Closing the Transport Gap
Meeting the transport needs of transport disadvantaged people in NSW

October 2010
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Executive Summary

This document proposes the following policies as a means to improve transport access in NSW for older people and people with disability.

Public transport services for everybody
The NSW Government should introduce a social transit agenda to work alongside its mass transit agenda. There has been a heavy focus on commuter services, with increasing peak services and re-routing buses along major thoroughfares with fewer stops, at the expense of off-peak, non-commuter services. This has made public transport increasingly difficult for older people and people with disability to use. A social transit agenda would aim to deliver a minimum level of service so that most currently transport disadvantaged groups were able to access transport most of the time.

Demand Responsive Transport
The NSW Government should introduce Demand Responsive Transport services to improve public transport access for people who are unable to catch traditional public bus services, as has been introduced in other parts of Australia and overseas.

CountryLink services
Investment in CountryLink services needs to be increased. CountryLink is a vital means of transport for many living in rural and regional areas. Improving services will also make CountryLink an attractive means of travelling around NSW.

Transport for people in Residential Aged Care
The NSW Government should expand eligibility of the Taxi Transport Subsidy Scheme to all who are in receipt of residential aged care services and to improve their ability to get to essential services. The Australian Government should introduce a transport supplement to provide funding for transport services for people in residential aged care.

Older drivers
The NSW Government should abolish the older driver test as the test has no proven benefit, and there is no evidence that transport safety has improved for both older people and the wider community since its introduction.

Community Transport
Greater funding is required for Community Transport and Transport for Health services to meet the needs of a growing population who are not able to use public transport. Funding for the Community Transport Program has not been increased for at least a decade and health-related transport is taking an increasing share of community transport resources, reducing the ability of providers to meet other needs of other community transport users. These services received no attention in the NSW Metropolitan Transport Plan and this should be addressed.
Introduction

Whether by public or private means, transport is fundamental in ensuring access to services and supports participation in civil society, through maintaining connections with family and friends and engaging in community activities. Transport is a key part of supporting the physical and emotional health and wellbeing of a person.

In spite of this fundamental role played by transport, many people are unable to access and use the type of transport services that meet their needs. This is commonly referred to as transport disadvantage. In NSW, transport disadvantage is particularly prevalent in Sydney’s outer metropolitan areas and in the state’s rural and regional areas. Groups particularly at risk of experiencing transport disadvantage include older people, people with disability, families with young children, youth, people from culturally and linguistically diverse backgrounds and indigenous communities.

Transport disadvantage can arise from:
- limited or no availability of public transport options;
- reliance on expensive private transport because of poor or no public transport options;
- unaffordable transport options, transport services and/or infrastructure not being accessible to people with disability or other mobility impairments; and/or
- a lack of access to private transport.

This paper reports on transport problems encountered by older people and people with disability. It identifies major problems and their causes in areas such as metropolitan, regional and inter-regional bus and train services; community transport and transport for health; and older driver testing. The paper then presents possible solutions to alleviate transport disadvantage for these groups as well as the wider community.
Bus Services

Poor access to buses often afflicts older people and people with disability, especially in rural and regional areas, and suburban areas on city fringes. Recent reforms to bus services have increasingly prioritised commuter services – peak hour services directed to the Central Business District – at the expense of non-peak hour services and those that travel through residential streets. Bus services have been cut or modified in order to accommodate commuter-oriented transport, with the re-routing of buses along more major thoroughfares and the reduction in the number of bus stops.

It appears that the current rationale behind public transport service delivery is that commuter services are most likely to garner greater capacity and are therefore the most economical. Alongside this rationalisation is the belief that fewer services at off-peak times and fewer non-‘streamlined’ services are justified because of low utilisation. Reducing or removing services produces a negative spiralling effect; inadequate services leads to low patronage, giving reason to further reduce services. This in turn reduces patronage.

Trips to work comprise less than a third of total trips made in Sydney. Commuting to and from work constitutes only 27% of the kilometres travelled by residents and less than 16% of all trips.\(^1\) Policy focus on commuter services at the expense of other services ignores the added external costs when people do not have access to a comprehensive public transport system. These include increased road usage/car usage; road accidents; CO\(_2\) emissions; and health costs as a result of pollution and physical inactivity.

In regional and rural areas public transport services are often few and far between and lack coordination between service types. Given the shortage of regular bus services, a public transport user must often wait a long time for connecting bus or train services. Bus services in these areas often conclude in the afternoon making it impossible to travel in the evening without a private vehicle or taxi. Many people are therefore prevented from attending a variety of activities that take place at night because there are no public transport options.

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\(^1\) Transport Data Centre (2009), *2007 Household Travel Survey – Summary Report*, Sydney: Transport and Infrastructure, p. 3.
Case Study 1

The residents of Mount Annan, Narellan Vale and Currans Hill have only 4 buses that travel to Narellan Town Centre on any weekday in the mornings and only one bus that does the return journey. There is nothing on weekends.

They also have no direct public transport to Camden. This makes reaching essential services in either Camden or Narellan, such as local medical centres, the local library or the local Council offices, extremely difficult. A CPSA Member and Currans Hill resident explained that visiting family or friends in Camden Hospital was also almost impossible due to the lack of public transport.

Buses to and from Narellan Vale and Currans Hill are only connected to one major centre, Campbelltown. The CPSA Member said that this is OK in peak hour for those travelling to the city by train. But because of this situation, if a person wants to travel to Narellan or Camden from Currans Hill it is easier to first travel back to Campbelltown about five to seven kilometres to catch a second bus and double back. “What a waste of time, an extra 14 unnecessary kilometres”.

To get a direct bus to Camden, the CPSA Member would have to walk a great distance to Narellan Rd and still have a considerable walk to the nearest bus stop on that road. Their other option is to catch the bus that goes through Currans Hill and alight in Mount Annan. There is no interchange or connecting bus service, meaning that they have to walk and wait for the next Camden bus. “An elderly person would have to walk about one kilometre across busy roads from Mount Annan shops to the nearest bus stop along Narellan Road with no cover and wait out in the wet or heat”.

Case Study 2

Bus timetables and routes have recently changed in the Illawarra. The Dapto CPSA Branch travel to outings in Sydney once a fortnight. They previously used the no. 37 ‘LakeLink’ bus service which, at approximately 7.00am, travelled through Kanahooka and Koonawarra to Dapto station, in order to catch the 8am train to Sydney. The morning diversion has been ‘streamlined’ and the no. 37 does not go through the main streets of Kanahooka and Koonawarra anymore but continues along the Princes Hwy. The only way now to catch the 8am train to Sydney is to catch a bus at 6.30am, which arrives at Dapto station at 6.43am, leaving them with a 1 hour and 15 minutes wait at the station.

Case Study 3

A CPSA Member who lives in Flinders and travels to Dapto to attend CPSA meetings has been severely affected by changes to the bus timetable in her area. There are only two buses that allow her to get to her 10.30am meeting on time: the no. 76 bus that departs Shellharbour Village at 5.27am and 7.47am.

Catching the 7.47am bus gets her to Oak Flats Train Station at 8.20am, which allows her to catch the 8.44am train to Dapto Station, arriving at 8.54am. This means she must wait 1.5 hours until her meeting. Her alternative is to alight from the 7.47 am bus at Shellharbour Stockland at 8.14am, wait for the no. 57 bus, arriving at 8.55am, which gets to Dapto at 9.21am. She then must walk 600 meters to the Branch’s meeting spot.

In total she has nearly two hours of waiting time between transport connections and her meeting. The time between her leaving home and attending her meeting is almost three hours. If she was to drive this 14 kilometre route it would take approximately 20 minutes. To walk this distance, according to Google Maps, it would take three hours – approximately the same period of time taken to get there by public transport.
The streamlining of bus services has had a detrimental impact on the ability of older people and people with disability or mobility impairment to use public transport. The Western Sydney Community Forum has called this problem the ‘360 metre gap’, where people who would have used buses can no longer do so because of the distance from their home to the bus stop. This gap:

“…refers to the difference in access to the services provided by the route bus system [for which guidelines aim to ensure peak hour bus services are within 400m of households] and the community transport system [a door-to-door service]”.\(^2\)

This gap is significant, because this same group of people would not necessarily qualify for Community Transport (CT) services, as they are not deemed in need, however they cannot access adequate public transport. WSCF continues:

“It is the difference in access for people who do not qualify for [Community Transport] (HACC eligible) or do not find CT services adequate for their needs, but find the distance to the nearest bus stop too difficult and are left without access to a service able to meet their needs. The people most commonly found in this gap are active, well, older people and people with mobility difficulties or restrictions”.\(^3\)

Many in this group feel socially excluded because they have lost an important means of maintaining their independence and connection with their community. Although private vehicles and taxis operate in this ‘gap’, they too do not meet the needs of this group. Taxis are generally too expensive, many people are unable to drive and do not want to ‘burden’ others by asking to be driven around.

Accessibility to bus services for people with mobility impairments is also a point of concern. These concerns are also relevant to many train services. The Disability Discrimination Act 1992 (DDA) includes the Disability Standards for Accessible Public Transport, which took effect in 2002. These standards outline the ways compliance can be tested against the DDA, which has the objective to eliminate discrimination on the grounds of disability.\(^4\) The Standards can be tested in areas including (but not limited to) access paths; manoeuvring areas; ramps, boarding devices and boarding points; surfaces; hand and grab rails; signs and symbols; doors and doorways; and toilets.\(^5\) Transportation and transport infrastructure introduced after 23 October 2002 must meet the standards immediately. However, anything existing prior to this date must meet benchmarks set on a progressive timetable over a 30-year period.

Although public transport services in metropolitan areas meet five-year benchmark,\(^6\) there are still a number of barriers for people with disability in terms of accessing

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\(^3\) ibid.


\(^6\) See Appendix A
buses and trains. The five year draft review of the Disability Standards noted some of these difficulties stressing that access concerned more than the number of wheelchair accessible buses on routes.

Access issues included:
- Few low-floor accessible buses in non-metropolitan areas;
- some routes having accessible services in one direction, but none on return journeys;
- some routes offering only one accessible vehicle in the morning and one in the afternoon, limiting flexibility for passengers;
- when accessible bus services break down they are often replaced by non-accessible buses;
- hydraulic ramps are found to be out-of-order, and the bus still runs on the route with the non-functioning ramp, without a manual ramp to compensate;
- non-compliant bus stops and train stations prevent passengers with mobility impairments from using accessible services;
- stops that comply with access standards are not accessible themselves;
- in many rural and regional areas, bus stops are on unsealed roads; and
- the height of bus stop platforms in rural and regional areas is inconsistent making it difficult to use bus ramps properly.

Difficulties in using public transport are compounded by interchanges between services. For the most part, passengers not using a daily ticket (full- and concession-fare passengers) face increased travel costs because they must purchase a new ticket when they change services. This added cost of travel makes public transport less attractive. Interchanges can create difficulties for people who are unconfident or inexperienced public transport users. One section of a trip may be accessible but the other not for people with disability and lack of service information, delays or missed connections may cause anxiety or concern for personal safety.
CountryLink Trains and Coaches

Many people travelling to, from and between rural and regional areas rely on CountryLink services. However, many older people and people with disability find CountryLink services have declined in meeting their transport needs.

Coach services have replaced a number of train services. Although coaches used by CountryLink exceed current Disability Standards for public transport benchmarks, (as most coaches have two wheelchair spaces), travelling by coach is considerably more difficult for people with mobility impairments or medical conditions as they are unable to move around as freely as they would be able to on a train. Passengers are also prohibited from eating or drinking on coaches and have limited or no access to on-board toilets. This can pose problems for people with medical conditions, especially people with diabetes, a condition particularly prevalent among people aged 65 and over in NSW. In addition, limited assistance is provided on board and when boarding or alighting. This does not only apply to people who use wheelchairs but also those who use other mobility aids such as walkers, walking frames and sticks. Travel can easily become problematic if a person is unable to travel with their carer or somebody else who is physically capable of assisting.

Case Study 4

In 2004 the NSW Government, as part of its April mini-budget, announced that the XPT service between Casino and Murwillumbah would cease as of the following month. Despite much opposition, including rallies in major towns in the region, the trains were replaced with a coach service. The closure of the rail service occurred despite population growth, a dramatic increase in the number of older people in the region and the region’s popularity with tourists.

The CPSA Lismore Branch and many other community groups made submissions to the NSW Parliamentary Inquiry ‘Closure of the Casino to Murwillumbah rail service’, arguing that the closure of the rail service discriminated against older people and people with disability. The submissions stated that train services were much more amenable to the needs of older people and people with disability with toilet facilities with easy access, facilities for wheelchairs or using walking frames, as well as accessible train stations. The Trains On Our Tracks (TOOT) campaign run by Northern Rivers Trains for the Future Inc. has since called for the introduction of a local passenger train service to run on the currently disused line, providing sixteen services a day for which there is strong community support. Such a service was also a recommendation of a PricewaterhouseCoopers feasibility study. The Inquiry also recommended the introduction of regular rail services connecting with XPT services between Sydney and Brisbane. None of these recommendations have come into fruition.

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12. General Purpose Standing Committee No. 4, op cit.
Services provided by CountryLink across NSW are quite limited in frequency and are poorly scheduled so as to avoid extended waiting periods between connecting services. CountryLink services have a poor on-time running record. Since 2002, services have only met CountryLink’s on-time running record 37 per cent of the time.\(^\text{13}\) CountryLink passengers thus face an unnecessarily long ordeal when travelling and this discourages people from using CountryLink services, much in the same way as the streamlining of bus services does.

People travelling from rural and regional areas to Sydney for medical and other appointments typically find CountryLink services their only travel option. However, because of inconvenient timetabling, such as the CountryLink service between Dubbo and Sydney, passengers must stay overnight in Sydney (see case study 5 below). Unnecessary overnight stays because of infrequent services as well as long travel times have a substantial financial impact on individuals because of the need to pay for accommodation. People travelling for health-related purposes may be eligible for reimbursement for some of their travel and accommodation costs through the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS), however, the reimbursement under this scheme is small (see Transport for Health Program, page 14).

**Case Study 5**

In Dubbo, there is no way of conducting a day-trip to Sydney. CountryLink train and coach services from Dubbo to Sydney leave too late in the day and services in from Sydney to Dubbo leave too early. For a two day journey, the daily XPT from Dubbo arrives in Sydney at 8.49pm. A daily connecting coach service to Lithgow departs Dubbo at 9.15am with the Lithgow CityRail service arriving after 4.30pm. Both daily services arrive too late for a medical appointment that day. The last train back to Dubbo leaves Sydney at 12.18pm. So, for someone attending a medical appointment in Sydney, they must ensure that the appointment is completed by 12pm at the very latest otherwise they must take up to three days for travel.

While CountryLink services may exceed current disability access benchmarks, there is great variance among other coach companies that operate in the same space. Murrays Coaches, for example, is being prosecuted on the grounds of discrimination. A passenger, who has brittle bone disease, claims that when she tried to book a seat with the coach operator, “the company told her none of their coaches could take her because she uses a wheelchair”.\(^\text{14}\) The outcome of this action obviously remains to be seen. However, this case highlights a glaring oversight within the NSW transport network where people with disability, mobility impairment, or who are frail-aged, have poor access to transport services because the network offers few, if any services.

Apart from ‘on board’ issues, similar access difficulties as those identified in public bus services are present in CountryLink coach services. Walkways and footpaths are not

\(^{13}\) It is important to note that CountryLink determines a service to be on-time if it arrives within 10 minutes of the expected arrival time. Furthermore, public reporting of on-time statistics is presented in total weekly percentages, with all services being grouped together and the number of on-time services presented as a percentage. This means that if a particular service is perennially delayed or cancelled, it is obscured amidst the records of other services (see Appendix B).

always accessible to bus stops, and facilities at bus stops, such as toilets and cafeterias, are not always wheelchair accessible.
Community Transport

Community Transport (CT) is an important means of addressing social isolation for people who are unable to drive or use public transport. Its functions include transport for shopping, social activities as well as health related transport for treatment or medical appointments.

The main source of funding for CT is the Commonwealth and NSW State funded Home and Community Care (HACC) program. HACC funding is allocated using a formula partly based on population size. There has been an annual increase above inflation to HACC funding. HACC CT services are restricted to people who meet the HACC eligibility criteria. These are frail-aged people and people with a moderate, severe or profound disability. Eligibility does not automatically entitle a person access to HACC CT. Access is based on need and service providers determine priority of access.

For those not eligible for HACC CT, CT may also be available through the Community Transport Program (CTP) funded by the NSW Ministry of Transport. CTP is intended for people unable to access mainstream transport services due to physical, social or geographical factors. Funding is not allocated on the basis of population or geographic variations and has not increased (save inflation) to reflect increased demand for at least a decade.

The Community Transport Organisation (CTO) is the CT peak body in NSW, representing approximately 120 CT providers. Over the last few years the CTO has recorded a considerable increase in the number of passengers and trips provided.

Table 1: CT trips in NSW

<table>
<thead>
<tr>
<th>Year</th>
<th>Approx. passenger trips</th>
<th>Est. passengers carried</th>
<th>Est. kms travelled</th>
<th>Providers supplying data</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-06</td>
<td>1,499,001</td>
<td>92,046</td>
<td>20,210,432</td>
<td>89</td>
</tr>
<tr>
<td>2006-07</td>
<td>1,628,402</td>
<td>129,123</td>
<td>20,760,539</td>
<td>75</td>
</tr>
<tr>
<td>2007-08</td>
<td>2,262,150</td>
<td>139,103</td>
<td>28,984,165</td>
<td>93</td>
</tr>
</tbody>
</table>

17 See Appendix C;
18 Denmark, D., Hurni, A. & Cooper, B., (2007) No Transport, No Treatment: Community Transport to health services in NSW, NSW: The Cancer Council NSW; Council of Social Service of NSW (NCOS); and NSW Community Transport Organisation (CTO)
According to Helen Battellino, women are by far the main users of CT services.\textsuperscript{18} Her 2005 research of CT in the Sydney Metropolitan Region found that for those trips where demographic data was available, 79 per cent were made by women.\textsuperscript{19} The gender ratio among people aged 65 or over is 56/44 between women and men respectively (with the female ratio inclining the older the cross-section).\textsuperscript{20} CT is also predominantly used by older people as compared with CT eligible cohorts. Under HACC funded services of four CT providers in South West Sydney, those aged between 71 and 80 made up 30 per cent of clients and those aged 81 to 90 made up 40 per cent. Younger people with disability (under the age of 65) made up only 15 per cent.\textsuperscript{21}

\textit{Figure 1: Age distribution of Community Transport clients in Sydney}\textsuperscript{22}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure1.png}
\caption{Age distribution of Community Transport clients in Sydney}
\end{figure}

\textsuperscript{19} ibid., p.5
\textsuperscript{20} ibid., p.5
\textsuperscript{22} ibid., p.125.
Transport for Health Program

In August 2006, a policy directive of NSW Health saw the amalgamation of a number of separately funded, non-emergency, health related transport programs into Transport for Health (TFH). TFH includes the following schemes:

- The Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS);
- The Health Related Transport Program;
- Inter-facility transport (non-Ambulatory);
- State-wide Infant Screening-Hearing Program (SWISH); and
- Services funded under the previous Transport for Health Program.

Eligibility for support is wider than that under HACC. The aim of TFH is to assist patients who are unable to reasonably access health services by public or private transport. Priority is generally given to patients whose medical condition would otherwise become more severe if they were not able to access health services, or where the development of a medical condition is preventable by accessing health services.

Most patients receiving assistance under Transport for Health are from rural and regional areas travelling to Sydney or other major centres. Generally this group is serviced by IPTAAS. In July 2009, monetary assistance under IPTAAS was improved by removing the $20 mandatory contribution pensioners and health care card holders had to pay; reducing the required travel distance for eligibility from 200 kilometres to 100 kilometres (one way); and increasing the private vehicle-use subsidy. Despite this, IPTAAS is not a full reimbursement scheme and reimbursements tend to cover a small percentage of the travel and accommodation costs incurred.23 CPSA also understands that reimbursements can take a long time to be processed, which poses difficulties for people on low-incomes as they must wait a long time before they receive the financial assistance, and may not be able to afford the up-front payments.

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23 See Appendix D
Issues in Community Transport

The original purpose of Community Transport was to assist older people and people with a disability unable to use public transport or private vehicles to attend social and recreational outings. With the re-routing of, and/or timetable changes to, public transport services, CT is under increased pressure to assist people who had previously been able to travel on public transport. CT now receives a very small amount of funding for health related transport. However, CT is a specialised service with limited frequency and availability.

Generally, most people are able to access CT once a week. Services can be expensive as, although no one is refused service because of inability to pay, CT services usually come at a much higher cost than public transport, costing around $5-$10 a round trip.

There has also been growing demand on CT for health related transport. This is placing pressure on CT providers to reduce their services in other areas. CT was designed to support social inclusion, but it is increasingly becoming a service that facilitates health related transport needs. Obviously, health-related transport is an essential service and must continue. However, the lack of targeted funding for both CT and health related transport programs has resulted in both falling behind in meeting demand.

A report jointly commissioned by the Community Transport Organisation, NCOSS and the Cancer Council, entitled No Transport No Treatment, highlighted that apart from changing demographics, a number of important changes to health care over the last 10-15 years has led to increased demand for health-related transport. These changes include the concentration of services in fewer hospitals; early discharge policies and increased day-only surgery; and a reduction in home visits by doctors. Furthermore, a ministerial inquiry in 1983 An Inquiry into all aspects of the NSW Ambulance Service led to changes in the role of the NSW Ambulance Service which resulted in a 75 per cent reduction in non-emergency trips provided by the service.

No Transport, No Treatment highlighted that funding for health-related transport to CT under both HACC CT and the CTP combined was significantly disproportionate to the level of assistance being provided. CT receives over 75 per cent of its funding from HACC but only approximately five per cent from NSW Health’s Transport for Health Program. However, since 2006, health-related transport has accounted for 28 per cent of all CT trips. In urban areas, the percentage is much higher at 44 per cent. Health-related trips are much more expensive on a unit cost basis compared with other CT services. This occurs for a number of reasons, including the level of ‘out-of-
area travel’; the higher cost of service for high-needs clients; and the greater proportion of individual travel.

According to the *No Transport No Treatment* report, there is a profound lack of proportional funding provided to CT under the Transport for Health program. The report estimated that Transport for Health funding covers the cost of only ten per cent of health related transport delivered by CT. This, and the limited scope of transport services provided by NSW Health, has contributed to one in six requests for health related transport being turned down by CT providers. This equates to 90,000 trips annually.29

Those particularly disadvantaged in accessing transport for health treatment include indigenous communities, cancer patients and patients requiring therapy services.30 CT providers are unable to provide the required number of trips to patients and they are often unable to provide the type of specialised assistance required by patients either due to lack of expertise (drivers are not trained in health areas, especially volunteers) or due to the lack of staff or appropriate vehicles.31

As highlighted earlier, younger people with disability (under 65s) use CT services at substantially lower levels than those over 65. There are a number of reasons why younger people with a disability may use CT services less so than older clients. People with disability and their carers are generally less aware of services and there is also a perception that CT is restricted to older people.32 Furthermore, the needs of younger people with disability differ greatly from those of older people. Services may only be available for shopping, health and medical appointments or group outings during the day and may not cater for their needs such as transport for work or study, or for socialising in the evenings and on weekends.33

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29 ibid., p.34.
30 ibid.
31 ibid.
33 ibid.
Unmet transport needs of Nursing Home residents

In 2003, NCOSS produced a report outlining the transport needs of people in NSW nursing homes. It found that most residents were reliant on friends and family to provide them with their primary means of transport. Those unable to utilise this support network (approximately 33 per cent of over 10,000 respondents) found great difficulty in accessing transport services. A very high proportion of residents required somebody to accompany them when travelling or waiting. When this was a staff member, it further compounded nursing levels at the home. A lack of an escort would commonly lead to the resident cancelling their trip.

Cost was also another major consideration for residents. 95 per cent of responding residents said that they could afford only $10 or less per week for transport. Apart from family and friends, residents were mostly reliant on taxis, a facility-owned vehicle or CT, suggesting their income could not stretch to cover extensive trips. This was particularly an issue in rural and regional areas and urban fringes where there were greater distances to essential services. A very low proportion of residents were registered with the Taxi Transport Subsidy Scheme (TTSS), despite the use of taxis as an important means of transport by residents.

One of the major recommendations made by NCOSS in the report was to expand the eligibility criteria of the TTSS to all people living in residential aged care facilities and in receipt of care packages. TTSS eligibility remains quite restricted to people with some forms of total and permanent disability. These include severe ambulatory restrictions; severe vision impairment or total loss of vision; severe and uncontrollable epilepsy; severe intellectual disability; and severe and permanent communication difficulties.

NCOSS also called for the development of a Residential Aged Care Transport Supplement. The supplement would mirror other supplements provided under the Aged Care Act (1997) and would directly fund transport services for aged care service recipients. This recommendation is also yet to be acted on.

34 Council of Social Service NSW, (2003), On the Road, Again: The Transport Needs of People in Residential Aged Care, NSW: Council of Social Service NSW
35 ibid.
36 ibid.
37 ibid.
38 ibid.
39 ibid.
40 ibid.
42 Council of Social Service NSW, op cit.
Older driver testing

In NSW drivers who reach 85 years of age are required to pass a practical driving test every two years in order to retain their unrestricted licence. Once a driver reaches age 75, they are required to pass an annual medical examination determining their fitness to drive.\(^43\) If they wish not to take the test, they can apply for a ‘modified licence’ which restricts them to driving in their local area (which is not clearly defined by the RTA). If they take the test and do not pass, they are allowed another two attempts. If they do not pass after three attempts, their driving may be restricted with a modified licence. A modified licence typically imposes a 10 kilometre radius from the driver’s home that they are not allowed to drive beyond (exceptions are made for people who live more than 10 kilometres from services). A driver may also have their licence cancelled.

There is no evidence that on-road older driver testing makes roads safer, or that older driver testing is needed at age 85 and beyond.\(^44\) No evidence exists that demonstrates older drivers as a group pose a greater risk to road safety than any other group. The evidence presented to the NSW Government by the Roads and Traffic Authority in NSW (RTA) suggests that older drivers, as a group, are safer drivers compared with other road users. There is, therefore, no reason to treat this group differently from any other group. To do so is discriminatory, and is why the Older Driver Test is NSW should be abolished.

\(^44\) See Appendix E
The Metropolitan Transport Plan

In 2010 the NSW Government released its Metropolitan Transport Plan (the Plan) and it is expected that it will also release a regional transport plan in the near future. The Plan highlights the NSW Government’s transport priorities and funding commitments for the Sydney metropolitan area over the next 10 years. Unfortunately, the Plan fails to shift the Government’s priorities away from private vehicle use and roads, toward public transport and other initiatives. Of the total $50.2 billion of funding in the Plan, almost half ($21.9 billion) is going towards road upgrades and expansions, including adding extra lanes on the M2 and M5. This funding for roads equates to 7.5 times the funding apportioned to buses and is over 660 times the amount of funding provided to CT services.45

The Plan has a stated aim of providing an accessible transport system that meets the needs of the ageing population:

“A quality transport system will meet varied travel needs and personal abilities. Our active but ageing population – by 2036, one in six will be aged 65 or over compared to one in eight now – will have increasing needs for accessible transport options”.46

There is, however, no plan outlining how this increased demand for accessible transport options will be met. The Plan continues to focus public transport towards commuter-oriented services and there is no mention of alternative services such as Demand Responsive Transport or to CT and TFH.

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46 ibid., p.11
Possible Solutions

Changing focus

Greater focus on the needs of non-commuter transport is required to alleviate current high car dependency, and the exclusion of those unable to drive. Greater utilisation of public transport will only come with more frequent services at all times of the day, with better connections and breadth of services. Furthermore, greater public funding from all levels of government should be made towards Disability Standards to hasten the meeting of benchmarks, especially in rural and regional areas.

Demand Responsive Transport (DRT) offers a combination of fixed route and demand responsive services, enabling passengers to be picked up and dropped off anywhere along or within the bus route or zone. This allows people who are unable to access traditional bus services due to distance or mobility difficulties to continue to independently go about their day-to-day activities. DRT has the power to significantly reduce the ‘360m gap’, ensuring everybody has access to appropriate transport services.

Where DRT is offered as part of CT operations, the cost of CT services is reduced because DRT makes more efficient use of service capacity. It also pools available transport resources (drivers, cars, buses, etc.) to deliver services that are appropriate to the needs of clients. If DRT is integrated with traditional public transport services, demand for CT can be relieved and CT providers would therefore be able to focus on maintaining and improving the independence of those who most need their services in line with the original intention of CT.

The NSW Government should investigate a variety of DRT options with key stakeholders including public transport authorities, the CTO, CT providers and taxi companies, as well as local governments and community organisations. Depending on the format of the DRT services and who is charged with providing them, legislation may be required as DRT and CT are not covered by the NSW Passenger Transport Act 1990.

DRT has become commonplace around Europe and is being utilised in other parts of the world. A number of DRT services have been established in Australia as well. These include RoamZone in South Australia which operates in six locations in metropolitan Adelaide, as well as the Telebus network in Melbourne servicing five suburbs in the cities east. Melbourne’s Telebus network offers a very comprehensive approach to integrating DRT into the public transport network and deserves close consideration. In NSW, a DRT program has been established by Great Community Transport (Penrith, Blue Mountains and Hawkesbury regions) through its SmartLink Transport initiative.
Case Study 6

Melbourne’s Telebus service incorporates demand responsive transport within a fixed route arrangement and operates over seven zones in five suburbs. The services connect passengers with stops at train stations, shopping precincts and schools. There are no restrictions on eligibility for using Telebus. Those choosing to use the service by catching the Telebus along its route pay the same fare as they otherwise would for a conventional bus service, whilst those requiring or choosing to catch the bus to and from their doorstep (demand responsive), pay a small surcharge.

A recent study into Melbourne’s Telebus found that use of the service has been most utilised by young adults (generally students), over 55s (mostly retired) and people without a driver’s licence. Use of the demand responsive feature increased with age and was significantly linked to health and mobility issues, with eighty per cent of demand responsive users having a health condition or disability which would otherwise affect their travel. The report highlighted the advantage of DRT for older people, stating: “The availability of the pick-up and drop-off feature has certainly improved access to activities and the opportunities for social inclusion for older persons in general … (and) offers additional sense of safety for travelling in evenings and independent mobility for young persons.”

Case Study 7

In Sydney’s South West, the Community Transport Taxi Voucher project provides HACC eligible clients whose needs are not being met by traditional CT services transport. It was developed to meet the transport needs of younger people with disability who need transport at times when CT does not operate.

For $10, clients are provided a month’s allotment of vouchers to the value of $55 in $5, $10, $15 and/or $20 denominations. While clients must be from the area, they are able to use the vouchers for services anywhere within Australia so long as they have booked ahead with the taxi company. A 2009 survey of the project found that transport needs of most clients were being met and, importantly, clients felt a sense of independence and freedom by not having to rely on family, friends or other services.

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48 ibid. p.5
49 ibid. p.6
50 The Community Transport Voucher Scheme is a joint project of South West CT, Southern Highlands CT, Bankstown CT and Walomi Aboriginal CT. These cover Sydney South West Area Health Service which is made up of Bankstown, Fairfield, Liverpool, Campbelltown, Camden, Wollondilly and Wingeecarribee LGAs.
Improving CountryLink services

Investment in CountryLink is required to improve services for those who rely on CountryLink, and make it a more attractive transport option for those travelling across NSW. CountryLink is a vital service for people living in rural and regional areas who are not able to drive.

The NSW Government should consider the introduction of railmotors for CountryLink services between regional areas. Railmotors should replace CountryLink coach services, which have replaced train services to the detriment of many rural and regional communities. This type of service can be beneficial for a number of reasons. Railmotors are smaller and more cost-effective when there is less passenger demand. They are better able to meet the needs of older people and people with mobility impairments compared with coaches and are a safer and more stable mode of transport. Furthermore, they provide the opportunity to reintroduce more frequent services from smaller communities to regional centres, and in turn, create better connections with trains to other major centres.

Improving transport services for nursing home residents

The major recommendations made by the NCOSS report into the transport needs for nursing home residents should be implemented by both the Australian and NSW Governments as appropriate. The NSW Government should expand eligibility of the TTSS to all residential aged care service recipients. This would help improve transport affordability for nursing home residents and aged care package recipients. The Australian Government should also implement the Residential Aged Care Transport Supplement recommendation. A dedicated funding stream for the transport needs of nursing home residents would help deliver a coordinated approach to transport provision.

Abolishing the Older Driver Test

The NSW Government should abolish the older driver test as the test has no proven benefit, and there is no evidence transport safety has improved for either older people or the wider community since its introduction. Rather, the test is having a severe and detrimental effect on the independence of older people by restricting their ability to travel with consequential impacts on their physical and emotional wellbeing.

In 2006, New Zealand removed the mandatory on-road driving test, maintaining only the requirement for a medical certificate for fitness to drive following a report commissioned by the New Zealand Ministry of Transport and a subsequent public consultation of the proposed changes.52 Similarly in the state of Victoria, a 2003 inquiry entitled Improving Safety for Older Road Users recommended that “mandatory age-based on-road driver testing or road knowledge testing not be introduced in

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Victoria at this time”. The NSW Government should follow this path and remove the mandatory older driver test.

**Increasing funding and priority for public transport, CT and health transport**

Continuing heavy focus on roads for private vehicle use will only maintain the status quo. It will not deliver improvements to those who experience transport disadvantage. Funding priorities should focus on areas that are not well serviced by public transport and on delivering public transport services for people who do not fit the commuter demographic.

The NSW Government should follow the example set by the Victorian Government by establishing a ‘social transit’ agenda alongside a ‘mass transit’ agenda. While mass transit projects aim to reduce congestion and improve services where public transport is the most efficient mode of transport, the aim of a social transit agenda would be to deliver a minimum service level that would likely enable “most groups of transport disadvantaged people to engage in most of the activities they were seeking to undertake most of the time”. Such an agenda would place primary focus on the type and level of services required by people who are excluded by the current, commuter-focused ‘mass transit’ agenda.

In the Melbourne metropolitan area the social transit agenda has focused on upgrading bus routes to a minimum service level with increased hours of service, creation of new services and reduced fares for certain tickets and user groups. Analysis of the improvements indicates that the Victorian Government’s social transit agenda has delivered substantial improvements:

> “These service increases have successfully resulted in patronage gains in line with international evidence, and users are benefiting particularly from increased social and employment opportunities, and notably increased independence for younger people. This suggests the service upgrades have delivered increased social capital and social inclusion”.

The NSW Government should develop a social transit plan with benchmarks and initiatives to meet the needs of the transport disadvantaged. Comprehensive community consultation will be required and any plan must be subject to periodic reporting.

Greater funding for the Transport for Health program under NSW Health will alleviate the number of unmet calls for assistance and reduce the rationing of CT. The No Transport No Treatment report called for an increase of more than $7 million (from

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less than $3 million to $10 million in 2006). Along with increased funding, Transport for Health requires better coordination so that resources are better and more equitably distributed. This requires consideration of demographic, geographic and workforce issues and designing Transport for Health programs accordingly. IPTAAS should also be reformed to allow payments to be made for estimated travel and accommodation costs in advance. This would make travel for treatment considerably more affordable and thus accessible, especially for people on low incomes.

With a growing proportion of older people in the community as well as older people with disability, CT requires funding increases above inflation to meet demand and deliver the type of services for which it was originally established. Funding can also assist in better coordination of services and vehicle fleets. CT providers should be funded in such a way that they are able to deliver services that are closely tailored to the needs of clients rather than providing services within which the client must fit or otherwise be excluded. A call for increased funding was made as one of the recommendations of the 2003 ministerial inquiry into transport (known as the Parry Report).57

A review into CT and unmet need for transport should be conducted by the NSW Government to identify the current gaps in providing a complete picture of the level and type of services required in the community. The review should investigate both current and future demand based on geography, communities, required services and workforce issues. Other issues that should also be investigated include the potential to maximise vehicles and other resources between CT providers and other service-type providers as well as improving coordination of CT services with public transport providers.

Data on unmet need for CT services should be collected on a regular basis by Ministry of Transport and be made publicly available. The data should be used to guide CT providers, transport planners and the NSW Government in addressing gaps in the system, to ensure that those who currently miss out on CT services get them.

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### Appendix A

**Transport Standards Schedule 1: Compliance Target 31-12-2007**

<table>
<thead>
<tr>
<th>Part</th>
<th>Responsibility</th>
<th>Requirement</th>
<th>Application</th>
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<tr>
<td>1.1</td>
<td>Operators Providers</td>
<td>Full compliance with the relevant standards in relation to:</td>
<td>Conveyances: All</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hearing augmentation</td>
<td>Premises: All</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Information</td>
<td>Infrastructure: All except bus stops</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Booked services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Food and drink services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Belongings</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Priority</td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Radio networks Co-operatives</td>
<td>Response times for accessible vehicles are to be the same as for other taxis.</td>
<td>Conveyances: Taxis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Premises: Dial-a-ride services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Infrastructure: none</td>
</tr>
<tr>
<td>1.3</td>
<td>Operators Providers</td>
<td>Compliance with the relevant standards by 25% of each type of service in relation to:</td>
<td>Conveyances: All</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Handrails and grabrails</td>
<td>Premises: All</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stairs</td>
<td>Infrastructure: All except bus stops</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Symbols</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Signs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• TGSIs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lighting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Street furniture</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Information</td>
<td></td>
</tr>
<tr>
<td>1.4</td>
<td>Providers</td>
<td>Compliance with the relevant standards by 25% of bus stops in relation to:</td>
<td>Conveyances: None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Handrails and grabrails</td>
<td>Premises: None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stairs</td>
<td>Infrastructure: Bus stops</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Symbols</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>• TGSIs</td>
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<td></td>
<td></td>
<td>• Street furniture</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Information</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

CountryLink on-time running record

CountryLink’s benchmark for on-time running is 78% of services arriving at their destinations within ten minutes of the scheduled time within weekly periods.

<table>
<thead>
<tr>
<th>Year</th>
<th>On-time running weeks</th>
<th>Average on-time running (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>15/35</td>
<td>78.0</td>
</tr>
<tr>
<td>2009</td>
<td>24</td>
<td>75.0</td>
</tr>
<tr>
<td>2008</td>
<td>14</td>
<td>73.9</td>
</tr>
<tr>
<td>2007</td>
<td>6</td>
<td>69.8</td>
</tr>
<tr>
<td>2006</td>
<td>16</td>
<td>74.3</td>
</tr>
<tr>
<td>2005</td>
<td>19</td>
<td>74.8</td>
</tr>
<tr>
<td>2004</td>
<td>13</td>
<td>71.5</td>
</tr>
<tr>
<td>2003</td>
<td>38</td>
<td>83.5</td>
</tr>
<tr>
<td>2002</td>
<td>14/27</td>
<td>74.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>159/427</strong> (37%)</td>
<td><strong>75.0</strong></td>
</tr>
</tbody>
</table>

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## Appendix C

Community Transport funding by government program

<table>
<thead>
<tr>
<th>Year</th>
<th>HACC</th>
<th>CTP</th>
<th>Area Assistance Scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/09</td>
<td>$31.424m</td>
<td>$2.310m</td>
<td>$541,333</td>
</tr>
<tr>
<td>07/08</td>
<td>$29.003m</td>
<td>$2.209m</td>
<td>$524,040</td>
</tr>
<tr>
<td>06/07</td>
<td>$27.453m</td>
<td>$2.166m</td>
<td>$507,299</td>
</tr>
<tr>
<td>05/06</td>
<td>$25.330m</td>
<td>$2.119m</td>
<td>$413,891</td>
</tr>
<tr>
<td>04/05</td>
<td>$21.333m</td>
<td>$2.148m</td>
<td>$476,789</td>
</tr>
<tr>
<td>03/04</td>
<td>$18.058m</td>
<td>$2.092m</td>
<td>$467,441</td>
</tr>
<tr>
<td>02/03</td>
<td>$16.730m</td>
<td>$2.037m</td>
<td>$311,909</td>
</tr>
<tr>
<td>01/02</td>
<td>$14.500m</td>
<td>$1.862m</td>
<td>$333,344</td>
</tr>
<tr>
<td>00/01</td>
<td>$10.070m</td>
<td>$1.700m</td>
<td>$288,955</td>
</tr>
<tr>
<td>99/00</td>
<td>$10.455m</td>
<td>$1.802m</td>
<td>$288,955</td>
</tr>
</tbody>
</table>

Funding for non-emergency transport services delivered through the NSW Health Transport Program remains largely unreported. In 2006/07 the program was allocated $15.9m, of which funding for non-emergency transport services was estimated to be between $1 and $3 million. In 2009-10 $2.3 million was allocated to IPTAAS.

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Appendix D

IPTAAS Reimbursements

- Mandatory $40 contribution to the cost of travel and/or accommodation (not applicable to pensioners and health care card holders). This is deducted for the total reimbursement per return trip.

- Public transport assistance is reimbursed at economy rates less GST. If upgrades required on medical grounds, must be certified by referring doctor/treating specialist.

- Private motor vehicle reimbursed at rate of 15c per kilometre.

- Taxi fares subsidised at following rates
  - One visit/consultation Max $20
  - Short-term visit (2-7 days) Max $40
  - Medium-term visit (to 14 days) Max $80
  - Long-term visit (15 days or more) Max $160

- Assistance towards commercial accommodation costs – hotel, motel, hostel, apartment and residential park – paid on per room/per night basis.
  - Single room up to $33 per night
  - Double room up to $46 per night

- Pensioners and health care card holders staying in private accommodation are able to claim an allowance of $30 per week after the first week.

- Air travel costs only reimbursed if medical practitioner or treating specialist has obtained prior approval from Health Transport Unit.

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Appendix E

Older Driver Testing

In NSW drivers who reach 85 years of age are required to pass a practical driving test every two years in order to retain their unrestricted licence. Once a driver reaches age 75, they are required to pass an annual medical examination determining their fitness to drive. If they wish not to take the test, they can apply for a ‘modified licence’ which restricts them to driving in their local area (which is not clearly defined by the RTA). If they take the test and do not pass, they are allowed another two attempts. If they do not pass after three attempts, their driving may be restricted with a modified licence. A modified licence typically imposes a 10 kilometre radius from the driver’s home that they are not allowed to drive beyond (exceptions are made for people who live more than 10 kilometres from services). A driver may also have their licence cancelled.

Older driving testing has been a controversial issue because both the justifications for it and the results it aims to achieve are based on limited and relatively weak evidence. The justification for testing older drivers is based on two major factors. First, older drivers are overrepresented in figures for fatalities of drivers and motorcyclists and second, that older drivers are overrepresented in accidents on a per kilometre driven basis.

Older drivers are more likely to suffer injury or fatality from a motor vehicle accident due to their greater physical frailty. Older adults have a lower biochemical tolerance to injury than younger people, due mostly to reduced bone strength and fracture tolerance.

Although drivers over 70 only made up 31 of 314 driver and motorcycle rider fatalities in 2006, or 9.9 per cent, they were the second-highest group on a fatality per licence-holder basis. As can be seen in Figure 2, there is a u-shape effect where the youngest and oldest age groups are the most likely to die in an accident.

A similar u-shape is evident when considering incidents on a per kilometre basis, with older drivers again being over-represented as seen in Figure 3. Based on these factors, the argument goes that as a person ages, they are more likely to be involved in accidents and be killed or seriously injured whilst driving, hence the need for older driver testing.

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Such use of figures, however, does not represent the full situation and other factors, once examined, highlight that there is little to no difference between the incidence of accidents between older drivers and younger cohorts. One of these factors is known as frailty bias. Older drivers are more likely to suffer injury or fatality from a motor vehicle accident due to their greater physical frailty. Analysis of data from the United States by Guohua Li et al. suggests that for drivers aged 60-74, 80-85% of fatalities could be explained by frailty. For drivers over 75 years of age, between 60% and 90% of fatalities could be down to frailty. Lynn Meuleners et al. conducted similar analysis on data from Western Australia. Their results were consistent with the findings of Li et al. with frailty accounting for between 47% and 95% of serious injuries.

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67 ibid., p.74 and 86
68 Austroads, (2005), Assessing Responsibility for Older Drivers’ Crashes. Canberra: Austroads
and fatalities for drivers aged over 65 years. Compounding frailty bias, older drivers are more likely to drive older vehicles which tend to have fewer, less advanced safety features than newer cars. 51% of older drivers in fatal crashes in Australia were in cars 11 years or older, compared to only 30% of middle-aged drivers.

The use of distance of travel per accident as an indicator of older drivers’ overrepresentation in crash statistics has also been increasingly called into question. A factor termed short distance bias indicates that, regardless of age, those who drive fewer kilometres have a higher risk of accident than those driving more, on a per kilometre basis. Studies conducted in 2002 and replicated later on – as well as having been established elsewhere – highlighted the correlation between annual distances driven and accident rates. In each survey drivers were allocated into three groups based on annual distance driven (less than 3,000km; 3,000-14,000km; and over 14,000km). Jim Langford et al. showed that in Holland, independent of age, “those who drove less than 3,000 km per year, have a six-fold crash rate, relative to drivers with an annual distance exceeding 14,000 km” (see Figure 4). Interestingly, in the studies conducted by Liisa Hakamies-Blomqvist et al. and Langford et al. older driver cohorts who drove medium and high annual distances were the safest of all driver cohorts, with the lowest incidence of accidents.

Figure 4: Crashes per 1 million driver kilometres, by age, 2003

Older drivers tend to drive less annual kilometers compared with other cohorts as they increasingly self-regulate their driving habits based on their understanding of their continuing ability to drive. Self-regulation generally involves a gradual reduction in driving distances, limiting driving at night, taking mostly familiar environments, and

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71 Austroads, op cit. p.28.
driving slower. Individuals who drive only short annual distances tend not to use highways – roads typical of uninterrupted travel for many kilometres – but rather use roads in built-up, urbanised environments. Such roads, by their nature, comprise many more conflict points such as intersections (with or without traffic lights or roundabouts), varying degrees of congestion “and other situations that require a higher degree of information processing and decision making”. 

In spite of such evidence highlighting that older drivers are not more likely to be involved in accidents once distances have been accounted for, older people reasonably perceive that they are portrayed negatively in the media when an accident involving older drivers result in death or injury to others. Langford et al. replicated finding from the US and Europe with Australian fatality data, showing that once distance bias was accounted for, older drivers involved in accidents were least likely to be associated with fatalities of other road users.

While the need to single out older drivers for compulsory regular testing has been substantially shown as unnecessary, the test remains in NSW. Is the test having the desired effect of reducing fatalities and injuries amongst or caused by older drivers? Research both overseas and in Australia argues that it does not. Langford et al. compared crash statistics between NSW and Victoria (where there is no mandatory older driver test). They concluded that such tests have no demonstrable road safety benefits and that they may be negatively impacting on the mobility of otherwise good older drivers who may decide to cease driving rather than go through the test.

Apart from having the detrimental effect of prompting good older drivers to stop driving – thus unnecessarily restricting their mobility and independence – the older driver test may also increase the likelihood of being involved in an accident for some older drivers. If older drivers are unable to pass the test they may be put on a restricted licence. As discussed previously, older drivers may wish to automatically be placed on the restricted licence. By being on a restricted licence, older drivers are restricted to driving in their local area and in a set distance from their home. This essentially replicates the areas within which a greater number of accidents occur, as defined by short-distance bias. Older drivers would be safer if they were able to drive longer distances on longer stretches of roads, such as freeways and highways.

The test has impacted on the independence of older people in a number of ways. They may be prevented from visiting family and friends, attending appointments or other essential services. They may be the only driver among their network and so many more people suffer as a consequence of this policy. They may also become reliant on other services, such as CT or public transport which may not meet their

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82 ibid.
need. These issues are particularly pertinent in rural, regional and outer-urban areas where there is greater distance to reach services and where other transport services are minimal and/or costly.

As the evidence highlights, older drivers are not a greater risk than other demographic cohorts to other road users. Rather, those that are at greatest risk are older drivers themselves, as they are more likely to be seriously injured or killed should they be involved in an accident due to their frailty and their typical driving patterns. This makes driving in older age not an issue of public health and safety but one of individual freedom of choice. Older drivers should be aware of these risks and be able to weigh this up against the potential negative effects not driving would have on their lives.

The NSW Government should scrap the older driver test as it is based on inadequate evidence that has been solidly disproven. The test has no proven benefit, having not improved transport safety for both older people and the wider community. Rather, the test is having a severe and detrimental effect on the independence of older people by restricting their ability to travel with consequential impacts on their physical and emotional wellbeing.

In 2006, New Zealand removed the mandatory on-road driving test, maintaining only the requirement for a medical certificate for fitness to drive following a report commissioned by the New Zealand Ministry of Transport and a subsequent public consultation of the proposed changes. Similarly in the state of Victoria, a 2003 inquiry entitled Improving Safety for Older Road Users found that “mandatory age-based on-road driver testing or road knowledge testing not be introduced in Victoria at this time”. The NSW Government should follow this path and remove the mandatory older driver test. The Government should encourage and support older people in purchasing safer vehicles; and encourage and support the development of safety technology and equipment. The Government should also better support older people, their families and medical practitioners in becoming more aware of possible changes to their health which may have an impact on their ability to drive.

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83 Sullivan, C., op cit., 84 Road Safety Committee, op cit.
Meeting the transport needs of transport disadvantaged people in NSW

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