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ACTA
Australian Community Transport Association

Rethinking the Support-at-home program for community transport

The proposed Support-at-home program seeks to replace previous models including the Commonwealth Home Support Program (CHSP) and Home Care Packages (HCP) with a predominantly 'fee-for-service' (FFS) model. The stated aim of this program is to improve the equitability of service access and for senior Australians "to remain independent and in their own homes for longer"[1]. For anyone in the community relying on Community Transport (CT) to access daily needs, a transition from the grant-funded CHSP model to an FFS model will have a significant and likely devastating impact.

We understand that the Government aims to maximise value for clients and taxpayers, by achieving tangible outputs for dollars invested. Where the SAHP aims to address this, is by capping the number of highly variable "trips" and funding the service on a 'pay-as-you-go' basis. Prior to making these significant changes, the government needs to fully understand the complexities of service provision to inform a robust funding model. The current lack of engagement and understanding is of great concern to the sector and community, given the changes are proposed to occur swiftly.

To avoid the devastating outcomes a 'fee-for-service' transition is likely to bring, for the reasons outlined above it is critical that CT providers continue to receive 100% supplementary grant-funding until at least 1st July, 2024. Over this two-year period, we would seek to work closely with the Commonwealth Department of Health and key State level Departments of Transport and Health to share deeper insights, data and lessons learned on the strengths of the current system. We urge the Government to take additional time to closely investigate, monitor and review how CT providers currently use available funding to provide the highest quality service at the best value to the taxpayer.

Across Australia, CT providers (represented by ACTA) support 238,000 clients annually to complete over 95 million kilometres of travel. Most CT providers are not-for-profit community based organisations. The most variable trips (which are most at risk through the proposed funding model) are those in rural and regional Australia, the communities that have the least access to essential care services.

Collectively the sector has around 2,200 paid staff and 8,000 volunteers – most of them drivers – who provide 2.4 million hours of service[2]. To replace this donated time with paid labour, would cost the Commonwealth government about $86M[3], equivalent to increasing the Commonwealth Home Support Programme (CHSP) transport funding for 2021/22 by 45%. Most of this effort is directed at eligible aged consumers, placing CT firmly into the category of Aged Care services. CT providers also interact with other care providers: observing, monitoring and reporting on consumers' well-being and the possible need for other types of support.

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[1] www.health.gov.au/sites/default/files/documents/2022/01/support-at-home-program-overview.pdf

[2] https://communitytransportaustralia.org.au/wp-content/uploads/2022/04/ACTA-Advocacy-Paper-Re-abling-Mobility.pdf

[3] Based on the average hourly wage in Australia: https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/employee-earnings/aug-2021

CT providers provide a "door to door" service and have established developed risk management protocols, rather than the "kerb to kerb" service provided by most private transport operators. This means providers will walk to the door and assist the client to the vehicle. If the client is not ready at the door for the service, CT providers follow emergency risk management procedures to contact the client by phone, and if necessary, their next of kin. They then call emergency services if deemed appropriate and await their arrival. This level of care is typically limited to the community transport sector, who are driven by a culture of care for their clients rather than by revenues.

The CT sector also fills a critical gap in areas where there is severely limited or no public transport or hospital patient transport. CT providers in these areas often transfer patients discharged from hospitals where state assets are limited in providing this service.

The Royal Commission into Aged Care (2021) found that transport services are particularly critical in social supports (especially in reducing and preventing social isolation and loneliness among older people). It is specified in Recommendation 33 (p.167-9 of vol. 3A) that transport service-types as part of a social supports category should be grant-funded. The reasons for this are quoted from The Royal Commission below.

> *"We recommend this category of social support services be grant funded because they:*
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> - *Have substantial infrastructure and capital costs—for example, in transport fleets or centres*
> - *Are often voluntary-managed and community-based organisations with high numbers of all volunteers*
> - *Can provide some innovative benefits when offered in combination."*

Despite this clear Royal Commission finding, SAHP proposes that transport services be no longer grant-funded but instead be funded on an ad hoc, "for service" basis. Grant funding enables CT providers the flexibility to organise services and allocate resources in a way which enables them to meet a range of client needs. Management of CT services depends on the service area, scale of coverage, client numbers and locations. Grant funding models provide more reliable funding of CT services, enabling CT providers to:

- Procure, maintain and store vehicles and other equipment – including vehicles which can accommodate wheelchairs
- Train staff to provide a high level of care to various clients with unique needs
- Pay drivers where volunteers are not available
- Organising complex bookings, managing volunteers, and rostering vehicles (optimised by long-term paid staff with deep understanding of client needs)
- Advertise services through a range of media (particularly to reach people with literacy issues and where English is a second language)
- Maintain operations when demand periodically drops or when clients are hesitant to travel (which has been a common experience through the bushfires, flooding and the COVID-19 outbreak, lockdowns and recovery)

Given many of these costs are fixed, it makes it very difficult to organise cash flow when funding is provided on an ad hoc basis.

For not-for-profit entities (90% of CT providers) who make thin margins, this would likely make operations precarious. Providers would need to adapt by making decisions based on revenue flow, rather than for client and community benefit.

Grant funding also enables CT providers to make investments and attract partnerships which in turn create higher value for the government. One example is the use of trip aggregation software, which analyses the most optimal route for a service to minimise deadtime and maximise the number of clients per trip. Grant funding also ensures long-term reliability for a service, which is essential for sponsorship agreements with the private sector (particularly when partnerships involve advertising).

Operating on a fee-for-service type model without grant funding, transport providers will have to make business decisions about:

- The scale of operations they can manage
- The geographic area their service can cover
- The amount they need to charge each client
- The clients they are able to serve and the level of care they can provide

Decisions will likely be needed on selling those vehicles that are more expensive (those that accommodate wheelchair users), reducing coverage, avoiding long or time-consuming trips where clients are dispersed and trips are difficult to aggregate (disproportionately outer suburban, regional, rural and remote CT trips), providing a "kerb-to-kerb" service only, and providing a disproportionate number of trips to people travelling short distances.

The resulting shortfall would need to be substituted by:

- **The for-profit sector (Demand-responsive transit, rideshare, taxis, private transport providers):** these can be far more expensive and less reliable than grant-funded shared transport (given the cost-inefficiencies of single occupant services, significant levels of deadtime and the need to generate profit)[4]. This would typically mean that clients' SAHP transport budgets would accommodate fewer trips
    - In the context of social trips (such as day care, shopping, meet-ups and other activities), this typically results in lower social capital in the community, lower quality of life outcomes for clients and social isolation – particularly for clients with cognitive, vision or mobility impairments who require a high level of support
- **Ambulances and hospital assets:** which would be required to meet the needs of clients attending medical appointments and operations. CT addresses a significant proportion of the medical trip demand among older Australians. The substitution of this service by hospitals would stretch already scarce resources (particularly in regional areas) requiring higher levels of state funding to address aged care
- **Public transport:** which cannot meet the same standard of care which CT services provide, especially in areas with low public transport coverage. CT services provide a "door to door" level of care, have capacity for wheelchair users and meet a variety of client needs (cognitive, vision, mobility impairments; and meeting the needs of people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander people). This would also require higher levels of state funding

[4] https://communitytransportaustralia.org.au/wp-content/uploads/2022/04/ACTA-Advocacy-Paper-Re-abling-Mobility.pdf see pages 2 & 5 which reference studies by the University of Wollongong and Monash University

- **Premature entry into residential aged care:** which will be the only option for people who cannot have their health, errand and social trip needs met on a weekly basis

As previously mentioned, providing the funding in blocks provides certainty with which CT operators can organise services reliably and flexibly for clients, manage their overhead costs and make investments to improve value to the client and taxpayer each trip.

While funding proposed to change from this fundamental system will invariably lead to difficulties maintaining services, the value to the government at the unit level is unlikely to improve – given that the unit of pricing will remain the same as "trips". "Trips" are a highly variable unit and reporting on outputs of this kind gives a limited understanding of how funding is spent to meet client needs.

Trips are made in a wide variety of geographies (urban areas, forested areas, arid areas, hilly areas), over widely varying distances (typically 2km-10km in metro areas but up to 1,000km+ in rural and remote) and consuming of varying levels of time (some metro services take an hour to provide a 5km long services due to the quality of roads and traffic conditions). Trips can also mean several "links" in one journey (where someone may stop at one or several points between the origin and key destination, like including a grocery trip on the way home from an appointment) or simply a return trip between an origin and destination. There is a need for better understanding of how CT operators use funds serve their clients' needs in order to best inform a funding model if it is to change.

The Commonwealth Home Support Programme has consistently delivered low-cost, high impact funding to support older Australians. It has enabled CT providers to carry out forward planning and optimally organise their services. This has provided a high level of care consistently and enable older Australians to travel to medical appointments, weekly errands and social activities. The changes proposed in SAHP as they stand would represent a step backward in achieving the objective of helping older people to retain independence.

For the reasons outlined above, it is critical that the Support-at-home program and transition steps be urgently reconsidered. We understand a payment of CHSP grant-funding in arears will be provided from July 1, 2022 until June 30, 2023, but this period of time will not be sufficient for the sector to reorganise in a way which guarantees the same level of service to clients. This period will also not be sufficient for the Government to investigate current and best practices in community transport service provision in ways which provide a high level of care for each client and value for each taxpayer.

We urge the Government and Department of Health to extend 100% supplementary grant-funding until July 1st 2024 and utilise this critical time to investigate how services are currently provided and how this could be improved going forward.

As a sector, we continue to be committed to working with the Government and other stakeholders to create a system that we can all be proud of – one which best supports older people to retain their independence and remain in their homes.