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Position Paper

Transport and access to health care services for older Australians

May 2007

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1. Introduction

1.1 Purpose

The quality of older people's health is inextricably linked to their capacity to get transport to health services. The present lack of transport to take older people to health care is a barrier to good health.

This transport barrier prevents older people getting to both local and distant health services. For example, older people find it difficult to get transport to General Practitioners, to physio and occupational therapists, to x-ray services or to regular life-supporting care such as dialysis units. They find it difficult to get to pathology services for one-off tests and for the regular tests needed for chronic disease management, and difficult to get to dentists for prevention or treatment. It is transport to routine and preventative health care, as well as to specialist services and acute care centres, that older people need to limit the decline in their health. Investment in transport to health care will reduce the cost burden associated with the use of acute care services by older people that results from their inability to get to preventative and ongoing care.

The National Aged Care Alliance (the Alliance) calls on the Commonwealth Government to agree, through the Council of Australian Governments, to include in all Australian Health Care Agreements in 2008, criteria and funding to ensure that lack of transport to health care services does not continue to be an impediment to the good health of older Australians.

1.2 Proposal

The proposal has two aspects:

- That resources for transport be factored into the delivery of all components of the health care system to older people including primary health care, rehabilitative care, community care and acute care services. Additional health sector funding will be required to provide this transport. Existing transport programs, services and subsidies may be reviewed or resources reallocated; however, there are not currently resources within health systems that can provide transport services to meet the needs of older people accessing health care.
- That public and community transport services, and programs provided through the private sector, be restructured with the intention of meeting the needs of people to get to health care; ie. to meet the needs of the large and growing proportion of our population that is older, as well as servicing the needs of people who travel to work and to school.

To achieve these, the Alliance seeks that Australian Health Care Agreements include requirements for jurisdictions to provide transport that supports access for older people to the health care they need. Minimum criteria to be met by jurisdictions to be funded under their Agreements include:

- The provision of transport services in all health services, attached to the health care of the client;
- Access to the transport provided must be available to the client at the time that arrangements are made to attend the health service, and must be contactable through the service for both the client and their carer or support person;

- That transport for travel of the client to the service, or the practitioner to the client is based on the provision of the most appropriate health care;
- Transport for carers and/or support people to accompany an older person to and from health services;
- That the transport needs of all older people in gaining health care be met, irrespective of their geographical location within each jurisdiction. Jurisdictions must allow for the travel needs of regional, rural and remote clients and for the travel needs of older people travelling locally and within metropolitan areas;
- The requirement that travel services be both appropriate and affordable to the individual client and their carer, allowing for differing levels of mobility and for differing capacities to pay;
- Travel that is provided for all forms of health care service; acute, primary, allied, preventative and rehabilitative;
- Transport that supports access of older people irrespective of actual age, frailty or current health status; and
- Reciprocal arrangements that allow for travel between jurisdictions to access health care facilities that are also to be funded under the Agreements.

Rather than specifying models, the Alliance proposes that Australian Health Care Agreements with jurisdictions include transport delivery based on identified criteria. This approach allows jurisdictions to establish services on a range of models that are appropriate for the particular needs of their local communities, geographical distribution and demographic structures.

2. Options for the provision of transport for health

The House of Representatives Standing Committee on Health and Ageing identified that innovative approaches to transport were possible through the better coordination of the total transport infrastructure and brokerage arrangements for transport services that give older people door-to-door service[1].

Importantly, it judged that:

> "Health-related transport is one area where door to door service would be ideal."

The UK Department of Health is currently exploring options for health authorities to commission transport, as well as develop options and advice on getting to health care services; and the issues around accessibility (whether people can get to key services at reasonable cost, time and ease) will be factored into future planning of services[2].

In Australia, the House of Representatives committee has acknowledged that:

> "To date transport policy for older persons appears to have been considered largely in terms of concessions. Overseas research demonstrates that other factors (accessibility, reliability, safety) must be taken into account.[3]"

A review of existing funding models may assist identification of innovative approaches to existing funding arrangements. Alternatives to concessional models include:

- Introduction of transport subsidies into transport funding streams; eg. residential aged care, so that providers are required to provide older people with transport to health and other community services;
- Reallocation of funding earmarked for transport concessions to supporting more door to door and community transport initiatives;
- Inclusion of a transport component into Medical Benefits Schedule items for chronic disease;
- Investigation and/or pilot of a brokerage model to improve the accessibility and flexibility of patient travel assistance schemes for older people in rural and remote areas where public transport services are non-existent; and
- Models that draw on the specific skills and knowledge of local governments.

There may be aspects of the Repatriation Transport Scheme (Department of Veterans' Affairs) and in the Home and Community Care Program that inform agreements with jurisdictions on the provision of transport for health care. State and Territory government fund a variety of programs[4] providing subsidised transport and coordinating access to existing transport. Local governments are also active in the provision of transport for older people. The Australian government could support jurisdictions through knowledge sharing and evaluation about such models, as well as with cross border arrangements for travel for health care. A national stocktake of community and public transport programs could reveal options.

Lack of accessible transport means that some older people do not seek assistance early and may not attend health services for preventative or rehabilitative care. The resultant cost of ambulance transport and treatment in an acute care facility is significantly more costly than investment in accessible transport for health care earlier in the health episode. There is considerable anecdotal evidence that supports the value of early investment in older peoples' health through the provision of accessible and affordable transport. Documentation of the value of the impact of this form of early intervention would usefully inform the development of the 2008 Australian Health Care Agreements.

Communities expect and deserve the ability to influence the decision made regarding transport services and access to health care. Existing health consumer forums provide a starting point for the creation of services that reflect client experience, and groups with high health care transport needs are a prime source of knowledge for the development of appropriate and accessible services. Health care providers are also in a unique position to provide observation and input to the development of transport for health care.

3. Transport for health care

Access to appropriate transport is a strong determinant of whether people will get the health care they need. Nearly one-third of older Australians report needing assistance with personal activities; health care and transport are identified in the top three areas where they need help[5]. Despite this need, the Australian Institute of Health and Welfare reports that transport is the area with the highest proportion of older people reporting that their need for assistance was completely unmet[6]. The Institute also notes that such figures "do not tell the full story" as those persons receiving some assistance may also not be having their needs fully met.

The actual number of journeys to and from acute care and treatment facilities is increasing. A recent study into the use of hospital beds by older people in Australia found that although numbers of older patients and episodes of care increased between 1993 and 2002, the proportion of beds occupied by elderly patients remained stable at about 47%. The researchers suggested that this might be due to reduced length of hospital stay and the associated increase in episodes of care[7]. Hospital separation rates for older people are increasing at double the pace of the under 65s (38% versus 19%).

The link between transport and access to primary and rehabilitative health care by the elderly in the community is increasingly important. In the first quarter of 2006 almost 22,000 General Practitioners were reported as providing Medicare services, of which only 46% provided a standard home visit. The number of home visits provided by General Practitioners fell from 1.76 million in 2000-2001, to 1.05 million in 2005-2006[8]. General Practitioners aged over 65 are about six times more likely to do home visits and five times more likely to visit residential aged care facilities than those aged under 35[9].

Furthermore, the Alliance believes that often better care can be provided at the practice, particularly where a General Practitioner is co-located with diagnostic and allied health practitioners.

The increasing incidence of dementia is further disadvantaging access to health services for people with dementia. At present there are over 220 000 Australians with dementia. It is estimated there will be over 50 000 new cases in 2007[10] with this increasing to 70 000 new cases annually by the end of the decade[11]. People with dementia often have difficulty accessing public and community transport. The length of time waiting for either the public or community transport often adds to the confusion of the person with dementia. This group of people are commonly considered to be unsuited as passengers in public or community transport and in taxis. Often it is just too hard for families to get the person with dementia to the doctor/hospital appointment transport being one issue and the other is for people with moderate to later stage dementia two people are often needed to accompany the person. They are considered to be unfit to drive from an early stage of the disease. Many people with dementia are cared for by ageing family members who may themselves have difficulty accessing transport. However, they require a range of health services frequently, whether living in the community or in residential care. The increased prevalence of dementia and lack of access to health care as a result of a lack of transport services will be likely to result in premature access to long term residential care and emergency care in hospital costs.

There have been efforts[12] to fund the provision of age-specific health services and these have been moderately successful. However access to these services is clearly associated with whether a person or the health care provider can travel to and from facilities and whether there is funding within the health system organisation to support such models in the community.

Box. 1 Can we predict future transport requirements?

The changing demographic and models of health care delivery raise a number of questions:

- What are the implications of older people preferring to age in place?
- Will treatment and management of conditions and illnesses be undertaken in several different sites in the community?
- How will their need for transport assistance to access health care be met?
- What will this mean for independent or other travel?
- How can the needs of isolated and vulnerable older people who lack access to the support of family and friends be addressed?

Carers Australia 2006

3.1 Private Cars

Currently, private cars are the most accessible and convenient form of transport for most of the population, and other forms of transport are provided largely as an adjunct to cars. The gap between the capacity to get about on a daily basis by privately owned car, and the capacity to get about using any other form of transport service, is very wide. Anyone who cannot afford to buy, maintain and run a car, or does not have the capacity to drive, and who does not have a spouse or other family member who can drive them, will restrict their travel behaviour to the few options available to them.

Older people are a population group with limited access to private cars because they experience a coincidence of the factors including:

- Fixed incomes that can be prohibitive to owning and running a car;
- A high likelihood of declining fitness to drive, and of actual incapacity to drive; and
- Low likelihood that a spouse or other family member lives with them or close by.

Currently jurisdictions variously respond to matters relating to fitness to drive. These responses focus largely on technical aspects of driver assessment. Little is provided to address the travel needs of the person being assessed and the impact on their health and wellbeing of lost capacity to drive.

It cannot be assumed that people have a family member or friend who can drive them to health services as and when required. Research conducted by the UK Government found 31% of people without a car and 17% of people with a car have difficulties travelling to their local hospital. More than 1.4 million people said they missed, turned down, or chose not to seek medical help over the previous 12 months because of transport problems[13].

Members of the Alliance report similar experiences in their constituencies[14].

Furthermore, people with health problems that limit their mobility may not be able to travel in the types of vehicles owned by their friends and relations[15].

3.2 Taxis

While taxis can potentially offer the flexibility required by older people for travel to health facilities, there are many barriers to their actual use. Cost is an obvious limiting factor for people on fixed incomes; however, older people face many other barriers to using taxis to get to health services.

In a suburban setting, travel to local health services is commonly only a short car ride. However, irrespective of regulation, many taxi drivers will not take jobs that are for short distances. In addition, there can be delays if seeking a taxi outside a central business district. Many older people have experienced lengthy delays and missed medical appointments, or cannot get a taxi at all if they need to travel to a health service during times of peak taxi demand. An older person is faced with the uncertainty that they will be on time for a medical appointment, followed by uncertainty and delay in getting home.

Waiting for taxis also creates anxiety for some older people if they are not able to wait in a reception area, or if they have to wait for long periods without access to a toilet.

Older people with dementia and with visible illnesses can be refused travel in taxis as drivers fear incontinence. While many drivers assist older people into and out of the car, and help with baggage or walking aids, there is no guarantee that an older person will get such assistance. This is a source of anxiety for older people who are feeling vulnerable in ill health. Some older people also have fears for their safety, whether that be a fear of falling or of being assaulted, defrauded or robbed, irrespective of the actual high level of safety experienced by older people using taxis.

Subsidised taxi programs are focussed on people with long term and ongoing disabilities or limited mobility. The length of time and capacity to attend several locations (eg. doctor, photographer, justice of the peace) that is required in the application process, as well as eligibility criteria, prevent older people with acute conditions from accessing these programs to get to the immediate health care they require. People who are eligible face a restricted number and length of subsidised journeys and so affordability is still a barrier. There are relatively few access cabs and so older people cannot rely on one being available at the time needed for a medical appointment. Furthermore there are competing demands for larger taxis that people with walking aids or wheel chairs can use as the vehicles are also required for groups travelling (eg. for school and childcare). This can be a particular problem for attendance early in the day for acute care such as day surgery.

The needs of older people to travel to and from the health care they need are not being met by accessible and affordable taxi programs provided in isolation from the delivery of health care.

3.3 Access to public transport

Traditionally, public transport has been provided to get adults to work and children to school within well populated areas. Its provision continues to reflect those routes. Public transport provision is effectively

restricted to urban areas, and operates on hub-and-spoke route designs. This design has limited relevance for older people who need to travel locally and to travel across suburbs. Older people do not have fewer transport needs than others in the population[16]. Rather, older people have different needs that include more travel to health care services. General Practitioners may be only a few kilometres from where a person lives but not on a direct bus or train route. Acute care centres are often not located close to commercial and shopping facilities, and can have infrequent bus services. Rehabilitative and allied health services may be distant from other medical services such as the General Practitioner and pharmacies, limited an older person's capacity to go to the range of services that may be required at any one time.

If an older person does not live close to a public transport route, and is not able to drive or be driven to a route, public transport becomes inaccessible for them. The condition of footpaths and walkways, and fall hazards such as uneven pavers and tree roots, can restrict access even for ambulatory older people. Access is further limited for those using aids such as walking frames, and for people with poor continence.

While older passengers are likely to pay reduced fares for public transport, the cost can be prohibitive when many trips are required (eg. to travel to a number of health services over a period of time that is not covered by a single fare). If an older person goes to their doctor, then needs to go for tests or x-rays, and needs to return to the General Practitioner, the cost of fares as well as accessibility and time can be prohibitive.

Recent research of Sydney residents showed some elderly were too frail to use public transport and for others the services were just not there (eg. locations of a bus route or stop). Making better use of existing public transport infrastructure has real potential but requires an approach that is strategic, addresses wider needs than work and school travel, and that includes cost benefit analyses beyond infrastructure investment.

Box. 2 Public transport in rural areas

In most rural areas of Australia, the public transport infrastructure is minimal. Public transport is often not available to required destinations, especially regional centres or, where it is available, may not meet the needs of older people due to timetabling and route constraints, or expense. Instead residents rely on family, friends and volunteers to transport them to services in their local town or more distant centres such as the nearest regional centre or capital city for health or medical appointments. Alternatively, overworked health and aged care staff take on this role, volunteering to transport clients in their own time, creating a reliance which is unsustainable.

Aged & Community Services Australia and the National Rural Health Alliance 2005

3.4 Community transport

Community transport provides free or subsidised transport from the home to shops and services. It can be provided in a variety of ways – using company or private cars, community buses or vehicles located in the community primarily for other purposes, such as a school bus.

Community transport potentially offers flexibility for people without access to private cars or taxis that is not offered by public transport. It can, for example, be useful for transport to local health services and those not on standard transport routes. Research conducted with Sydney residents (mentioned above) found that community transport prompted greater satisfaction rates than public transport[17].

A number of barriers to the successful implementation of community transport have already been identified, including:

- Complex funding arrangements and an overall lack of funds (eg. for vehicle replacements);
- A lack of coordination between different government agencies, each of which provides transport in some form. Community transport is the responsibility of a range of portfolios across jurisdictions, and is not accessible through a central point;
- Program funding arrangements which mean that some members of the community who do not meet the criteria for access remain isolated from community activities if no other form of transport is available;
- Lack of appropriate supports for volunteers (often older people themselves);
- Decline in the number of volunteers able to assist such services as the volunteer population itself ages;
- Incapacity of community transport to meet the demands of early morning attendance (eg. for day surgery procedures), discharges late in the day or at short notice, or any medical travel required out of hours, as community services tend to operate within standard office hours; and
- Insurance and fuel costs.

Furthermore, these barriers are exacerbated in rural and remote areas where services are more expensive to operate than in metropolitan areas[18], and where smaller populations can mean fewer volunteers are available.

The Home and Community Care program in some areas provides transport assistance to elderly and disabled people but there are difficulties with accessibility and scale of provision. With the reported shortage of CACPS and EACH packages available to people in the community, there is a substantial unmet demand for these people with mobility issues, which is likely to increase as Government policies lean towards people 'ageing in place' in their own homes. There are transport services available to assist people eligible for care under Federal Department of Veteran's Affairs programs[19].

3.5 Rural and remote transport issues

The National Rural Health Alliance identified transport as one of the three key issues impacting on older people in rural and remote Australia. The realities of transport barriers to health care for older people are well documented in papers by the National Rural Health Alliance and Aged and Community Services Australia[20].

Research conducted by Blue Care in 2006 indicated transport was constantly raised as a concern when country people had to travel to major regional hospitals or for specialist appointments in larger regional centres. This requirement is increasing given the loss of many localised health services, with many services now only available in large regional and metropolitan centres.

In many instances public transport between towns is simply unavailable meaning that families and/or friends have to transport a person for an appointment or admission to hospital. Further, on completion of a consultation or hospital stay relocating back to an individual's community continues as a problem as the client is again reliant on family or friends.

In the context of discharge from regional hospitals, often the immediacy of the discharge means that transport arrangements have to be hurried or in some cases people have to find overnight accommodation until arrangements are secured.

Further, many people are of the view that travelling to specialist appointments or elective surgery can also be problematic as delays often occur with appointments or admission, or simply elective surgery is cancelled, which means that personal transport arrangements are again thrown into disarray.

State and Territory Health Departments provide varying degrees of financial assistance for rural, remote and indigenous older people who must travel large distances to access specialised medical and hospital services, through transport and accommodation schemes that assist patients' access care that is not available locally[21].

As the population ages, and more people from rural and remote areas require assessment and/or treatment at distant health and specialist facilities, these travel assistance schemes will become even more important in reducing access barriers.

These difficulties with current transport and accommodation assistance schemes include:

- Provision of limited funding which varies between States and Territories;
- Focus on planned clinical care services rather than primary health care;
- Complex administrative arrangements, so that many of those who desperately need assistance do not seek it[22];
- Lack of flexibility to service people who need to cross State/Territory borders for medical treatment; and
- Lack of knowledge amongst patients and providers who are not often aware the schemes exist.

With the decline in the broader infrastructure in rural and remote communities and an inability nor a desire by many ageing people to relocate to densely populated areas, innovative policy is required to redress the impact of diminishing services and the gaps in meeting transport needs.

The Alliance is aware that the Uniting*Care* Aged Care National Advisory Committee intends to pursue rural and remote transport needs, particularly issues related to transport to major regional centres for medical reasons, as a national policy priority.

3.6 Metropolitan transport issues

While transport is thought of as a barrier to health care for people in rural and remote areas, lack of transport is just as significant a deterrent to gaining the health care they need for older people in metropolitan areas. As discussed earlier, unless a person is ambulatory and lives close to a route that takes them directly to the health services they need, current forms of public transport have limited use for access

to health care for older people. Routes that do service health care facilities often have a restricted number of services on the basis that the number of users does not warrant investment.

However, were cost benefit assessments of public transport routes to health care facilities to include the health costs arising from older people not accessing health care earlier, public transport routes to hospitals may well be considered viable.

Issues relating to taxi use for travel to health care have been discussed earlier. The reliability of taxis to get people to medical appointments on time, particularly where it becomes necessary to go to a number of locations, and to get people back home in a timely is a major barrier to an older person seeking health care. Medical appointments that coincide with time of peak taxi demand such as early attendance at a hospital for day surgery, are particularly problematic, even where a person lives quite close to the facility.

The cost of parking at major hospitals, the limited parking available, and the complexity of getting into carparks is frequently a deterrent to a family member driving an older person to a city hospital, particularly where the family member is themselves an older person.

Services and medical officers have many stories of older people in metropolitan areas putting off seeking medical attention until they become unwell enough to require ambulance transport to an acute facility.

4. The need for accompanied travel

Some older people are not able to travel alone to get the health care they need. This may be due to underlying health conditions that affect mobility or cognitive capabilities, or may be as a result of current treatment. Early discharge, attendance as outpatients, day treatment at doctors' surgeries mean that older people must travel more frequently for health care, often under circumstances when they require support while travelling. Services providing for travel accompanied by medical or para medical staff will continue to be in demand. There is current, largely unmet, demand for transport for carers or support people to accompany older people to and from all types of health service.

Many carers of older people are themselves elderly, are frequently spouse carers, and may have a disability or health problem. Other carers face a range of transport and non-transport related barriers to accompanying the older people for whom they are responsible. In many cases younger relatives and friends who are carers and support people do not have access to private means of transport that is affordable or appropriate for assisting older people to attend medical and other health appointments. Relatives and friends also face significant competing responsibilities for care and transport of other family members, and those in employment have limited opportunity to provide transport for health care to older people in their care. Professional and community volunteer carers face complexities and limitations on access to transport that enable them to accompany the person in their care.

There are also particular problems that arise for rural and remote older people and their carers who may need to travel considerable distances to access their health care. Likewise people who need to travel frequently (eg. for chronic disease management) face affordability as well as availability issues that limit their capacity to attend health services.

5. Transport and older Indigenous Australians

In 2006, Blue Care developed an Indigenous Care Strategy, which involved consultations with over 600 people, 25% of whom were Indigenous. Whilst many issues were raised in rural and remote Queensland regarding aged care, and not necessarily specific to Indigenous people, the two consistent concerns expressed were transport and transition care.

Overall, Indigenous people living in rural and remote Australia have lower income and are less likely than others to have their own transport. Transport to mainstream health care services for Indigenous people is a huge concern, with people facing considerable barriers to attend treatment at major regional centres. They also experience more cultural difficulties when dealing with that system.

In most cases, local Indigenous service providers are not funded for transporting people for medical reasons nor are services at the 'receiving end' funded to provide supports, leaving Indigenous people totally reliant on a carer (usually a person designated to accompany the patient) to transport them to services. Indigenous carers face all the pressures of non-Indigenous people in trying to provide transport and/or accompany older people to health care services. However, the burden of ill health compounds the barriers. Carers Australia has provided a case in which an Indigenous person in need of dialysis had to rely on the capacity of her carer to interrupt her daily employment to provide transport as no other form of accessible transport was available.

The National Rural Health Alliance considers that the lack of additional assistance and other resources such as inability to travel at certain times, lack of communication and understanding of the system, all significantly contribute to Indigenous patients' non-attendance for care and treatment, contributing to significantly higher mortality rates.

Research with Aboriginal Communities and other stakeholders in South Australia documented the impact of lack of transport, and inappropriate transport, including unaccompanied transport, for rural and remote South Australians seeking to use health care services for regular as well as one-off treatment.

With respect to post discharge, the issues for the ageing population in remote Indigenous communities, are no less complex as attested to recently in the Northern Territory where aged people who had returned to their communities, but with no arrangements in place, wandered into the bush and died.

The problem for Indigenous people, even before they are returned to their country is the plethora of services to navigate in the regional centre which may include but may not be necessarily restricted to - hospital admissions officers, Indigenous health services, hostel or other accommodation options, discharge planning, transition care options – all which may occur before or after a person is admitted.

Given the health needs of Indigenous people particularly from remote communities transport is an ongoing concern.

6. A strategic approach

An ongoing Australian parliamentary inquiry into health funding was told recently of the potential to use innovative transport models to overcome transport issues:

> "Transport might be a health care service…In our after hours service we provide free transport to people because it turns out that that is the most cost-effective way of managing people when there is a doctor shortage. You bring people to the doctor; you do not necessarily bring the doctor to the people. It is cheaper, so transport is actually a health service provision."[23]

From an Alliance perspective, there seems to be a real opportunity for policy action in this area based on the growing overseas and local evidence of awareness of transport and access to health care issues for older Australians. The Alliance supports a strategic approach to developing policy on transport and access to health care services, regardless of geographical location, as the first step in piecing together what is currently a fragmented system.

A mechanism is required that enables and requires all jurisdictions to provide transport that gets people to and from health care, with the flexibility for jurisdictions to meet the specific demographic and geographical needs, and that allows for cross border travel to be funded. Therefore, the Alliance proposes that this discussion take place at the Council of Australian Governments as a matter of urgency, with consideration given to how transport to health care services for older Australians will be resourced in the 2008 Australian Health Care Agreements.

Further, the Alliance proposes that the 2008 Australian Health Care Agreements contain a supplement for transport of older people to health care services. In such a system each jurisdiction would meet defined criteria in order to access funding, but would have the capacity to adapt to meet local needs within their jurisdiction.

Appropriate work to identify and agree on those criteria is required for their inclusion in the Agreements.

7. Appendices

7.1 Appendix A. About the National Aged Care Alliance

The National Aged Care Alliance (the Alliance) is a representative body of 26 peak national organisations in aged care including consumer groups, providers, unions, and health professionals, working together to achieve a more positive future for the aged care sector in Australia.

The Alliance was formed in April 2000, and has developed a united policy agenda to achieve better outcomes for the care of older people in Australia.

Alliance members are concerned about the future sustainability and funding of aged care services, and are seeking the establishment of industry wide benchmarks of care.

The Alliance's vision for aged care in Australia is that:

All older people in Australia have access to planned, properly resourced and integrated quality aged care services that are flexible, equitable, that recognise diversity and promote choice and respect for users and workers.

The following organisations are members of the Alliance:

Aged and Community Services Australia; Aged Care Association Australia; Alzheimer's Australia; Anglicare Australia; Australian Association of Gerontology; Australian Council on the Ageing; Australian General Practice Network; Australian Healthcare Association; Australian Medical Association; Australian Nursing Federation; Australian Pensioners' and Superannuants' Federation; Australian Physiotherapy Association; Australian and New Zealand Society for Geriatric Medicine; Baptist Care Australia; Carers' Australia; Catholic Health Australia; Diversional Therapy Association of Australia; Geriaction; Health Services Union; Liquor, Hospitality and Miscellaneous Union; Lutheran Aged Care Australia; OT Australia; Pharmacy Guild of Australia; Royal Australian College of General Practitioners; Royal College of Nursing Australia and Uniting*Care* Australia.

More information about the Alliance is available on our website: www.naca.asn.au.

7.2 Appendix B. Scope of Proposal

It is recognised that appropriate transport is essential for maintaining a person's general well being, independence, and inclusion in society, and that older people need safe transport options that preserve dignity, maximise independence, and provide access to the full range of activities that contribute to quality of life. Access to appropriate and affordable transport is vital for older people to get to health and community services. It is also for central to older people's capacity to participate in social, recreational and community events. The Alliance intends to pursue elsewhere, changes to the provision of transport services for older Australians that will improve their wellbeing, along with matters relating to urban housing design.

The scope of this proposal is limited to access to health services as the specific need is for transport to be accessed at the point of health care delivery and through the health system. The Australian House of Representatives Standing Committee on Health and Ageing recently concluded that appropriate transport systems for older people were "not optional but essential"[24]. Therefore, the Alliance, while, acknowledging the breadth of issues surrounding access to transport services, focuses this proposal specifically on transport to health services.

There are other issues associated with access to health services for older people, including access to accommodation for older people and their carers or support people when attending distant health services. However, the lack of suitable transport for older people to access health care is a barrier to good health for older Australians who require care from local as well as distant health services. This proposal is limited to the provision of transport.

Older people may require a carer or support person to attend health services or to travel with them. Transport services associated with health care need to include the capacity for an older person to be accompanied over both short and long distances. This proposal includes transport for people accompanying older people to health services.

7.3 Appendix C. Notes

[1] House of Representatives Standing Committee on Health and Ageing, "Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years", tabled March 2005

[2] "Making Connections: Final report on Transport and Social Exclusion", UK Government, February 2003

[3] House of Representatives Standing Committee on Health and Ageing, "Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years", tabled March 2005

[4] These include patient assisted travel schemes for travel to and from rural and remote locations for acute health care, and subsidised taxi travel for people deemed to have a disability and carers accompanying them. See for example, National Rural Health Alliance Inc. Transport and accommodation for health patients from rural and remote areas, Position Paper October 2005

[5] Older Australians represent 13% of the population; however, their higher need for health services means they are associated with 37% of all hospital episodes and 26.5% of General Practitioner services

[6] Australian Institute of Health and Welfare, "Australia's Welfare 2005", November 2005

[7] Gray et al, "Trends in the use of hospital beds by older people in Australia: 1993-2002", Medical Journal of Australia, 2004, 181: 478-481

[8] Medicare statistics, www.medicareaustralia.gov.au, accessed 9 August 2006

[9] Charles, J, et al, "The independent effect of age of general practitioner on clinical practice", MJA 2006; 185 (2): 105-109

[10] Dementia in the Asia Pacific: The epidemic is here. Report by Access Economics Pty Ltd for Asia Pacific Members of Alzheimer's Disease International, September 2006

[11] Dementia in the Asia Pacific: The epidemic is here. Report by Access Economics Pty Ltd for Asia Pacific Members of Alzheimer's Disease International, September 2006

[12] For example:

- More than one-third of General Practitioners provided a Medicare-funded health assessment (for over 75s, and indigenous people over 55) in the first quarter of 2006. Health assessments are the most established and well used of a new range of age specific Medicare items and more than 240,000 were provided in 2005-2006;
- Only 7% of General Practitioners provided a domiciliary medication management review service in the community, however its use it also on the rise from about 6,500 in 2001-02 to nearly 45,000 in 2005-2006;
- A greater recent policy focus on the decline in services to residential aged care facilities meanwhile has led to small improvements in access to General Practitioner care, with the number of services to residential aged care facilities rose 15% from 1.545 million in 2000-2001, to 1.778 million in 2005-2006; and
- One such program is the Aged Care General Practitioner Panels initiative, introduced in July 2004, which aims to help General Practitioners in the provision of services to aged care facilities through the funding and organisation of panel work. Within 12 months, there were 267 panels across Australia involving 1379 General Practitioners (out of 21,000) and 1760 aged care facilities (out of 3029). Total medical services to aged care facilities increased 5.4% and the number of General Practitioners providing them increased by 202 to 12,278 (Australia Government Department of Health and Ageing, March 2006, Aged Care General Practice Panels Initiative: Report of the Initiative.

[13] UK Government, "Making Connections: Final report on Transport and Social Exclusion", February 2003

[14] For example, older people have a declining chance of receiving a home visit from a General Practitioner. If they live in the outer suburbs, and become ill at a time when health services are not open, they may have to travel some distance to a hospital emergency/outpatients service to get the care they require. Unless a family member is able to drive them at night, the option is to use a taxi. As well as the cost barrier, they may encounter problems in getting a driver who will transport a person who is not well, will accept the job when there may not be a return fare, and will be able to do so in a time frame that meets the person's needs. Having reached the service, the older person may then face the same obstacles to getting home again. Older people often choose, therefore, not to seek medical assistance at that point, leading to the need for later ambulance transport and acute care. See also The National Aged Care Alliance Paper AHMAC and Beyond - A Strategic Framework for Health Care for Older People: At home, in residential care, in hospital and in transition between settings.

[15] While there are subsidised services such as access taxis and low priority ambulance travel, they are restricted by conditions of access, and availability within the timeframes needed to get to and from medical appointments, and do not meet need

[16] Alsnih, R, (supervisors Professor David Hensher and Dr John Rose), "Travel needs of seniors", Institute of Transport and Logistics Studies, University of Sydney, Higher Degrees by Research program, http://www.its.usyd.edu.au/hdrpresentations.htm, November 2005

[17] Hensher, DA, Institute of Transport and Logistics Studies, University of Sydney, "Social exclusion - informed reality thinking on accessibility and mobility in an ageing population", presentation to "Transport, Social Disadvantage and Well-Being", April 2006

[18] National Rural Health Alliance Inc. & Aged and Community Services Australia Older People and Aged Care in Rural, Regional and Remote Australia: National Policy Position. September 2005

[19] The percentage of the population eligible for Veterans' Affairs assistance can be expected to decline as the numbers of World War 2 veterans and their spouses decline

[20] See, for example, Aged and Community Services Australia Older People and Aged Care in Rural, Regional and Remote Australia. Discussion Paper, June 2004; National Rural Health Alliance Inc. & Aged and Community Services Australia Older People and Aged Care in Rural, Regional and Remote Australia: National Policy Position. September 2005; National Rural Health Alliance Inc. Transport and accommodation for health patients from rural and remote areas, Position Paper October 2005

[21] It is acknowledged that in rural and regional NSW, transport services, including those provided by human service agencies, are fragmented in terms of service planning and funding. Attempts are in place to reduce the level of duplication between various agencies providing transport, for example, in the Southern Slopes Division. Health transport networks have been established to improve communication and collaboration between the Area Health Services, health related transport providers and other health service providers. (Healthy Communities in South East NSW: Plan of Action 2004-2007 pp 41. Southern Area Health Service). See also note #4 relating transport programs and coordination in other jurisdictions

[22] National Rural Health Alliance Inc. & Aged and Community Services Australia Older People and Aged Care in Rural, Regional and Remote Australia: National Policy Position. September 2005

[23] Dr Arn Sprogis, Hunter Urban Division of General Practice, Hansard, House of Representatives Inquiry into Health Funding, public hearing, 20 July 2006

[24] House of Representatives Standing Committee on Health and Ageing, "Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years", tabled March 2005