle utilisation (and lower costs per passenger).

### 3. Resourcing issues

Additional resources may need to be applied in the future to purchase or provide appropriate transport services for those who require them, particularly given the projected rise in need for such services.

## Section 7. Options to Address the Issue of Non-emergency Health-Related Transport in NSW

### 7.1 Types of demand for health-related transport

The volume of travel to health facilities is growing due to public health policies that are moving many aspects of health care from hospitals to the community. Patients that would have previously been treated in hospital are now staying at home and are travelling to be treated as outpatients.

The study survey of users of health facilities showed that 70-80% of patients travel to and from health facilities by private vehicle. About half of those who used private vehicles depended on friends or relatives for transport. An even higher level of dependence on friends and relatives for transport has been identified in a recent study of the transport needs of older people in Sydney<sup>52</sup>. A 1998 survey of people with disabilities, older people and carers showed that of all respondents needing transport assistance 81% depended entirely on family and friends<sup>53</sup>.

In urban areas there is also significant use of public transport.

A small number of transport disadvantaged people who have problems accessing private or public transport, use community transport, Area Health patient transport services and Ambulance services.

It should also be recognised that there can be significant differences between transport to facilities and transport from facilities in terms of the health status of the patient. Patients travelling home from facilities will tend to be less well and need greater care than those travelling to facilities due to the effects of treatment, anaesthetics and medication. In some cases different types of transport service may need to be provided to take someone in to a health facility and to take them home.

### 7.2 Problems identified in the course of the study

While most people will be able to find the transport to health facilities that they require, there are others for whom finding appropriate transport will remain a problem. Our research suggests that these difficulties are not confined to rural areas. It appears that a substantial additional volume of transport assistance will be needed to address current unmet need and the projected increase in the number of people who require transport assistance. The options below have been developed in order to address the key problems and issues that were raised during the consultation phase of the project. These included:

- the centralisation and specialisation of health services which is increasing the demand for long distance travel to health facilities;
- the continuing rise in the volume of day surgery and earlier discharge practices which results in patients having to return to health facilities more often for follow-up treatment;
- the lack of public transport in rural areas and the need for additional community transport services<sup>54</sup>;

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<sup>52</sup> Dent O.F., Broe G.A., Creasley H., Waite L.M., Cullen J.S. & Grayson D.A. (1999) *Transportation needs of Community Living Older People in Sydney*, Australian Journal on Ageing 18 (4) Nov. pp 186-190.

<sup>53</sup> NSW Department of Ageing, Disability and Home Care (yet to be published) *Disability and Use of Transport*.

<sup>54</sup> Also identified in the Sinclair Report. Problems with access to affordable and responsive transport was also identified in the Health Council Report, p 44.

- the difficulties experienced by transport providers in aligning appointment times of passengers with transport services in order to increase the utilisation of transport capacity;
- the need to improve understanding and cooperation between transport service providers and health facilities<sup>55</sup>;
- discharge planning practices that do not adequately address transport issues;
- the need to recognise that patients access transport systems both through the health system and by approaching locally based transport providers directly;
- problems associated with the skill levels of community transport and Patient Transport staff, particularly volunteers, in relation to some passengers with medium to high care needs;
- the diminishing number of volunteer drivers available in some communities; and
- the heavy dependence that many patients have on friends and relatives for transport, some of whom are elderly and who may have disabilities themselves.

### **7.3 Principles underpinning the options**

In consideration of the above issues, the development of the model has been underpinned by the following principles. The model should enhance social justice in terms of:

- equitable distribution or use of transport resources;
- people's ability to access health facilities;
- ensuring groups and individuals are not discriminated against in terms of travel to health facilities; and
- the opportunity that service users have to participate in the decisions about transport provision;
- devolving decision-making on transport issues to Area Health Services<sup>56</sup>;
- creating a clear point of reference in each region of NSW for non-emergency health-related transport;
- establishing a closer link between the services that drive the demand for non-emergency health-related transport and the provision of transport services;
- establishing a mechanism whereby cooperative practices can be developed between health facilities and transport suppliers;
- providing mechanisms to ensure that transport services are provided that are appropriate to the needs of passengers travelling to, from or between health facilities;
- being flexible enough to be applied in both urban and rural areas;
- building on existing infrastructure and expertise;
- discouraging cost-shifting between Governments or departments or to the patients;

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<sup>55</sup> The Sinclair Report also found that there was limited collaboration between rural AHS and transport services.

<sup>56</sup> See the Health Council Report p 81.

- enabling the consolidation of Area Health resources used to purchase or provide non-emergency health-related transport so that more efficient use can be made of those resources;
- providing incentives to purchase or provide services that are both efficient and effective;
- encouraging transparency in terms of the costs of patient transport services and contracted transport services; and
- encouraging improved reporting and accountability information systems to provide Area Health Services with more meaningful data for planning purposes.

The model will also allow for the creation of meaningful linkages with other transport programs and projects and recent Government initiatives such as the Health Care in the Community Re-investment Strategy and through integrated health models such as Healthshare<sup>57</sup>.

These options have been developed at a time when significant reforms to the Ambulance Service's Patient Transport Services are also under consideration<sup>58</sup>. As these reforms may involve increased participation in non-emergency transport by the Ambulance Service, the model needs to be able to make the best use possible of this extra capacity.

#### 7.4 Outline of the proposed model

It needs to be recognised that the NSW Health Department can only propose models that relate to the core business of ensuring that the people of NSW can access the health services they provide. There is clearly a need for a broader approach to address the whole of government issues that arise from a sector with multiple funders across Commonwealth, State and Local Government and organisations located outside of Government.

The issue of improving the coordination of community transport across the entire sector, falls outside the jurisdiction of the NSW Health Department. NSW Health raised this issue with the Premier in later 2000 who agreed that a whole of Government approach for the delivery of community transport in the future would be developed. An Inter-agency Working Group has been established to develop a strategic policy framework for community transport. The model includes four elements:

1. Health Transport Units. These units will act as budget holder for transport funding and will administer a patient transport cost centre within the Area Health Service. The unit would also be the entity that will negotiate contracts with suppliers of transport services. A key role for each unit will be the development of local and regional health transport plans. The number of units may vary between Area Health Services. Area Health Patient Transport services, would provide transport under standards and performance levels established by Health Transport Units.
2. Transport Suppliers. These include the existing suppliers, the Ambulance Service, Area Health Services, community transport groups and public transport. There would also be benefits if new suppliers enter the market including additional commercial passenger transport operators and alternative, commercial non-emergency Ambulance Services.

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<sup>57</sup> NSW Department of Health (2001) *Healthshare: A discussion paper for NSW*, NSW Health Department Website.

<sup>58</sup> Ambulance Service of NSW (2001) *Draft Patient Transport Service Business Case*

3. Health Care Transport Networks. These forums will include core staff from the Area Health Service whose work is impacted upon by the timely and appropriate provision of transport services, other Area Health Staff as necessary, health transport suppliers from the area including internal patient transport services, planners from relevant Government funding programs such as Home and Community Care, Divisions of GPs, Aboriginal Medical Services and other agencies as deemed appropriate. This is consistent with a recommendation of the Sinclair Report that suggested that “...AHSs play a pro-active role in facilitating the development of community forums with all Government, non-Government providers and members of the public at a local level”<sup>59</sup>. The Health Council report also called for “...greater cooperation with the private and non-Government sectors in the planning and delivery of health care...”<sup>60</sup> and suggested that Area Health Services should plan around a coordinated service network that should include ambulance and community based transport<sup>61</sup>. These Networks will therefore liaise closely with the proposed Primary Health Care Networks as part of the Healthshare regional service model.
4. Resources. The key resource for the model will be the Health-Related Transport Program. There may also be the potential for Area Health Services to invest savings from the more efficient purchase or supply of transport services in the model.

Each Transport Unit and Transport Network will differ according to the environment in which it operates. It is not our intention to prescribe exactly how each Unit and Network will work as they need to be flexible enough to adapt to the local conditions relating to geography, population characteristics, the range of health facilities in place and available transport supply. As the Sinclair Report commented “...Given the diversity of rural communities, there is a need to be flexible in the way in which health and related services are delivered. A single model will not be suitable for every community...”<sup>62</sup>.

The model is illustrated in Figure 7.1 and described in more detail in the following section.

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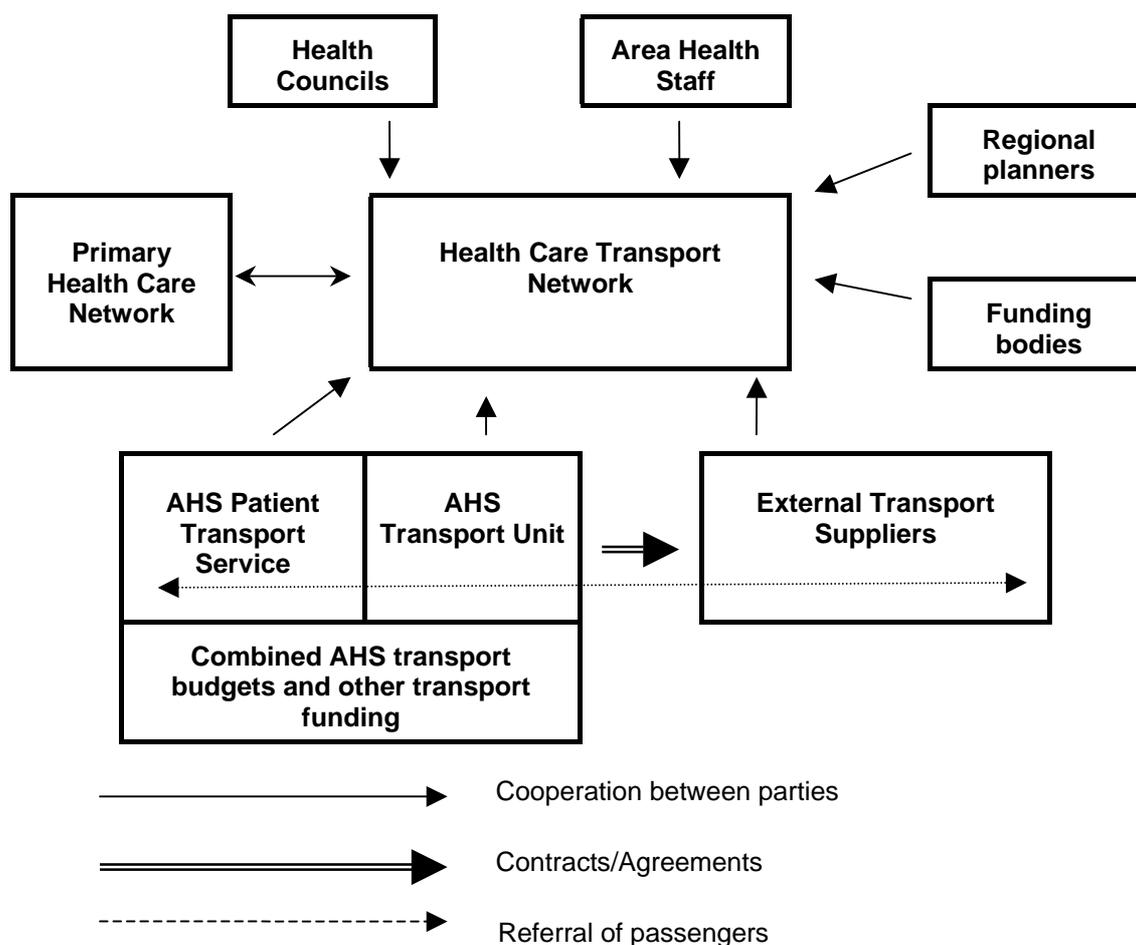
<sup>59</sup> NSW Ministerial Advisory Committee on Health Services in Smaller Towns (2000) *A Framework for Change*, p9.

<sup>60</sup> NSW Health Council (2000) *A Better Health system for NSW*. P xxiii.

<sup>61</sup> *ibid.* p 40

<sup>62</sup>,NSW Ministerial Advisory Committee on Health Services in Smaller Towns (2000) *A Framework for Change* p 39.

**Figure 7.1 Non-emergency Transport Model**



**7.5 Responsibility for non-emergency transport**

Within each Area Health Service an Executive Sponsor will be given the responsibility for non-emergency transport. This task will include the establishment of a Health Transport Unit and a Health Care Transport Network (both described below) and the administration of internal transport budgets and funding from external sources. This responsibility may be delegated to a designated staff member at Director level or above (referred to here as the Designated Director). Patient transport strategies should appear in each Area Health Plan<sup>63</sup>.

The purpose of this is to raise the profile of transport within each Area Health Service, with a view to ensuring that the transport needs of patients are effectively addressed. The need to do this was highlighted in the Sinclair Report - *“Across rural NSW the Committee observed that the transport needs of patients are not consistently viewed as a high priority issue or core business by rural AHSs. This is despite the fact that transport needs prior to hospitalisation, at discharge and at home post-discharge are an important element in the continuum of care.”*<sup>64</sup>

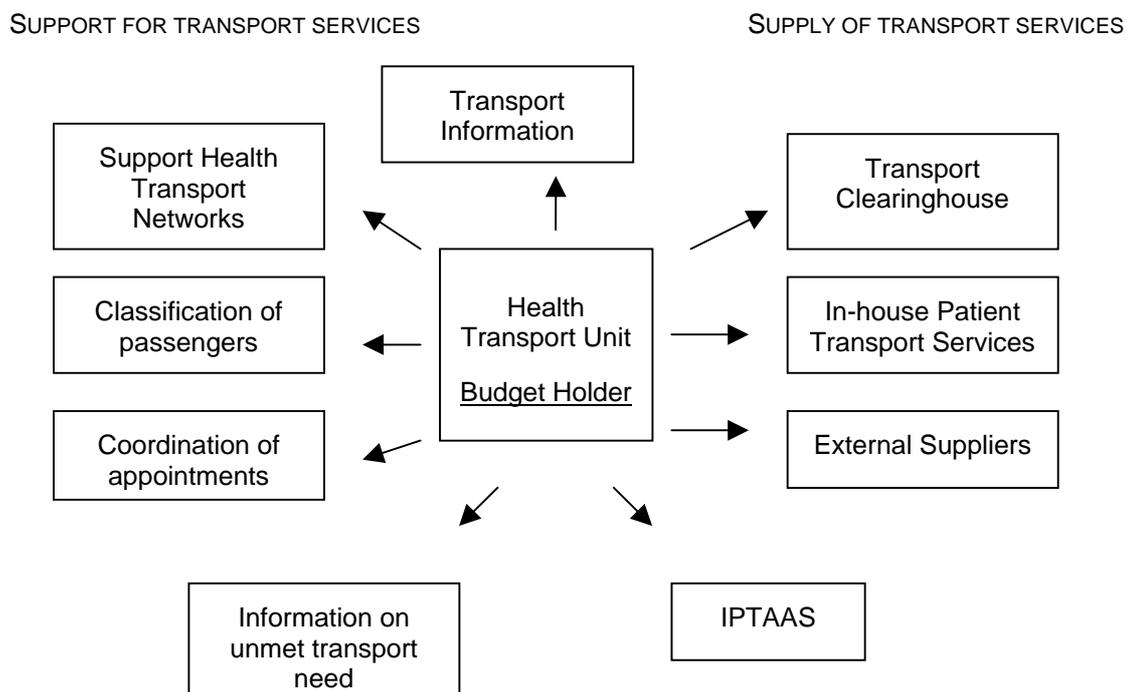
<sup>63</sup> The development of Area Health Plans was suggested in the Health Council Report (p 83) and in NSW Health’s *Healthy People 2005: New Directions for Public Health in NSW*.

<sup>64</sup> NSW Ministerial Advisory Committee on Health Services in Smaller Towns (2000) *A Framework for Change*. p35.

## 7.6 Health Transport Unit

Each Area Health Service will be required to establish a Health Transport Unit to take responsibility for non-emergency transport. These units will be the key entities in improving the appropriateness and quality of non-emergency transport services. In some circumstances the unit may also be a supplier of in-house patient transport services. The Unit will have ten core functions:

1. to act as a budget holder for all patient transport funds/expenditure within the Area Health Service, the Health-Related Transport Program (H RTP), (IPTAAS) and other resources as they become available;
2. to gather evidence on unmet need for transport to health facilities;
3. to develop health transport plans at a local and regional level;
4. to identify and purchase appropriate transport services, including those funded through the H RTP, as required, on behalf of wards, clinical units and other divisions of the AHS and on the advice of the Health Care Transport Network;
5. to maintain a centralised clearinghouse for inter-facility transport, home to facility and facility to home transport;
6. to resource and support the Health Care Transport Networks;
7. to provide assistance to wards, clinics and external suppliers in relation to patient classification for transport purposes;
8. to assist with the synchronising of appointments within health facilities to assist in maximising the use of transport resources;
9. to administer the IPTAAS; and
10. to ensure the provision of adequate training is available for the staff of transport services.

**Figure 7.2 Function of Health Transport Units****7.6.1 Health Transport Unit as budget holder**

At present, expenditure on patient transport within Area Health Services generally takes place via a variety of budgets held at local, sector and area level. This has made it difficult for Area Health Services to track patient transport expenditure and to cost the services they provide themselves. In some Area Health Services expenditure on patient transport is well above \$1 million per year. Significant funds are also spent on purchasing non-emergency ambulance services.

A consolidated patient transport budget would be created from which such payments will be made. This will bring about a number of benefits including:

- improved knowledge about total transport expenditures;
- better information about the cost of various forms of transport (in-house and external);
- improved control of transport expenditure and
- better accountability.

The Unit would also be the area fundholder for the Health-Related Transport Program. Other funds, both internal and external to Area Health Services, that relate to the provision of health-related transport could be also be administered by the Unit.

Funding for the Isolated Patients' Travel and Accommodation Assistance Scheme would also be held by the Unit which would also administer the scheme at a regional level. This funding, which is quarantined, would be held and administered separately from other transport funding.

**7.6.2 Health Transport Unit's role in identifying unmet need**

It is difficult at present to assess the level of unmet need for transport to health facilities in NSW because of problems associated with the collection of relevant data. The Health Transport Unit will have a role in the collection of such evidence from a number of sources. These include:

- Transport suppliers who can provide information about the nature and volume of transport requests that they are unable to respond to;
- Discharge planners who can provide information on where, when and how a lack of suitable transport impedes effective discharge planning processes;
- Wards, clinics and health professionals who can provide information about the attendance at appointments in terms of “no-shows”, cancellations and postponements because of difficulties with transport; and
- Evidence from other sources such as relevant data from departmental planners, community support programs and transport development workers.

The Unit will have a role in establishing such data collection where it does not take place at the moment, and in the collation of existing information. The Unit will take advice from the Health Care Transport Networks in this regard.

Where possible, such data collection systems should be computerised, using agreed standard data formats in order to facilitate collection and analysis.

The information gathered will be used in transport planning, to feed into transport purchasing decisions and to inform Government on the level of unmet need for assistance with transport to get to health facilities over time.

### **7.6.3 Health Transport Plans**

Each Health Transport Unit would be responsible for the development of Health Transport Plans at both a local and regional level. Plans would be developed in close cooperation with the Health Care Transport Networks. Each plan should contain the following:

1. A summary of unmet or partly met need for transport to health facilities in the area in question. Transport disadvantaged groups in the population would be identified and their ability to get to health facilities assessed. Feedback from health facilities about “no shows” and cancelled appointments would also be considered.
2. A summary of the available supply of transport services would be provided. This summary would include information on availability in terms of hours of operation, capacity and cost. Transport modes would also be classified in terms of their ability to provide various levels of passenger care in relation to passenger needs.
3. Strategies to address unmet or partly met need for transport to health facilities in the area in question. These may include transport purchasing or subsidy strategies, liaison with transport providers in terms of making the supply of services more relative and effective in terms of assisting patients with transport disadvantage to access health facilities and linkages to other processes such as discharge planning and bed management.
4. A description of how the health transport system works. This should include information about individual transport providers, eligibility criteria, times and frequency of operation, fees or charges and, most importantly, how patients can gain access to the system.

### **7.6.4 Health Transport Unit as a purchaser**

The Health Transport Unit would be responsible for the purchase of non-emergency transport services on behalf of the Area Health Service. Purchases may be made on a contract or casual basis. In some circumstances it may be beneficial to treat in-house Patient Transport Services as separate business units. In these circumstances they would also be subject to these arrangements. This will engender greater

contestability of transport service provision between the public, private and non-Government sectors<sup>65</sup> and should lead to more efficient and effective services becoming available in the long run.

The Unit would have several roles in this regard.

- On advice from the Health Care Transport Network, the Unit would identify which patients should be targeted for transport support.
- The Unit would identify appropriate suppliers and enter into contracts with them for the provision of services. Aspects of service provision that will need to be taken into account will include cost, ability to cater for the care needs of patients and timeliness of services. Potential suppliers include the NSW Ambulance Service, community transport operators and taxi and hire car companies.
- The Unit would develop minimum standards and practices to apply to contracted transport suppliers.
- The Unit would be responsible for drawing up contract specifications and terms, identifying performance measures and for monitoring contract performance<sup>66</sup>.
- The Unit would report on its activities and, in particular, on the performance of contracted services, to the Chief Executive of the Area Health Service in order to provide internal accountability and to the Health Care Transport Network in order to ensure accountability to the community. This is in concert with the Health Council's call for greater transparency of costs to allow for market testing and benchmarking of different providers<sup>67</sup>.

#### Incentive charging system

Services provided on contract to Area Health Services will be subject to an incentive charging system. Rather than paying for transport services for a standard fee in relation to kilometres travelled or trips provided, a system that encourages more effective use of transport resources should be used. For example, the system could involve a base charge per kilometre or trip for transporting a patient to or from a health facility. An additional charge, at a lower rate, would apply for additional passengers carried and passengers carried as a back-load. This will provide a double incentive to make better use of existing resources. These arrangements will need to be developed by each Area Health Service within the context of local need for services and the transport options available.

1. The transport supplier will earn extra fees for carrying more than one passenger at a time and for avoiding empty running.
2. The Area Health Service will save money by organising appointments, admissions and discharges in a way that maximises the number of passengers carried at the lower rate (ie. additional passengers and back-load passengers).

#### Status of Area Health Patient Transport Services

Patient transport services could either be provided as part of the function of Health Transport Units or established as separate business units. Service specifications should be developed and monitored in any case. These should include staff skill levels, minimum service levels and identified performance benchmarks.

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<sup>65</sup> This approach is supported in the Health Council Report, p 81.

<sup>66</sup> This is also supported in the Health Council Report, p 81.

<sup>67</sup> NSW Health Council (2000) *A Better Health system for NSW*. P xxiii.

The form and status of each service will depend on the area of operation and the demand for transport services. An Area Health Service may have more than one such service (as in South West Sydney currently). For example, there may be a service in each major hospital or sector within an Area Health Service.

#### Costs of Area Health Patient Transport Services

Area Health Service will benefit from identifying the costs of providing services in-house for comparative purposes. Patient transport services should operate as a separate cost centre within the Health Service using an identified core budget and a transfer pricing system under which wards and clinics will be charged for in-house transport services. The transfer prices should be cost based. The purpose of this initiative is to encourage Area Health Services to recognise the costs of providing services in-house and to allow Health Transport Units to make transport purchasing decisions with better knowledge of the costs involved.

The move to a patient transport cost centre and transfer pricing will also assist Area Health Services in assessing the future benefits of tendering patient transport services out to the Ambulance Service or the wider passenger transport market.

#### **7.6.2 Health Transport Unit as a clearinghouse**

The best way to make more efficient use of existing resources or contracted services is to aggregate the demand for transport through one point or clearinghouse. It is then possible to recognise travel patterns and to identify where multiple passenger trips might be provided and where trip matching can reduce empty running.

The clearinghouse has three potential functions – providing information, taking bookings and providing referrals.

A lack of information is often found to be a significant barrier to people's use of transport services. The clearinghouse will act as a central point for information about transport to health facilities. The information will include data on all relevant transport services including in-house Patient Transport Services, community transport, public transport and other services as appropriate.

The clearinghouse could also take bookings for in-house patient transport services (and possibly external services) and will also refer patients to other appropriate providers.

In some areas these functions may already be undertaken by internal Patient Transport Offices. There is potential to contract this function out to an outside agency.

In terms of long distance trips across a number of different Health Areas there may be scope to use the existing ability of the Ambulance Service to coordinate transport services and to make best use of current resources. Within New England, long distance trips are already coordinated within the Area Health Service using a computer based booking system available to all staff. The system allows the user to not only reserve places on existing transport services, but to make cost comparisons across a variety of transport modes including Area Health Service transport, Ambulance and taxi services.

The coordination of transport supply across service types, including community transport warrants further investigation.

### **7.6.5 Health Transport Unit as a resource for Health Care Transport Networks**

The Networks will require a range of support including organising and facilitation of meetings, secretarial and administrative services, advice and research, and in terms of overseeing the implementation of any decisions. This will be the role of the Health Transport Unit.

### **7.6.6 Health Transport Unit's role in passenger classifications**

One of the key issues identified during this study was the need to classify passengers so that they can be directed to transport services that can appropriately cater for their needs while travelling. Even the simple classification system used in our supply survey did not prove very useful as the different operators use of the system was subjective. A more robust system would enable better analysis of the need for different types of transport supply and would represent a key input into the development of Health Transport Plans.

This will be an important aspect of the Unit's work. The Unit will develop a passenger classification framework that relates to the available transport supply.

The groundwork undertaken by the Illawarra Integrated Community Transport Coordination Project will be useful in this regard<sup>68</sup>. This project has developed a Health-Related Assisted Transport Classification Framework that identifies classifications for passengers and related generic service specifications and service mode specifications. Linked to the framework is an easy to use patient assessment tool which helps identify patient care needs and the appropriate type of transport that should be provided. The project is also in the process of developing a useful guide to the risks involved in the carriage of patients after a range of identified treatments<sup>69</sup>. This represents a very useful tool that can be used by both assessors and transport suppliers.

Clinical staff may need to be made available to assist with both developing the classifications for use in particular areas and circumstances and to provide advice on specific occasions. For example, in the Illawarra project a registered nurse provides this advice; in the Lower Hunter the advice of a Nurse Unit Manager is available.

There would be benefits in the development of a standardised set of classifications across the State. Service conditions and supply will vary from region to region and within regions and the classification system will need to be flexible enough to cater for this, however, we would not wish to see the development of a range of disparate systems in different areas. A standardised system would assist in the meaningful analysis of health transport demand and delivery across the State. The NSW Department of Health should have a coordinating role in this regard.

The Ambulance Service is also now using a classification system with advice provided from a central contact number. An operator asks a series of questions about the patient after which they can assess what type of transport may be appropriate. How this might align with the development work already taken in the Illawarra should be taken up by the NSW Department of Health.

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<sup>68</sup> Illawarra Community Transport Coordination Planning Project (2001) *Final Report*.

<sup>69</sup> *ibid.* p 21.

### **7.6.7 Health Transport Unit's role in the synchronisation of appointments**

One of the greatest barriers to achieving better utilisation of transport resources is the difficulty faced by transport operators in aligning passenger's appointments so that groups of people can travel together and to avoid empty running (mainly on return trips). This is a key issue in terms of reducing the cost of health-related transport services. The Unit would play a key role in negotiating the synchronisation of appointments and transport services. This role will vary from connecting staff on wards and clinics with staff at transport providers, to assisting with negotiations with regard to establishing multi-appointment transport services.

The results of the Health Facility User Survey undertaken as part of this study showed that 19% of survey respondents who indicated they had difficulty getting to health facilities, said that they had had to come back for separate appointments that could have been arranged for the same day. The Unit will have a role in seeking to rearrange appointments around core times for individual patients, particularly those who have to travel long distances, as a form of transport demand management.

### **7.6.8 Health Transport Unit as IPTAAS budget holder**

The Isolated Patients' Travel and Accommodation Assistance Scheme which is designed to assist patients who live more than 200 kilometres from specialist medical treatment with travel and accommodation costs, would be incorporated in the Unit.

### **7.6.9 Health Transport Unit as a training resource**

There are no standard skill levels among transport staff except in the Ambulance Service. This has been raised in the consultations, particularly with regard to volunteer drivers used by community transport operators. The study identified that 50% of community transport passengers have medium level care needs who may require assistance in getting in and out of vehicles or in walking, or supervision because the passenger may be confused or have an intellectual disability. For many of these passengers, the use of untrained staff may be considered inappropriate. Often there is a lack of suitable training available and the costs to small volunteer groups of purchasing it can be prohibitive.

Some ad hoc training is currently provided by Area Health staff, however the primary function of the Unit in this regard will be to ensure that suitable training is made available on a regular basis for driving and care staff of all non-Ambulance operations in the local area. Such training should be subsidised according to the ability of the operators to pay.

Other Government departments such as the Department of Ageing, Disability and Home Care may be in a position to offer information and material support for the development of training programs for non-Government agencies, particularly those funded through the Home and Community Care program.

### **7.6.10 Support for new Health Transport Units**

It must be recognised that in some areas Health Transport Units will need to be developed from scratch. In such circumstances it may be necessary to call upon other organisations with relevant experience and expertise, such as the Ambulance Service or Community Transport groups to assist in the development of the Units. Such support should initially be sought through the Health Care Transport Networks.

In the early stages of development it would also be beneficial if Area Health Services could share expertise and knowledge. This could be achieved through Statewide seminars hosted by the NSW Department of Health during the development period.

### **7.6.11 Health Transport Units in remote rural areas**

In some small remote communities there are few transport resources available for purchase or coordination. This is particularly true in some Aboriginal communities. In such cases the transport needs of the community should be considered as a whole, not just in terms of transport to health facilities. While there will continue to be heavy reliance on Aboriginal Medical Services and community transport groups for health-related transport there will be a need to examine transport needs irrespective of destination if sufficient passenger traffic is to be generated to make transport services commercially viable, even where subsidies exist. The recent initiative of the NSW Department of Transport in relation to transport in rural and remote areas will be critical in this regard. Health Transport Units in areas where this initiative are taking place (the areas surrounding Broken Hill and Dubbo) should work closely with the Department of Transport to develop new ways of providing services that reflect both the needs of transport disadvantaged people and the disparate and fragmented transport supply.

## **7.7 Health Care Transport Networks**

The study has identified that there is a need to improve communication and understanding between Health Services and transport providers if efficient and appropriate services that meet the needs of transport disadvantaged patients are to be developed and provided.

The network model is loosely based on the Wentworth Area Patient Related Transport Committee. This committee was established with a view to improving equity, accessibility, quality, efficiency and effectiveness of health-related transport services for people in the Wentworth area (Penrith, Hawkesbury and the Blue Mountains). The committee seeks to achieve its aims through:

- analysis of services provided, health status information and service utilisation data;
- recommendations for changes to service provision;
- implementation of changes to service provision;
- development of standards for better practice; and
- monitoring and review of the impact of implemented changes.

Members of the committee include staff from health services, suppliers of health-related transport in the community and includes both Government and non-Government organisations<sup>70</sup>. Members may be called from other services and the community to assist the group from time to time.

Health Care Transport Networks, to be established in each Area Health Service, will have a similar membership and function. The networks will also provide a mechanism by which transport issues can be fed to other initiatives such as the Primary Health Care Networks, Healthshare and other transport pilots and programs being undertaken by the Department of Transport and the Premiers Department. A key function will be to act as a primary conduit through which the views and opinions of a wide variety of stakeholders will be able to contribute to the development of an effective health-related transport system.

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<sup>70</sup> Wentworth Area Patient Related Transport Committee, *Terms of Reference*, May 2001.

### **7.7.1 Composition of Health Transport Networks**

This group will be chaired by the Designated Director and comprises representatives of:

- Area Health Services;
- Suppliers of transport services;
- Planners from relevant Government departments and from programs such as the Home and Community Care Program;
- Aboriginal Medical Services; and
- Other key advocacy groups/agencies.

Area Health Service staff will include the senior discharge planner, senior staff from Community Health, Primary Health, Clinical Support Services, Health Policy Development and other staff with a direct interest in patient transport. The chair will have the ability to invite selected staff to attend meetings that will discuss matters relevant to them (e.g. Unit Managers, Continuing Care Coordinators etc.).

Hospital discharge planners will be key members of this group. The NSW Health Department's current patient discharge policy notes that effective discharge should be *"based on planning and timely communication around the patient's transport needs, including the special needs of rural patients and patients lacking adequate access to public transport or transport by family and carers"*<sup>71</sup>. The Network will enhance the ability of discharge planners to achieve this.

There are a number of State Government departments and agencies that need to provide input into the Networks. These include the Department of Ageing, Disability and Home Care, the Department of Urban Affairs and Planning, the Office of Regional Communities, the Premier's Department (through the Regional Coordination Program) and the Department of Transport. In addition the involvement of the Commonwealth Department of Veterans' Affairs and Commonwealth Department of Health and Ageing will also be vital in terms of promoting the interests of their constituencies.

The group will include the significant providers of health-related transport in the Health Service Area. This recognises that a significant existing problem is the common lack of understanding and cooperation at the interface between health facilities and transport providers as identified consultations during this study. Providers of such transport will encompass community transport operators, the Ambulance Service, Area Health Service in-house transport services and other regular suppliers of transport.

Advocacy groups and other relevant agencies will also be involved. These may include patient advocacy groups, representatives from Health Councils and Aboriginal Medical Services.

Decisions of the Network will be made by the Designated Director in consultation with the Network members.

### **7.7.2 Purpose of Health Transport Networks**

The group will primarily provide advice to the Health Transport Unit, but also to transport suppliers, relevant Government agencies and other organisations involved in the provision of health-related transport.

The Network will have a wide ranging brief to include the following:

- the identification of health-related transport need;

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<sup>71</sup> NSW Health (2001) *Shared Responsibility for Patient Care between Hospitals and the Community – An Effective Discharge Policy*, p 5.

- resource distribution planning;
- providing input into local and regional transport plans;
- providing advice on the establishment of a passenger classification system which relates to the local transport supply;
- the establishment of a primary interface between health services/facilities and transport suppliers;
- ongoing transport service evaluation;
- addressing training/skill levels within contracted/purchased transport services;
- the facilitation of the development of a consistent approach to transport service delivery and charges among all providers (including AHS based providers);
- to reduce duplication of services and to fill gaps in service delivery;
- planning ahead for significant changes to health service delivery or transport supply; and
- the development of consistent Fees Policy among transport providers in each region.

### **7.7.3 How the Networks will fit with other Government initiatives**

The network would work closely with other relevant agencies and forums, in particular with the Primary Health Care Networks, the whole-of-Government strategy on community transport, Healthshare and other initiatives.

The Primary Health Care Networks are part of the Health Care in the Community Re-investment Strategy. The strategy commits Government to a “whole of community” system of health care.

Part of this strategy, which will implement a population health approach to health care services, involves:

- providing integrated services for people no matter where they live;
- enabling services to be more accessible;
- ensuring Area Health Services include the principles of equity and community participation; and
- to ensure Area Health Services intervene early to prevent health problems developing or worsening.

If the strategy is to be successful it will be necessary to effectively address the health travel needs of the transport disadvantaged in the community. Making appropriate transport available is a key consideration in implementing the four elements of the strategy indicated above. The Health Care Transport Networks will play an important role in this regard. As described above, the Networks will have a role in identifying transport disadvantaged health service users, in considering how their travel needs can best be addressed and in ensuring that the available resources are applied in an equitable manner.

The work of the Primary Health Care Networks will have particular relevance with regard to discharge arrangements for hospitals and the transition of patients from hospital to community settings and in terms of the development of information systems for use by both Networks and patients.

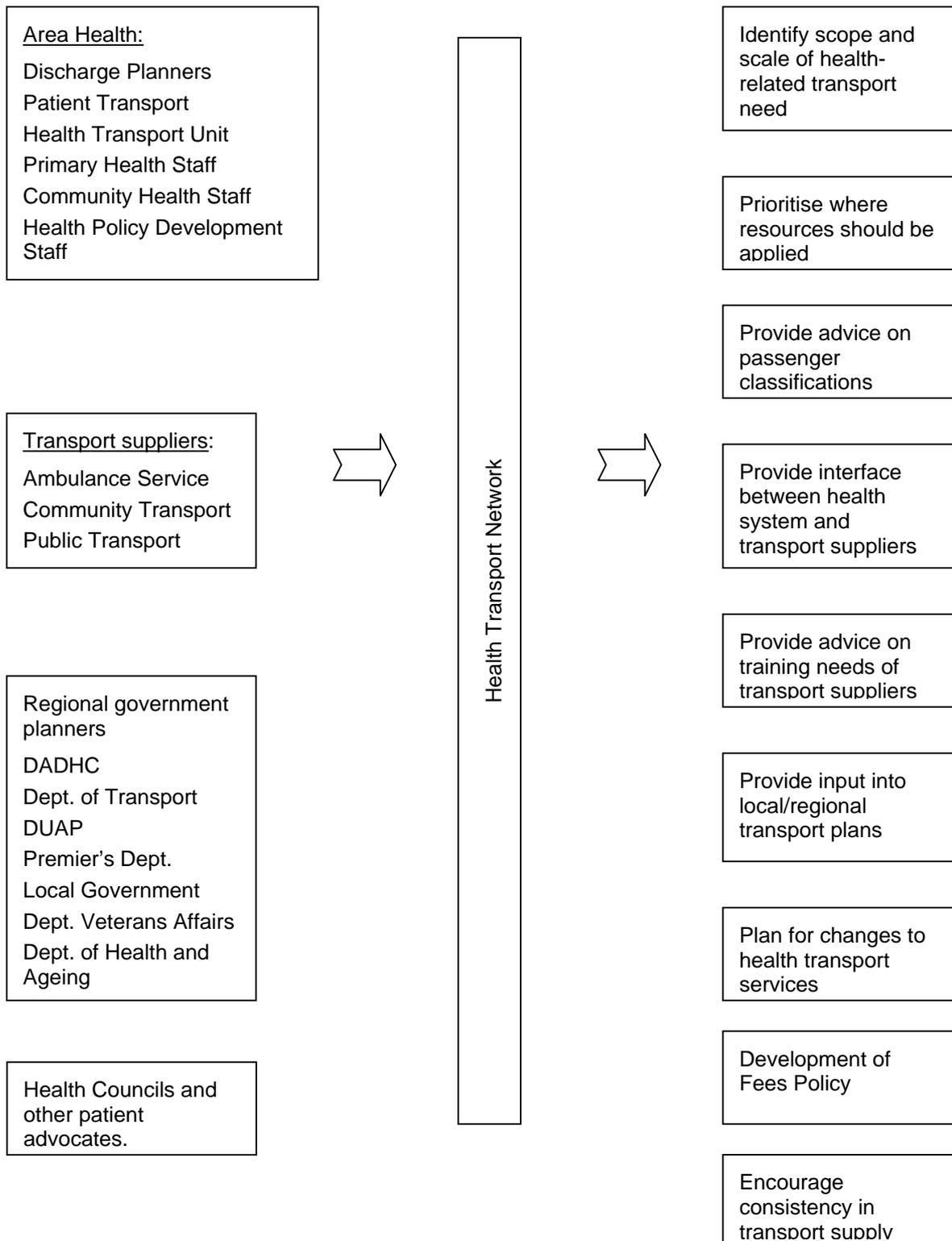
Effective links, therefore, will need to be forged between the Health Care Transport Networks and the Primary Health Care Networks. In some circumstances the Primary Health Care and Transport Networks may share the same staff. Where this is not the case protocols that create effective linkages may need to be developed.

Links also need to be maintained with relevant Commonwealth Departments and programs, in particular the Department of Health and Ageing. The health transport needs of residents of low level aged care facilities may require the Networks' particular attention in some areas.

**Figure 7.3 Function of Health Transport Networks**

INPUT

OUTPUT



The Network will incorporate the outcomes of the whole of Government Strategy on community transport.

Healthshare is a broader concept just announced by the Minister of Health. It is an integrated regional health services model that may be used to determine and deliver the most appropriate mix of services to meet the health needs of people in a particular geographic area regardless of who funds the services. Obviously, the needs of transport disadvantaged patients will need to be considered within this context. It has been suggested that health-related transport could be included in the Healthshare model at some stage. An existing small scale model of integrated funding, the Maitland After Hours GP service, has a “get you home” transport element that has proven to be very effective and cheap to operate.

## 7.8 Resourcing the model

It is proposed that the model will have two major sources of funding:

1. internal funding from Area Health Services from savings made from more efficient provision or purchase of patient transport services;
2. funding provided through the Health-Related Transport Program; and

In addition there may be scope to invest some of the savings from the more efficient use of hospital facilities in the model.

### 7.8.1 The Health-Related Transport Program

The Health-Related Transport Program was established by the NSW Department of Health in 1999, in recognition of the growth in demand for travel by community transport services to health facilities. The program is intended to target clients whose access to mainstream health-related transport services is limited by health, physical, social or geographical factors. There is no age restriction on eligible clients. The transport to be provided is aimed at assisting at a number of points during a patients journey through the health system including:

- at the point of entry to the health care system, eg attendance at a community health centre or hospital;
- at the interface between different parts of the health system, eg transfer between hospital, community health centres and other services;
- at the stage where continuing patient access to the health system must be ensured eg, rehabilitation, day care, dialysis etc.: and
- at the point of exit or follow-up, eg attendance at outpatient clinics<sup>72</sup>.

The Health-Related Transport Program is modest in monetary terms with an annual disbursement of \$800,000, but is important to those transport disadvantaged people in the community who benefit from the services it funds. The underlying principles and objectives for allocating funds through the program are:

*“Identification of unmet need in health-related transport in geographic areas is difficult to quantify. To address this, community transport organisations will need to liaise with their relevant Area Health Service to determine the level and type of services which can best meet current and future health service needs.*

*The following objectives will be used as guiding principles for allocating the additional funds:*

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<sup>72</sup> NSW Department of Health (1998) *Framework for the Allocation of Funds for Health Related Community Transport*, internal document.

- *to reduce inequities between and within Areas;*
- *to increase community access to appropriate health-related transport;*
- *to enhance the interface and coordination between community transport and the needs of health services to identify clients needs and maximise the use of existing and the new health funding; and*
- *to build on current health-related transport infrastructure provided by existing community transport providers.”*

The proposed management model enables these objectives to be realised more effectively than at the present time.

#### Administration of the program

Under the model the program will continue to be funded by the Department of Health at a State level. At a regional level funding under the program will be directly administered by Health Transport Units within Area Health Services.

#### Funding distribution

Under present arrangements the distribution of funds among the 17 Area Health Services is uneven and inequitable due to the original submission based process. Funding to organisations through individual Area Health Services ranges from \$94,000 to \$22,000 with over \$90,000 per year allocated to the Far West and Northern Rivers but under \$30,000 allocated to Macquarie, Central Coast and Central Sydney.

It should be noted that although funding is distributed widely across the State there are many areas in which no Health-Related Transport Program funding has been allocated and no services provided under the program at all.

It is proposed that a new Transport Resource Distribution Formula be developed that will take into account the number of people in each region, relevant population characteristics, the availability of transport services and the distances to key health facilities. This will create a more equitable distribution of Health-Related Transport Program resources and is consistent with the original intentions of the program.

However, it is not recommended that a redistribution of existing funds take place as the resultant reduction in service levels in some areas may be seen negatively in the communities concerned. Use of the formula would best be confined to any future growth in the program.

Application of funding at a local/regional level would be undertaken by Health Transport Units on advice from the Health Care Transport Networks.

#### Budget holders

The primary budget holders for the Health-Related Transport Program are to be the Area Health Services. This is consistent with the notion that because the policies and decisions of Area Health Services will suppress or stimulate the demand for health-related transport, the Services should be able to shape responses to that demand. The Department of Health will directly fund Area Health Services, not individual NGOs, private contractors or health facilities for the provision of transport.

#### Use of the funding

At Area Health Service level the Health-Related Transport budget will be divided into two parts. This is in recognition that patients access health-related transport in one of two ways:

1. Through Area Health Services - In-patients generally access transport through internal Area Health Service processes (e.g. transport is approved by clinicians on wards or at clinics). Outpatients who require regular transport may also access

transport services through internal Area Health Service processes, particularly if a clinic or unit has a transport resource (usually a minibus) attached to it.

2. Through Community Transport Operators - Other outpatients with no access to private transport who require regular transport and those that need transport on an irregular basis tend to be referred to or self-refer to community based transport providers.

Therefore it is proposed that the funding be divided into two pools. The first pool will be used by the Area Health Service for the following purposes:

- the purchase of transport services for regular or irregular transport as identified internally within Area Health Services. Such services could be purchased either in-house or from external suppliers;
- supporting the training needs of all providers of health-related transport; and
- supporting the Health Transport Coordination Network (see below).

The second pool, which should represent the bulk of the funding, is to be used to contract outside agencies to:

- identify appropriate clients;
- classify them in relation to the transport services available;
- refer them to suitable transport operators; or
- provide them with direct transport services.

Such services would be paid for by the Area Health Service Health Transport Unit at a set, negotiated rate. At this time, most of the external contractors are likely to be Community Transport operators given their knowledge and experience in this field.

Health-Related Transport Funding should be quarantined from any use except that described above.

### **7.8.2 Area Health Services internal funding**

Area Health Services currently spend significant amounts of money on the purchase and supply of patient transport services. On the basis of a stocktake undertaken by the Department of Health it is estimated that Area Health Services spend over \$10 million per year on the provision of non-emergency transport. This does not include funds spent on the purchase of non-emergency Ambulance Services or taxi vouchers. The recent development of AHS patient transport services which partly replace the use of the Ambulance Service for non-emergency transport, has led to significant savings in some areas. In large Sydney Hospitals the establishment of Patient Transport Services is reported to have brought about a significant reduction in the cost of non-emergency transport. The development of the Health Transport Units and Patient Transport Services will result in further savings that should be used to support the proposed model. Savings from the continued centralisation of services or shorter patient stays in hospitals could also be used to contribute to the transport budget.

## **7.9 Other issues**

### **7.9.1 Patient Discharge Planning**

In order to ensure the smooth transition of patients between hospitals and home, effective discharge planning practices must be in place. Such practices are described as “the quality link between hospitals, community based services, non-Government organisations and carers”, in a recent circular distributed by the Department of Health<sup>73</sup>.

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<sup>73</sup> NSW Department of Health (1996) *Principles of Discharge Planning*, Circular 96/21.

### Lack of transport as an impediment

However, a recent survey by the Department<sup>74</sup> shows evidence that transport remains one of the key impediments to effective discharge planning. The survey report identified that the three most frequently mentioned impediments that prevented timely discharges from hospitals were patient/family related (120 mentions), community related (112 mentions) and system/process related (107 mentions).

- Of patient/family impediments, having no transport or relatives able to collect the patient was the most common (39 mentions).
- Of community related impediments, the lack of community support services (which include transport) was the equal highest impediment mentioned (50 mentions). The third most commonly mentioned strategy to address these impediments was a better transport system (7 mentions).
- Of system/process related impediments, a lack of transport rated fourth highest (10 mentions).

Another of the system/process impediments that was identified was a lack of communication between stakeholders.

### Strategies to address transport impediments

Four strategies are proposed to address these weaknesses in the discharge planning process.

1. The identification of appropriate transport from hospital to home to be written into discharge policies and implemented through discharge planning processes at Area Health Service level.
2. Transport to be included in every patient's discharge plan on admission.
3. Discharge dates to be identified on admission to provide time to arrange appropriate transport arrangements.
4. Discharge planners or Nurse Unit Managers (where appropriate) to be permanent members of the Health Care Transport Networks.

The Department of Health has indicated that one of the key issues to be addressed in a proposed audit of discharge planning practices will include barriers to effective discharge including the availability of community services including transport<sup>75</sup>. The results of the audit should be made available to Health Transport Units and Health Care Transport Networks to assist them in their task of prioritising where and to whom health-related transport services should be provided.

### **7.9.2 Alternative transport suppliers**

There is a limited range of providers of non-emergency passenger transport services in NSW. This is, by its nature a limited market, however, the narrow choice of suppliers is, in part, due to restrictions on who can provide such services imposed through the provisions of the NSW Passenger Transport Act (1990). Changes to the Act or its regulations are outside the scope of this project.

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<sup>74</sup> NSW Department of Health (2000) *Current Discharge Practices Survey*, Compiled by the Nursing Branch for the Nurse Completed Discharge Working Party.

<sup>75</sup> NSW Health (2001) *Shared Responsibility for Patient Care between Hospitals and the Community – An Effective Discharge Policy*, p 4.

### Public passenger services

The Passenger Transport Act governs who can provide “public passenger services” to entities that have been accredited by the NSW Department of Transport.

The supply of transport services is governed in that accreditation is available for only a narrow range of service types including regular passenger, long distance, tourist, charter, taxi, private hire car and community transport bus services.

Overall, the current accreditation system suppresses the supply of public passenger transport operations. This is most keenly felt in small country communities that have no bus service and where there is often no taxi service either. Where there is a taxi service, the services offered are usually restricted to an exclusive ride operation which makes travel expensive and not affordable by many people. Even where there are commercial bus contracts in place, the services that are provided are usually based on fixed routes and often run infrequently. In most small towns fixed route services are inappropriate and attract relatively few passengers.

There is a need to examine the current regulatory system in terms of finding ways of encouraging the supply of additional operators of public transport services, particularly in rural communities that have restricted transport options at the present time. Two recent initiatives of the NSW Department of Transport may assist in this regard. They are a review of the regulatory framework for community and courtesy transport services, to be completed by the end of August 2001 and the development of a Rural and Regional Transport Strategy which will include examining methods of improving access to services by public transport in major regional centres and the implications for smaller towns.

#### **7.9.3 User side subsidies**

Another method of enhancing the ability of transport disadvantaged people to access health facilities is to provide subsidies directly to the users of both formal and informal transport services.

For example, there may be scope to expand the Taxi Transport Subsidy Scheme which is funded and administered by the NSW Department of Transport. This scheme is, at present, restricted to passengers who have permanent mobility restrictions but could be expanded to encompass people with temporary mobility problems.

As noted earlier in this report, there is heavy dependence on carers to provide transport assistance to people with disabilities and some older people. The Carers Association of Australia has recently promoted the idea of a Carers Transport Allowance<sup>76</sup> to “remove one of the major costs of caring”. They suggest that the allowance could be used to assist the carer to enable them to access medical services among other destinations. The allowance would enable carers who cannot use public transport to pay for transport assistance for themselves and the person(s) they support. The Association suggests that the allowance be set at the same level as the Mobility Allowance but that both allowances be set at a higher rate than at the moment.

If the transport needs of carers are to be addressed by Government, this may be an alternative to the direct subsidy or funding of transport suppliers.

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<sup>76</sup> Carers Association of Australia (2001) *A Fair Go for Carers*, Sydney NSW.