

# *Travelling to Treatment – Patience or Patients*

**A snap shot of the provision of transport to  
medical facilities from communities to the  
North of Brisbane**



Queensland Council of Social Service Inc  
Unmet Transport Needs Forum

# Acknowledgements

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**Travelling to Treatment — Patience or Patients**

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# Travelling to Treatment – Patience or Patients

## Executive Summary

In recent years there has been an increase in the need and demand for non-urgent medical transport. As a result, community based transport providers have expressed concern that there has been a significant increase in the demand for their services and that the demand for out of local area non-urgent medical transport is stretching their resources.

Consistent with its vision and purpose, the Unmet Transport Needs Forum (UTNF) commissioned research of the provision of medically related transport by community based organisations. The areas chosen for study were within approximately 50 km north of Brisbane city and included Pine Rivers, Redcliffe, Caboolture, Kilcoy and Bribie Island.

Six community based transport providers participated in a two phase research project. Phase 1 involved face to face interviews with staff at each of the participating organisations. Phase 2 involved the logging of transport activity over a four week period. During the study period, 864 trips (a one way journey by a passenger) were provided, with approximately half of the trips to medical facilities and the other half were return journeys home. The highest number of trips were within the study area (42%) followed by trips to Brisbane city (39%). Of the trips to medical facilities the majority (41%) were to medical specialists. All except two trips were provided by drivers who were volunteers or unemployed people on mutual obligation.

Passengers mainly approached the services directly with referrals also coming from community health, hospitals and health professionals. Participants suggested that most passengers had limited transport options because of a lack of private transport and the unsuitability of public transport. Community transport was chosen because of cost, service quality, the availability of personal assistance and the use of accessible vehicles when required.

There was a lack of consistency in the level and type of service provided in the different parts of the study area. Access to an appropriate transport service depended on factors such as the size of the local service, the availability of drivers and vehicles, the availability of funding for transport, differences in eligibility guidelines and the size and demand from the “target group” in the local service’s catchment area. The demand for services outstripped supply in some cases. This led to service rationing and referrals to other services where they exist.

Four key issues and concerns emerged from the research:

### **1. Provision and access to services.**

The volume of services provided by each study participant varied a great deal, influenced by the availability and eligibility of funding, the size of the ‘target group’ population in each catchment area, the availability of volunteer drivers, the capacity of the available vehicles and the ability of different community based transport providers to achieve high passenger loadings. Variability in the level and type of service provided by participants raised questions about people’s abilities to gain equitable access to transport and ultimately, equitable access to health services.

### **2. Volunteers and other paid staff.**

Participants relied heavily on volunteers or unemployed people referred from mutual obligation programs to provide transport. For example, drivers who were volunteers or unemployed people on mutual obligation programs provided all except two trips. The heavy dependence on volunteers has a number of difficulties associated with it including; attracting sufficient numbers on an ongoing basis; ensuring appropriate skill levels; inconsistency in availability; reliability; and costs associated with their recruitment and retention.

### **3. Passenger Care Needs.**

Just under half (44%) of all trips had passengers with medium to high care needs requiring some assistance during the trip. With a number of participants reporting that the care needs of passengers are in fact rising. The higher level of care needed impacts on the capacity, effectiveness and efficiency of the transport as a result of increased loading time; type of vehicle that can be used, and type and number of personnel required on the trips. Questions are raised whether community transport is the most appropriate response to people with medium to high care needs.

### **4. Demand for medically related transport**

In Queensland, the demand for medically related transport is likely to rise significantly over the next 10 years as a result of rapid ageing and large increase in population over the age of 75, increase in number of people with disabilities living in the community, increase in incidence of day surgery, earlier discharge from hospital, and specialisation and centralisation of medical services.

Due to lack of affordable and appropriate options, the demand is likely to fall upon the existing community transport providers. One difficulty appears to be that there is no direct link, insofar as health services are concerned, between the implementation of policies that increase transport demand and ensuring that those who need to travel to obtain treatment are able to do so.

## Key Policy Issues

The UTNF considers that the key policy options offered for consideration that underpin these themes in turn are:

1. To improve provision and access to services, consider:
  - ⌚ Application of more flexible interpretation of the eligibility criteria of transport programs (particularly in isolated areas) in order to promote increased utilisation of service capacity.
  - ⌚ Establishment of a non-acute transport funding program – similar in scope to the Health Related Transport Program which is administered by the Department of Health in NSW - that would enable transport disadvantaged people who are not eligible for existing services to get to health services.
  - ⌚ Networking and cooperation between government and non government agencies involved in medically related transport be encouraged. In particular, given the rapid ageing of the population and the increasing care needs of passengers, cooperation should be encouraged in the field of passenger assessment and referral mechanisms.
  - ⌚ Collective use of resources (funding, vehicles etc.) across departments and programs in order to develop flexible and accessible transport programs and services. This could involve some programs or departments 'cashing out' transport money to a non-acute transport funding program, or to a particular transport agency or to a mobility management system.
2. To overcome problems associated with reliance on volunteers, Government, funding bodies and community agencies recognise the real costs of using unpaid workers in funding packages/applications; and commit to a program of skills enhancement for volunteer workers.

3. Mechanisms be established that place appropriate passengers with appropriate transport providers that are affordable to consumers. And that considers the support needs of passengers (carers, walking aids, translators, support workers).
4. That a whole of government approach to the increase in the demand for health related transport be undertaken, including initiatives such as:
  - enhancing transport services through existing and new funding programs;
  - encouraging the development of demand responsive transport services both by mainstream and alternative transport operators;
  - seeking to decentralise some health services in order to minimise the need for transport and
  - implement models eg. brokerage, to maximise the use of existing resources through improved information for potential service users, cooperative practices and the development of innovative service types.

This study has collected information that shows a great deal of community resources are expended on transporting individuals to medical facilities. Despite this, there are still many gaps and overlaps. The UTNF is of the view that doing more of the same to respond to this unmet transport need may not work. Innovative solutions are required. Solutions need to draw upon all the available resources and be appropriate to the local context.

The insights raised in this document are intended as tools for shaping policy development and decision-making at local, regional and state program and government levels. The UTNF also hopes that they will contribute to helping stakeholders to develop innovative responses to the unmet transport needs in their communities.



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## About the UTNF

The Unmet Transport Needs Forum (UTNF) is a coalition of organisations and individuals sharing a concern about the impact of unmet transport needs upon the lives and well being of Queenslanders and Queensland communities.

### **Vision**

A Queensland that supports the quality of life for all through the provision of safe, affordable, and equitable access to goods, services, opportunities and infrastructure, which meet the needs of all individuals.

### **Purpose**

- To engage all affected, interested and responsible parties in and around strategic issues of unmet transport needs.
- To identify and promote the cross-government cross-sector and community analysis of strategically significant issues relevant to advancing the vision and to address those issues by;
  - promoting the vision of the forum
  - influencing public policy and planing processes and decision-making;
  - promoting and facilitating the sharing of information and networking;
  - being a critical friend of the government; and
  - strategically connecting people and their organisations at all levels.

### **Key Task Areas**

- Influencing / Advocacy
- Linking / Networking
- Policy and Planning Development

## Executive Summary

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Consistent with its vision and purpose, the Unmet Transport Needs Forum (UTNF) commissioned research of the provision of medically related transport by community based organisations. The areas chosen for study were within approximately 50 km north of Brisbane City and included Pine Rivers, Redcliffe, Caboolture, Kilcoy and Bribie Island.

Six community based transport providers participated in a two phase research project. Phase 1 involved face to face interviews with staff at each of the participating organisations. Phase 2 involved the logging of transport activity over a four week period. During the study period, 864 trips (a one way journey by a passenger) were provided, with approximately half of the trips to medical facilities and the other half were return journeys home. The highest number of trips were within the study area (42%) followed by trips to Brisbane city (39%). Of the trips to medical facilities the majority (41%) were to medical specialists. All except two trips were provided by drivers who were volunteers or unemployed people on mutual obligation.

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people's abilities to gain equitable access to transport and ultimately, equitable access to health services.

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  - Establishment of a non-acute transport funding program – similar in scope to the Health Related Transport Program which is administered by the

Department of Health in NSW - that would enable transport disadvantaged people who are not eligible for existing services to get to health services.

- Networking and co-operation between government and non government agencies involved in medically related transport be encouraged. In particular, given the rapid ageing of the population and the increasing care needs of passengers, co-operation should be encouraged in the field of passenger assessment and referral mechanisms.
  - Collective use of resources (funding, vehicles etc.) across departments and programs in order to develop flexible and accessible transport programs and services. This could involve some programs or departments 'cashing out' transport money to a non acute transport funding program, or to a particular transport agency or to a mobility management system.
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This study has collected information that shows a great deal of community resources are expended on transporting individuals to medical facilities. Despite this, there are still many gaps and overlaps. The UTNF is of the view that doing more of the same to respond to this unmet transport need may not work. Innovative solutions are required. Solutions need to draw upon all the available resources and be appropriate to the local context.

The insights raised in this document are intended as tools for shaping policy development and decision-making at local, regional and state program and government levels. The UTNF also hopes that they will contribute to helping stakeholders to develop innovative responses to the unmet transport needs in their communities.

## 1. Introduction

Most people travel to and from health facilities for non urgent health treatment in private cars, however there is an increasingly large portion of the population who for whatever reason cannot and therefore rely on other forms of transport.

Queenslanders who require assistance to access centralised medical facilities or specialist services have the following support options:

- Qld Ambulance Service (QAS) non-urgent medical transport – This service is for people who have a medical condition unsuited for public or private transport, or require active management, or stretcher transport. The service is limited to availability and other consumer concerns include carers or interpreters can only travel in company with the nominated person subject to seat availability; persons with mobility aids can not take the aids in any vehicle and must rely on the use of a manual wheelchair at the destination; and wait times can be long.
- Public bus transport - Many health facilities are not easily accessed by public transport, particularly at the hours when many patients have to travel. For many people, public transport is not even an option because of difficulties with access to vehicles, a need for one-to-one assistance or because services do not exist at all.
- Taxis - The use of taxis over a long distance is costly even as a once off trip. Frequent treatment regimes (eg radium, dialysis) makes this option unsustainable. This applies even if the person is eligible for the Taxi Subsidy Scheme
- Patient Travel Subsidy Scheme - This scheme is administered at the hospital level and provides varying levels of transport subsidies (eg 10c per kilometre for car travel, bus fares for coach travel, airfares for plane travel) to patients who can not access particular specialist services in their local area. The scheme is only available when the referring hospital is 50 kilometres from the referred hospital.
- Department of Veterans Affairs Transport Scheme – This scheme provides door to door transport provided by a contracted provider to an approved Medical Officer. Persons must be war veterans with gold cards and their widows or veterans with white cards with approved medical conditions.
- Queensland Health Inter Hospital Transfer Scheme – Provides transport between medical health facilities. Person's must be an 'in' patient of a hospital to be eligible.
- Community Transport – This is the generic term used to refer to funded and un-funded community sector agencies that provide some form of services to deal with these transport needs. Different communities may have one, some or no community transport services.
- Family, friends and carers - who in many instances may need to take time off from their place of employment, also the costs involved can limit the amount of transport given to relatives or friends

In recent years there has been increasing concern voiced by the community regarding the provision of transport services to medical facilities in Queensland.

A report by the Non Urgent Health Transport Working Group (1999)<sup>1</sup> found that because of eligibility criteria, lack of access, and lack of availability many members of the community cannot utilise many of the options outlined above. In addition there has been a significant increase in the need and demand for transport to medical services. This demand has been driven by a number of factors including:

- the rapid ageing of the Queensland population and particular the large increase in the number of people over the age of 75, an age when personal mobility tends to decline markedly;
- the increase of the number of people with disabilities that are living in the community instead of in institutional care;
- improvements in medical technology;
- the specialisation and centralisation of medical services;
- an increase in the incidence of day surgery;
- earlier discharge from hospitals and the concomitant need to return to medical facilities for follow up treatment and
- the fact that stages of treatment (pre surgery procedures, surgery, post surgery procedures and rehabilitation) are no longer provided during one stay in hospital but now tend to be provided on different occasions requiring separate visits.

As a result, community based transport providers have indicated that there has been a significant increase in the demand for their services and that the demand for out of local area non-urgent medical transport is stretching their resources. Catering for this demand is of particular concern for community based transport providers based in areas that are distant from major medical facilities.

The Unmet Transport Needs Forum were therefore interested in conducting a case study of the provision of medically related transport by community based organisations. The areas chosen for the study were north of Brisbane city and included Pine Rivers, Redcliffe, Caboolture, Kilcoy and Bribie Island.

Six organisations participated in this study, this is a representation of community transport providers and by no means the total transports provided by community organisations in the location stated above, or all of the demand for transport.

## **Project Aims**

The brief for the project identified the following objectives:

1. *To identify and document the amount and nature of transport being provided by the sample group of community providers to medical facilities.*
2. *To identify issues and concerns from community transport providers around the delivery of medical related transport provision.*

This information is intended to inform development of strategies that could be adopted by interested or responsible bodies in order to reduce the unmet need for transport to health facilities.

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<sup>1</sup> Gap Analysis Report

## Methodology

The study had two phases.

Phase one involved face to face interviews with staff at each of the community based transport providers involved in the study. The purpose of the interviews was to develop a profile of each provider and to identify issues that affect the provision of transport to medical facilities. For full details of interviews see Attachment 1 – Profile of study participants.

Phase two involved the collection of information about transport services. The area in which the information was collected is approximately 50 kilometres from central Brisbane where most of the tertiary hospitals and many specialist medical facilities are to be found. The six community based transport providers that provide the bulk of community based transport services in the area, were asked to participate in logging transport activity over a four week period during August and September 2001. For full details see Attachment 2 – Survey Results.

Each service was provided with a master copy of a log sheet and drivers were asked to complete a record for each passenger on every journey undertaken during the survey period. A copy of the log sheet is included as an attachment to this report.

Survey responses were coded for ease of use and information on how to complete the log sheets was provided to all drivers in participant organisations. The results were entered onto a spreadsheet for analysis.

The survey period was four weeks during August and September 2001. It should be noted that some small agencies provided relatively few trips during the period and the results should be treated with caution, as these results may not be typical.

Verification and further cleaning of the data took place at a meeting of participants in February 2002.

## **2. Phase 1 – Summary of face to face interviews – Qualitative data.**

### **Study Participant profiles**

Senior staff from five of the six community based transport providers involved in the study were interviewed in order to build a profile of the study participants.

Two were small community based agencies, two were branches of large charitable organisations and one was auspiced by local government.

Four of the five study participants received funding from the Home and Community Care (HACC) Program which is targeted at frail elderly people, younger people with disabilities who live in their own homes and their carers. Three study participants received HACC funding specifically for transport. Other sources of funding included Post Acute funding (Qld Health), Community Aged Care Packages (Commonwealth Department of Health and Aged Care) and the Older Persons Action Program (Qld Department of Families, Youth and Community Care). All of the study participants are depend, in part, on passenger fares or internal agency contributions to operate.

All of the study participants also provide transport to non-health related destinations such as shops and in order to reduce social isolation.

The study participants varied in size and the resources they had available. Fleet sizes ranged from 0 – 6 vehicles, paid staff from 10 – 178 hours per week and the number of volunteers from 6 – 31.

### **Volunteers and unpaid staff**

There was a variable supply of volunteers with two community based transport providers identifying a shortage. Three services used unemployed people referred from mutual obligation programs. In one service 97% of all their driving was undertaken by Centrelink referees.

Most of the study participants indicated that their volunteers were older people and two said they had difficulty in attracting females.

The suitability of some volunteer drivers was questioned and each community based transport provider had different processes in place to vet potential staff. Two providers used a police check and one required a medical examination. There is also variation in volunteer reimbursement practices.

Many of the people referred from mutual obligation programs had poor communication skills and needed training in a variety of areas. It was noted that although training materials (including information about occupational health and safety) were generally made available it was difficult to get volunteers to undertake formal training. The one study participant that insisted on training for all staff had the fewest number of volunteers.

## **Passengers**

Most passengers for transport to medical facilities approached the study participant directly. Referrals also come from Community Health services, hospitals and health professionals.

It was suggested that most passengers had limited transport options because of a lack of private transport and unsuitability of public transport. It was felt that they chose community transport for a number of reasons including cost, quality, the availability of assistance and the use of accessible vehicles when needed. Community based transport provider staff also suggested that care needs of passengers are rising.

## **Demand for services**

Not all study participants were able to manage the demand for transport from their local communities. Demand management varied, with some providers rationing services and others referring people to other transport providers; only three study participants maintained a record of unmet transport demand. In some community organisations the length of time a passenger needs to book ahead to ensure a service is increasing.

## **Agency co-operation**

There was limited operational co-operation between study participants although some co-operative practices have been trialled in the past. Some agencies also had cross-referral arrangements in place. It was pointed out during the interviews that to deviate from a direct route in order to pick up passengers from another area can increase the duration of a journey significantly. This degrades the quality of the service and may be inappropriate for some passengers.

As this study predates the current insurance crisis, public liability and other insurance matters were not raised as a concern at the time.

## **5. Phase 2 – Summary of Survey -Quantitative data.**

### **Trips provided**

During the study period a total of 864 trips were provided. For this study a trip is defined as a one way journey for one passenger.

The trips that were provided by the participating community based transport providers in the study period were evenly split between travel to medical facilities (52%) and journeys home (48%). The small discrepancy may be explained because some providers have a policy not to undertake hospital discharges.

### **Trip purposes**

By far the largest proportion of trips were to medical specialists accounting for 41% of all journeys (except journeys to home). Of the 185 trips to medical specialists, 52 were to rooms in Wickham Terrace and in Caboolture. The balance was spread among a variety of medical facilities.

### **Destinations**

Transport was provided to 29 identified destinations:

- 42% of trips were journeys to destinations within the study area;
- 39% of trips were to central Brisbane;
- 15% of trips were to northern Brisbane destinations and
- 4% of trips were further afield.

Seventy five percent of trips within the study area were to one of four destinations: Redcliffe Hospital, specialists' rooms in Caboolture, Caboolture Hospital or the Peninsula Private Hospital. Sixty percent of trips to central Brisbane were to either Royal Brisbane Hospital or Qld Radium Institute.

### **Trips lengths and waiting times**

Average trip lengths varied with lowest being 14 klms and the highest 139 klms.

Trip times followed this pattern being in the range of 47 minutes to 3 hours. Trip times include loading times, which can be substantial for some passengers.

Waiting times (the time the driver waited at the destination for the passenger to finish their appointment) were more even within a range of just over 1 hour to 2 hrs 11 minutes. Drivers generally do not return to base after dropping their passengers at the destination because of the travel time involved. Where more than one passenger is carried waiting times tend to be longer.

As can be seen from these figures, a typical trip for some study participants could take 4 to 5 hours from the time the first passenger is picked up to when they are returned home again.

## **Staff**

All but two trips were provided using unpaid staff. Eighty seven percent of these were provided using volunteer drivers in agency owned vehicles and the remainder were provided by volunteers using their own cars.

## **Use of service capacity**

Passenger loadings appeared high with only 37% of trips carrying only one person. However, it should be noted that one study participant achieved significantly higher loadings than the rest (average of 2.9 passengers). Among the other 5 providers, 73% of the journeys carried only one passenger and 27% of journeys carried two passengers.

The provider that achieved the highest loadings (average of 2.9 passengers) also provided the highest number of journeys. This may be influenced by:

- their catchment is a small geographic area and has a higher aged demographic and
- differing operating principles such as policy about filling vehicles, broader interpretation of eligibility and approach to spare capacity.

This meant that they had shorter distances between pick-ups and could also juggle a relatively large number of bookings in order to match multiple passengers to destinations. The wider geographic spread of the catchment areas of the other providers and their lower passenger numbers reduces their capacity to carry more than one passenger at a time.

A wide variety of health service types and destinations were serviced both within and beyond the study area.

## **Care needs of passengers**

Of all the passengers carried during the study period, 56% had low care needs (needed little assistance), 41% had medium care needs (needed some assistance) and contrary to what was said at interview, 3% had high care needs (needed constant supervision).

Ten percent of passengers were accompanied by a carer.

## 6. Key issues and concerns

### Issue 1. Provision and access to services

#### Discussion

##### *Service Delivery*

The volume of services provided by each study participant varied a great deal within the range of 19 to 495 trips during the survey period. The differing number of trips provided were affected by the availability of funding, the size of the 'target group' population in each catchment area, the availability of volunteer drivers, the capacity of the available vehicles and the ability of different community based transport providers to achieve high passenger loadings.

An absence of co-ordination and co-operation between providers due to concerns about trading off 'quality' of service offered to individuals for greater loading rates may contribute to low vehicle loading rates achieved in all but one provider.

Another source of inefficiencies in both loading rates and economies is the availability of funding and the eligibility criteria of funding programs which impacts on the 'target group' (people) able to be transported by community based transport providers.

The large amount of time that vehicles were out of the local area whilst providing transport to Brisbane medical facilities, adversely affects the capacity of the organisation to respond to the demand for local transport needs.

The number of vehicles available to providers, who owns them and the size and accessibility of these vehicles also impacts on service provision.

Options for gaining better efficiencies include greater co-operation and co-ordination between services but it is limited by each provider operating in a different geographical area providing transport to a wide variety of destinations.

Another option to raise the likelihood of achieving high passenger loadings and technically efficient service would be to broaden the eligibility criteria and to service defined, small geographical areas.

##### *Funding and eligibility*

Study participants had various sources of funding that are tied to targets groups and in some cases geographical areas. Funding levels varied markedly between the study participants in both absolute terms and within funding programs. Passengers who qualify for services in one area may not be permitted to access services in another. Both access to, and supply of, transport services from the study participants is influenced by:

1. The sources of funding and their eligibility guidelines.
2. The type of funding available to the local group caused by the targeting of funds to geographical areas e.g. Community renewal tied to particular places.

3. Inconsistency statewide on the use of spare capacity for other persons in need outside the 'target group' within the population.
4. Increased unwillingness of government to joint fund initiatives e.g. HACC and Veteran Affairs.

### **Staffing**

All providers had some paid staff although only three of the study participants used paid drivers. During the period of the study only 2 trips were provided using paid drivers. Most paid staff were engaged in taking bookings, administration and volunteer recruitment and support. Paid staff hours among the providers ranged from 10 hours per week to 178 hours per week. This affects the volume and type of services that can be provided in each area.

All of the services used unpaid driving staff. The number of unpaid drivers in each service ranged from 6 to 30. Three services used and were dependant upon unemployed people on mutual obligation programs. Two study participants indicated that a shortage of unpaid staff restricts their ability to provide services. This reliance on unpaid staff impacts to a varying degree the capacity to deliver a transport service.

### **Policy implications**

For all of the reasons discussed above, there is a lack of consistency in the level and type of service provided in different parts of the study area. This raises questions about people's ability to gain equitable access to transport and ultimately, equitable access to the health services they need to attend.

The nature of the services provided differed between study participants for a number of reasons. These included the resources available and the focus of the agency in question. Consideration may need to be given to the development of a consistent network of community based transport operators in order that similar levels of service can be made available in each area. The HACC program, in particular, may need to examine the level and distribution of funding in the region and a consistent policy framework related to the transport service type.

The development of a standard level of community based services in each area will provide more travel options for passengers and may reduce the demand for expensive QAS non-acute transport services.

The following policy options are offered for consideration:

- That a whole of government approach be taken towards the provision of non-acute health related transport involving an appropriate lead agency. This approach should consider establishing a transport funding mix for geographical areas that reflects the transport needs of each community and allowing equitable access to services.
- Application of more flexible interpretation of the eligibility criteria of transport programs (particularly in isolated areas) in order to promote increased utilisation of service capacity.

- Establishment of a non-acute transport funding program – similar in scope to the Health Related Transport Program which is administered by the Department of Health in NSW - that would enable transport disadvantaged people who are not eligible for existing services to get to health services.
- Networking and co-operation between government and non government agencies involved in medically related transport be encouraged. In particular, given the rapid ageing of the population and the increasing care needs of passengers, co-operation should be encouraged in the field of passenger assessment and referral mechanisms.
- Collective use of resources (funding, vehicles etc.) across departments and programs in order to develop flexible and accessible transport programs and services. This could involve some programs or departments ‘cashing out’ transport money to a non acute transport funding program, or to a particular transport agency or to a mobility management system.

## **Issue 2. Volunteers and other unpaid staff**

### **Discussion**

All of the study participants used volunteers or unemployed people referred from mutual obligation programs. The number of unpaid staff in each agency ranged from 6 to 31.

#### ***Volunteers***

Volunteers are community members who are willing to provide transport services either by driving an agency car or their own car. During the study most volunteer drivers used agency vehicles (749 trips) rather than their own cars (113 trips).

It was reported that the recruitment and retention of volunteers is a time consuming task and that volunteers are not a cost free resource. Costs that relate to the use of volunteers include;

- recruitment (advertising and interviewing);
- training (induction, formal and informal ongoing training);
- support (debriefing, formal meetings, informal get togethers);
- reimbursement (mileage or petrol allowances and/or lunch money) and
- the greater levels of co-ordination and administration needed (large numbers of people involved, rosters, high turnover).

Two agencies reported difficulty in recruiting sufficient volunteers to cope with the demand for services and that they had difficulty in attracting female drivers.

There was a general view that it can be difficult to interest volunteers in anything beyond basic training (one agency that had mandatory training for all staff made the least use of volunteers). This brings into question the suitability of using volunteers for passengers with medium or high care needs. It should be noted that 45% of the passengers carried during the study were in these categories.

### ***Workers referred from Mutual Obligation Programs***

Some study participants were very dependent on the use of unemployed people referred by mutual obligation programs. This type of staff are required to work 32 hours a fortnight in return for which they do not have to actively seek employment. Concerns were expressed about changes in the scheme, introduced in September 01, that will require participants to continue to look for work and take part in Jobsearch training after their mutual obligation contract has expired. It was suggested that these changes have already discouraged people from participating in the program and that the number of participants has already declined.

It was also noted that even though Centrelink participants are often provided with on-the-job training, this is not resourced.

**Example:** One of the study participants uses Centrelink mutual obligation clients exclusively for driving their project owned vehicles. They are already suffering from a reduction in the number of drivers available to them that will have an effect on the volume of transport they will be able to offer in the future.

### **Policy implications**

The heavy dependence on volunteers by all of the study participants has a number of difficulties associated with using this type of labour including;

- attracting sufficient numbers on an ongoing basis;
- ensuring appropriate skill levels;
- inconsistency in availability;
- reliability and
- costs associated with their recruitment and retention.

Problems surrounding the suitability of volunteers' vehicles has been addressed by the heavy use of project owned vehicles in most agencies. However this remains an issue for others.

In terms of policy, government should ensure that agencies that are funded to provide transport have sufficient resources to recruit, train and support volunteer staff to a level appropriate to the needs of service passengers. As noted elsewhere, the demand for transport from passengers with medium or high care needs is likely to grow significantly over the next ten years.

There was a feeling that the time that is required to support volunteers, in terms of group meetings, individual debriefing and social 'thank you' occasions are not sufficiently recognised by funders. Programs that make heavy use of volunteers, such as the HACC program, need to acknowledge the cost of this valuable resource in their funding models.

The unsustainability and instability with heavy reliance on the social capital of volunteerism in delivering an essential service creates much trepidation for both those concerned with delivering a service and those reliant on the delivery of service.

Even where volunteer drivers are used, agencies should have the wherewithal to use their own vehicles. This will allow the purchase and use of appropriate vehicles and negates problems associated with volunteer car insurance. Small agencies, however, may not be willing to purchase vehicles where they may be required to become accredited under the provisions of the Transport Operations (Passenger Transport) Act 1994.

The following policy options are offered for consideration:

- Government, funding bodies and community agencies recognise the real costs of using unpaid workers in funding packages/applications.
- Government and funding bodies commit to a program of skills enhancement for volunteer workers.
- Federal government recognise the skills development that takes place among Centrelink mutual obligation participants and that the agencies that use such participants be reimbursed for the costs associated with such training.
- Acknowledge that decisions made in one area of government can have serious implications on other portfolios and ultimately, service delivery eg. Federal governments 'Mutual Obligation' decisions and community transport service delivery.
- Government encourage good practice in health related transport. Such encouragement may take the form of supporting training, seminars, conferences, research and networking between agencies.

### Issue 3. Passengers care needs

#### Discussion

As part of the survey we asked for an assessment of the care needs of the passengers that were carried on the services. The care needs were described as follows:

- **Low care needs:** Fully aware and capable of walking and getting in and out of vehicle unassisted, able to be left unattended at destination.
- **Medium care needs:** May have some confusion or mild developmental disability. May need some assistance with getting in and out of vehicle and in walking (eg support of arm or guidance if visually impaired). Can self-administer oxygen or drugs but will not require intervention during travel.
- **High care needs:** Requires constant supervision in transit and at destination. May require active monitoring in transit.

Of the 864 trips that were provided during the study, 56% of trips had passengers with low care needs, 41% had medium care needs and 3% high care needs. It was suggested during the interviews that the care needs of passengers are rising.

It was also noted during the interviews with study participant staff that many passengers also require emotional support and that this is a valuable, if not often recognised, element of community transport services. Another element offered by community transport providers is the support for carers of passengers who travelled at no additional cost (carers were involved in 10% of trips).

Rising high care need has implications for the long term appropriateness of services given the heavy use of unpaid staff (in the study period only two trips were provided using paid staff) among whom there is a reluctance to undertake anything beyond basic training.

With some providers formal training was provided for all staff, in others training was more ad hoc. This affects the ability of some services to provide appropriate services to people with medium or high care needs. In some areas such passengers may have no travel options unless they qualify for the Qld Ambulance Service non-acute transport service.

It should be noted that clients of the Home and Community Care program (which provides funding for five of the services surveyed) are becoming frailer and more in need of 'dependent transport' (transport where one-to-one assistance is provided). This trend is partly the result of a restriction in the number of residential care places both for older people and people with disabilities. Studies undertaken by the Australian Institute of Health and Welfare suggest that there are going to be significant increases in the number of "old old" people and in the number of people with disabilities living in the community. The increase in the number of people with profound or severe activity restrictions, living in the community, is estimated to rise by 12% over the next five years<sup>2</sup>. This higher level of care need, has an impact on:

- loading times;
- the time that travel that can be endured by individuals and this can therefore limit the providers ability to transport multiple passengers;
- the type of vehicle that can be used to provide a service;
- the type of personnel that can provide a service and
- potentially the need for more support personnel.

Government health policies such as same day surgery and early discharge from hospital are also likely to increase the number of passengers with medium and high care needs seeking assistance with transport to health facilities. In both cases patients are likely to need to return to hospital or associated clinics for physiotherapy or other forms of rehabilitative treatment.

## **Policy implications**

The demand for appropriate transport for medium and high care needs is greater than the current provision, adding to this is the projected increase in demand for medium to high needs groups. There will be increasing pressure on community based transport services to provide both an increasing volume of services and services that can offer a medium or high care component. It may not be possible

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<sup>2</sup> Australian Institute of Health and Welfare (1999) *Australia s Welfare: Services and Assistance*, AIHW, Canberra, Table 7.5

to achieve this by totally depending on unpaid driving staff or on driving staff with their current level of training. More importantly we need to consider if this form of transport (community transport) is an appropriate response to people with medium to high care needs?

Choices will need to be made between using more expensive services, such as provided by the Queensland Ambulance Service, developing new service types (contracting small bus operators or using minibus services based at health facilities for example) or providing existing community based providers with the resources to recruit more volunteers, to train volunteers to a higher standard or to employ professional driving/care staff.

Currently there is no single appropriate funding mechanism through which to achieve the latter. HACCC is the dominant recurrent funding resource for community based transport provision at the moment but has limited eligibility guidelines. An alternative, more broadly encompassing program may need to be developed.

The following policy options are offered for consideration:

- The establishment of mechanisms that place appropriate passengers with appropriate transport providers that are affordable to consumers.
- That provision of transport response considers the support needs of passengers (carers, walking aids, translators, support workers).
- The provision of training resources for community transport groups, to enable them to provide more appropriate services to clients with medium or high care needs (frequently Qld Health clients).

## **Issue 4. Demand for medically related transport**

### **Discussion**

The demand for affordable medically related transport is likely to rise significantly as discussed in the introduction, over the next ten years.

This demand will be driven by a large increase in the older population, particularly those over 75 at which age mobility tends to decrease and a dependence on others for assistance with transport increases<sup>3</sup>. Other factors are the increase in same day surgery and the earlier discharge of hospital patients many of whom will require return visits for rehabilitation or other therapy.

Due to the lack of affordable and appropriate options, the demand is therefore likely to fall upon the existing community transport providers. However, they have limited spare capacity and there are limited opportunities for increasing supply through further co-operation amongst each other. Already some groups have waiting lists or their passengers have to book ahead to ensure a service although others stated that they can cope with the current demand.

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<sup>3</sup> ibid p 169

## Policy implications

One difficulty appears to be that there is no direct link, insofar as health services are concerned, between the implementation of policies that increase transport demand and ensuring that those who need to travel to obtain treatment are able to do so. A program, funded through the health system, that would assist patients with non urgent medical travel, would achieve that link and provide an incentive to seek efficiencies in terms of the location of health facilities and in assisting with organising appointment times so more use can be made of spare vehicular capacity.

An alternative approach would be to investigate the possibility of supplying more health services on an outreach basis in regional hospitals or clinics, in order to reduce the need to travel. Similarly the policy of 'back referral' (referring back to the patients local area for follow up medical management after a hospital stay) is also meant to deal with this problem, but not consistently applied.

The following policy options are offered for consideration:

- That medical facilities co-operate and co-ordinate when scheduling appointments for people who have limited transport available to them.
- More consistent application of the 'back referral' policy be implemented.
- That the HACC program and other program administrators recognise the increasing growth in the demand for health related transport and develop strategies that respond to this demand.
- That QAS investigate the feasibility of contracting some of their non-urgent transport services to suitable non-government agencies in the region.
- That the Qld Government develop a whole of government approach to the increase in the demand for health related transport, including initiatives such as;
  - enhancing transport services through existing and new funding programs;
  - encouraging the development of demand responsive transport services both by mainstream and alternative transport operators;
  - seeking to decentralise some health services in order to minimise the need for transport and
  - implement models eg. brokerage, to maximise the use of existing resources through improved information for potential service users, co-operative practices and the development of innovative service types.

## **Conclusion**

The broad aims of the UTNF are to promote non-adversarial debate about the strategic policy issues associated with unmet transport needs and provide a space in which the current unmet transport needs of Queenslanders can be discussed and for networking between relevant stakeholders to occur.

In this context the UTNF sees there is a need to gain a better understanding of what medical transport is currently being provided by community and the issues and concerns providers have around the delivery of this medical transport. The data collected during this study has enabled the UTNF to identify and explore the strategic policy implications of community provided medical transport provision. It is clear from this health related transport study that unmet health related transport needs are a major policy concern. Not only is the current demand outstripping supply, the demand is increasing.

This study has collected information that shows a great deal of community resources are expended on transporting individuals to medical facilities. Despite this, there are still many gaps and overlaps. The UTNF is of the view that doing more of the same to respond to this unmet transport need may not work. Innovative solutions are required. Solutions need to draw upon all the available resources and be appropriate to the local context.

The insights raised in this document are intended as tools for shaping policy development and decision-making at local, regional and state program and government levels. The UTNF also hopes that they will contribute to helping stakeholders to develop innovative responses to the unmet transport needs in their communities.

## **Attachments**

### **Attachment 1- Profile of study participants**

This profile was developed after undertaking face to face interviews with the managers or co-ordinators of five agencies that provide long distance medically related transport from areas north of Brisbane. A standard set of questions was used to achieve consistency in the responses and for ease of analysis. The interviews were undertaken in the same agencies that participated in the transport provision survey.

#### **Type of organisation**

Of the five agencies involved in the study, two were small community based agencies, two branches of large charitable organisations and one was auspiced by local government.

#### **Main source of funding**

Three of the agencies received HACC funding for transport. One HACC funded agency was not funded specifically for transport but provided transport services. None of the agencies had received additional funding to cope with the recent increase in HACC administrative requirements. One agency subsidised their transport service out of internal resources.

One service received no HACC funding their service being financed through the Office on Ageing. Other sources of funding included CACP and Post Acute Funding.

All services depended on passenger fares or agency contributions to operate.

#### **Area of operation**

Each service had an discrete area of operation. There were no overlaps except in parts of Caboolture.

#### **Purpose of transport service**

All agencies provided services to health facilities but their functions were wider than this. All provided services to a range of destinations including shopping and in order to reduce social isolation. One service did not provide transport to local destinations.

#### **Target group**

Four agencies indicated they served the HACC target group, two served disadvantaged people and one indicated that they provided services to passengers that need supported transport. All services took direct bookings from new clients.

#### **Vehicles**

Four of the agencies had project owned vehicles. Vehicles included an accessible van, three people movers, six station wagons and six sedans.

One service depended entirely on volunteers' vehicles.

Agency	1	2	3	4	5
Fleet	6	4	4	2	0

### **Paid Staff**

All of the agencies used paid staff, mainly for bookings, administration and volunteer recruitment/support. Three services used paid drivers.

Agency	1	2	3	4	5
Weekly Staff hours	178	90	50	50	10

### **Volunteers**

All of the services used volunteers in both driving and administrative roles.

Agency	1	2	3	4	5
Volunteers	25 drivers	25 drivers 4 admin.	30 drivers 1 admin.	6 drivers	11 drivers 7 admin.

### **Volunteer supply**

Two agencies said the supply was satisfactory, two indicated that they had problems attracting enough. Three services used Centrelink clients. It was commented that the retention of volunteers can be a problem. Centrelink clients, in particular tend to be younger and, unsurprisingly, will move on if they find a job.

### **Profile of volunteers**

Four out of the five agencies indicated that most volunteers are older people. Two agencies indicated that they had problems attracting female volunteers. Centrelink clients also tended to be male. Some of the latter have poor communication skills and need training in a variety of areas.

### **Volunteer reimbursement**

Various methods for reimbursing volunteers were used. They included a per kilometre rate, lunch money, fuel subsidy and a percentage take from passenger donation.

### **Drivers suitability**

Processes to check the suitability of drivers varied although all agencies recognised that this was an important issue. Two agencies used a police check and another is looking into this possibility. One agency required a medical examination by their doctor. Four agencies interviewed drivers and one used a questionnaire to assess suitability.

## **Insurance for volunteers**

This does not appear to be an issue at the present time. All agencies carried volunteer insurance. Three agencies insisted that volunteer cars are comprehensively insured, with one agency it was not a requirement although most volunteers carried it.

## **Training/Skills**

Three of the agencies provide or purchase training for staff. Comment was made that it can be difficult to get volunteers to undertake training. Four of the agencies provide written training material for staff.

## **OH&S Issues**

Information about OH&S issues was provided to drivers by all agencies. One agency had a policy that no staff lift passengers. Three agencies provide access to OH&S training but it was suggested that not many volunteers take up the option.

## **Duty of Care**

Duty of care was approached in different ways ranging from formal in-house training to advice given in a general way. One agency used fitness to travel certificates.

## **Care needs of passengers – categories**

Three agencies indicated that most clients have low care needs, two services indicated that their passengers had medium care needs. No agency transported passengers with high care needs.

Emotional support may also sometimes be required in addition to physical support. Some passengers have good and bad days and it was difficult to categorise them.

## **What happens if they need a carer?**

All agencies indicated that they would provide a carer if asked. Drivers also assist when necessary.

## **Why do passengers request the service?**

There were a wide variety of responses to this question including:

- cost;
- restrictions on where people are allowed to drive;
- the quality of the service offered;
- assistance and the availability of an accessible vehicle;
- public transport routes not being suitable.

It was suggested that few passengers can use alternative transport services. One service took overflow demand from another service but it was suggested that competition between services for funds is destroying this type of co-operation.

### **Where referrals come from**

Most passengers self-referred to the services. Referrals also came from Community Health, hospitals and health professionals.

### **Excess demand**

The ability to cope with excess demand varied. One agency rations services and another indicated that demand is beginning to outstrip supply. Other options for transport were explored at the time of assessment by one agency including family, other community services, shopping buses and public transport.

### **Referrals out**

Three agencies referred to other community based agencies, two to taxi companies and two to the QAS.

### **How are unmet needs logged?**

Three services indicated that they recorded unmet demand as a matter of course.

### **How bookings are handled**

Bookings are handled by office staff in all agencies. Two agencies used a computer based system.

### **Who rings to change appointments?**

Generally passengers are asked to change their own appointments. Two agencies said they would do it on behalf of the passenger.

### **Co-ordination with other service providers**

This seems to have been tried in the past but not successfully. There are difficulties in competition between services. Achieving satisfactory co-ordination was seen as a difficulty by three agencies.

### **Tricks of the trade**

Drivers shared information about tricks of the trade (places to park etc.) in all agencies. Information was passed on at orientation or at staff or volunteer meetings. One agency used a mentoring program.

## Attachment 2 - Survey Results

The following tables were prepared using data provided on the survey returns.

**Table 1. Trips provided by individual agencies**

Agency ➡	1	2	3	4	5	6
<b>Outward trips</b>	104	45	21	9	257	13
<b>Return trips</b>	103	41	12	10	238	11
<b>Total trips</b>	207	86	33	19	495	24
<b>Percentage of all trips during study</b>	24%	10%	4%	2%	57%	3%

Over half of the trips during the survey period were provided by one agency. Three agencies provided 91% of all trips.

**Table 2. Average and median distances travelled per trip by individual agency**

Agency ➡	1	2	3	4	5	6
<b>Average distance</b>	91	N/a	27	139	49	14
<b>Median distance</b>	90	N/a	25	151	50	15

Average and median distances travelled per trip varied a great deal. Agency 4 operated in a rural area and targets isolated people.

**Table 3. Times taken for trips by individual agencies**

Agency ➡	1	2	3	4	5	6
<b>Average driving time per trip</b>	1:38	1:22	1:02	2:58	2:09	0:47
<b>Average waiting time per trip</b>	1:38	1:02	1:04	1:18	2:11	1:54

Times taken to complete trips did not reflect the corresponding distances. This may be a function of city vs rural driving or the pick up of more than one passenger, which would add to the time required.

**Table 4. Average number of passengers carried by individual agencies on each service**

Agency ➡	1	2	3	4	5	6
<b>Average number of passengers</b>	1.27	1.24	1.0	1.0	2.9	2.0

**Table 5. Travel type**

	<b>Trips</b>	<b>%</b>
Home to hospital or other health facility	449	52%
Health facility to home	415	48%
Total trips	864	100%

There was a fairly even split between transport to facilities and transport from facilities. The difference is partly explained by the higher number of hospital admissions than discharges.

Some groups have a policy not to provide discharge transport. There was a slight disparity between the answer to this question and an analysis of the trip purpose which showed a 53% - 47% split between to and from facility transport.

**Table 6. Purpose of trip**

<b>Purpose of trip to health facility</b>	<b>Trips</b>	<b>%</b>
Medical specialist	185	41%
Outpatient clinic	66	15%
Radiography	43	10%
Oncology	38	8%
Hospital admission	31	7%
Other therapy	26	6%
Dental clinic/dentist	10	2%
Physiotherapy	10	2%
Rehabilitation	12	3%
Cardiology clinic	11	2%
Allied health	8	2%
Pre-admission or post surgery appointment	7	2%
Other	2	0%
Total	449	100%

  

<b>Purpose of trip home</b>	<b>Trips</b>	<b>%</b>
Return from appointment	408	98%
Hospital discharge	7	2%
Total	415	100%

Trips to health facilities were dominated by travel to medical specialist appointments and outpatient clinics. These represented over half of the total trips. Other significant destinations included oncology, radiography, hospital admissions and other therapy. Other destinations accounted for only 17% of all trips.

The vast majority of trips home were from appointments. Only seven trips out of a total of 415 were hospital discharges.

**Table 7. Summary of main purposes of trips by agency – percentage of all trips by agency**

Agency ➡	1	2	3	4	5	6
Return passenger home	49%	47%	27%	53%	47%	46%
Medical specialist	17%	13%	10%	5%	25%	17%
Oncology	12%	3%	0%	0%	2%	0%
Radiography	6%	14%	0%	5%	4%	0%
Outpatient	4%	12%	7%	26%	8%	8%
Other therapy	0%	3%	7%	0%	5%	25%
Hospital admission	3%	0%	7%	0%	2%	0%

Trips to the major destinations varied markedly between service providers. Most provided mainly return journeys although one service only provided a return journey a quarter of the time and a second service provided no return journeys at all.

Trips to medical specialists varied from 5% of the total to 33%.

**Table 8. Trip origins in order of frequency**

From	Trips
Home	449
Royal Brisbane Hospital	66
Redcliffe Hospital	56
Prince Charles Hospital	50
Medical Specialists, Caboolture	38
QRI	34
Caboolture Hospital	26
Peninsula Private Hospital	20
The Wesley Hospital	18
Wickham Terrace	14
Riverview Private Hospital	11
Princess Alexandra Hospital	9
Caboolture Private Hospital	9
Morayfield Hospital	8

**Table 9. Trips destinations in order of frequency**

To	Trips
Home	415
Royal Brisbane Hospital	70
Prince Charles Hospital	60
Redcliffe Hospital	54
Medical Specialists, Caboolture	38
QRI	37
Caboolture Hospital	27
Peninsula Private Hospital	23
The Wesley Hospital	20
Wickham Terrace	16
Princess Alexandra Hospital	11
Riverview Private Hospital	11
Caboolture Private Hospital	9
Morayfield Hospital	8

Continued .

**Table 8. Trip origins in order of frequency**

From	Trips
War Veterans Home, Caboolture	7
Dental Hospital (Turbot Street)	7
Holy Spirit Hospital	6
Kippa Ring Medical Centre	6
Mater Hospital	5
NW Private Hospital	4
Royal Children's Hospital	3
Specialist McGregor	3
Greenslopes Hospital	2
Strathpine Hospital	2
Kelvin Grove Vision Centre	2
Nambour Hospital	1
St Andrew's Hospital	1
Royal Women's Hospital	1
Specialist Aspley	1
Other (unspecified)	5
Total	864

**Table 9. Trips destinations in order of frequency**

To	Trips
War Veterans Home, Caboolture	7
Dental Hospital (Turbot Street)	7
Kippa Ring Medical Centre	7
Holy Spirit Hospital	6
Strathpine Hospital	5
Mater Hospital	4
Royal Children's Hospital	4
NW Private Hospital	4
Specialist McGregor	3
Greenslopes Hospital	3
Keperra Hospital	2
Royal Women's Hospital	1
Nambour Hospital	1
Kelvin Grove Vision Centre	1
Specialist Aspley	1
Other (unspecified)	9
Total	864

**Table 10. Summary of destinations (other than "home") by area.**

	Within study area	Central Brisbane	Northern Brisbane	Further afield	Not indicated
Number of trips	189	177	67	7	9
Percentage of total trips	43%	39%	15%	2%	2%

**Table 11. Vehicles used**

<b>Vehicle</b>	<b>Trips</b>
Agency owned Car with paid driver	2
Agency owned Car with volunteer driver	445
Volunteers driving their own car	113
Agency owned People Mover* with volunteer	304
Total	864

\* People Mover holds up to 8 passengers.

Most of the trips (87%) were provided using agency owned vehicles. Cars were used for 65% of trips and people movers for 35%.

**Table 12. Number of passengers**

<b>No.</b>	<b>Frequency</b>
1	319
2	230
3	148
4	138
5	25
N/R	4
All	864

There appeared to be relatively efficient use of service capacity with only 37% of trips carrying only one passenger.

**Table 13. Level of care needed by passenger**

	<b>Trips</b>
<i>Low care needs:</i> <ul style="list-style-type: none"> <li>Fully aware.</li> <li>Capable of walking and getting in and out of vehicle unassisted, able to be left unattended at destination.</li> </ul>	480
<i>Medium care needs:</i> <ul style="list-style-type: none"> <li>May have some confusion or mild developmental disability.</li> <li>May need some assistance with getting in and out of vehicle and in walking (eg support of arm or guidance if visually impaired).</li> <li>Can self-administer oxygen or drugs but will not require intervention during travel.</li> <li>Discharged from hospital or after medical procedure but is alert and mobile.</li> </ul>	351
<i>High care needs:</i> <ul style="list-style-type: none"> <li>Requires constant supervision in transit and destination.</li> <li>May require active monitoring in transit.</li> </ul>	33
<i>Total</i>	864

**Table 14. Average care needs of passengers by individual agencies\***

<b>Agency</b> ➔	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
<b>Average care need</b>	1.97	2.23	1.6	1.15	1.12	2.0

\* Each passenger was assessed to have a care need on a scale of 1 – 3 as explained in Table 6. These scores represent the average score on that scale for all passengers carried by each agency.

**Table 15. Use of carers**

<b>Status</b>	<b>Trips</b>
Accompanied by own carer	154
Carer provided by agency (in addition to driver)	8
No carer	606
N/R	96
<b>Total</b>	<b>864</b>

Most passengers (70%) were not accompanied by a carer. Agencies only provided a carer on eight occasions.

## Attachment 3 – Trip Log sheet

### Medical Transport Data Collection Form

This form is to be used to collect information about transport provided to people to help them access health facilities **out of your local area**.

The information should be collected over a four-week period between the 20<sup>th</sup> of August to the 16<sup>th</sup> of September.

At the end of the period please return the form to us in the envelope provided. The first four pages describe how the form should be filled out. The fifth page is the form itself. The last should be used for copying if extra forms are required. We will send you some reply paid envelopes to send the survey back in. If you have any queries please ring me at (02) 9569 1396 or Sandy Dore at 3253 0534.

David Denmark (Senior Planner – Transport Planning and Management)

PO Box 165, Marrickville NSW 1475.

<b>Name of agency</b>			
<b>Contact person</b>		<b>Tel:</b>	

A. Please describe the eligibility criteria used to access to your transport service (eg authority from a doctor, HACC client, CTP etc).

B. On what days and between what hours does your transport service operate?

C. Total number of passenger trips (all trips including medical transport, shopping, social outings, day care etc.) provided during survey period.

D. Was there anything unusual about this collection period?

**HOW TO FILL THE FORM OUT** - The details of each trip (one way journey) should be entered on one row of the form. Most columns require a code. The codes are described below.

<b>1. Travel type</b>	<b>Code</b>
Home to hospital or other health facility	1
Health facility to home	2

<b>2. Purpose of trip</b>	<b>Code</b>
Hospital admission	1
Hospital discharge	2
Pre-admission or post surgery appointment	3
Oncology	4
Renal dialysis	5
Physiotherapy	6
Other therapy	7
Outpatient clinic	8
Radiography	9
Rehabilitation	10
Cardiology clinic	11
Dental clinic	12
Medical specialist	13
Return home	14

Other – please indicate on form

<b>3 Vehicle used</b>	<b>Code</b>
Agency owned Car with paid driver	1
Agency owned Car with volunteer driver	2
Volunteers driving their own car	3
Agency owned People Mover* with volunteer	4
Agency owned People Mover with paid driver	5
Minibus** with paid driver	6
Minibus with volunteer driver	7
Minibus (wheelchair modified) with paid driver	8
Minibus (wheelchair modified) with volunteer driver	9
Taxi Vouchers	10

Other – please indicate on form

\* People Mover holds up to 8 passengers. \*\* Minibus holds 9 passengers or more.

<b>4. From - trip origin</b>	<b>Code</b>
Home	1
Caboolture Hospital	2
Dental Hospital (Turbot Street)	3
Holy Spirit Hospital	4
Keperra Hospital	5
Mater Hospital	6
Prince Charles Hospital	7
Princess Alexandra Hospital	8
QRI	9
Redcliffe Hospital	10
Riverview Private Hospital	11
Royal Brisbane Hospital	12
Royal Children's Hospital	13
St Andrew's Hospital	14
Turrawan Private Hospital	15
The Wesley Hospital	16
Wickham Terrace	17
Royal Women's Hospital	18
NW Private Hospital	19
Peninsula Private Hospital	20
Greenslopes Hospital	21
Nambour Hospital	22

Other – please indicate on form

<b>5. To - trip destination</b>	<b>Code</b>
Home	1
Caboolture Hospital	2
Dental Hospital (Turbot Street)	3
Holy Spirit Hospital	4
Keperra Hospital	5
Mater Hospital	6
Prince Charles Hospital	7
Princess Alexandra Hospital	8
QRI	9
Redcliffe Hospital	10
Riverview Private Hospital	11
Royal Brisbane Hospital	12
Royal Children's Hospital	13
St Andrew's Hospital	14
Turrawan Private Hospital	15
The Wesley Hospital	16
Wickham Terrace	17
Royal Women's Hospital	18
NW Private Hospital	19
Peninsula Private Hospital	20
Greenslopes Hospital	21
Nambour Hospital	22

Other – please indicate on form

## **6. KIms**

Indicate the number of kilometres travelled.

## **7. Number of passengers**

Number of passengers (not counting carers) in vehicle on this trip.

<b>8. Level of care needed by passenger</b>	<b>Code</b>
<p><i>Low care needs:</i></p> <ul style="list-style-type: none"> <li>Fully aware.</li> <li>Capable of walking and getting in and out of vehicle unassisted, able to be left unattended at destination.</li> </ul>	1
<p>▪ <i>Medium care needs:</i></p> <ul style="list-style-type: none"> <li>May have some confusion or mild developmental disability.</li> <li>May need some assistance with getting in and out of vehicle and in walking (eg support of arm or guidance if visually impaired).</li> <li>Can self-administer oxygen or drugs but will not require intervention during travel.</li> <li>Discharged from hospital or after medical procedure but is alert and mobile.</li> </ul>	2
<p><i>High care needs:</i></p> <ul style="list-style-type: none"> <li>Requires constant supervision in transit and destination.</li> <li>May require active monitoring in transit.</li> </ul>	3

<b>9. Carer</b>	<b>Code</b>
Accompanied by own carer	1
Carer provided by service (in addition to driver)	2
No carer	3

### 10. Start time

Indicate the time the driver started the journey (not when the passenger was picked up).

### 11. Finish times

Indicate the time the driver finished the journey (not when the passenger was dropped off).

### 12. Time taken for journey.

Time taken from when driver started and finished.

### 13. Waiting time

Enter the amount of time the driver had to wait at the destination before commencing the return trip.

### 14. Date

Enter the date of travel

**Thank you for your assistance with this survey. David Denmark**