TRANSPORT ISSUES IN RURAL HEALTH ACCESS

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1 Introduction

Rural areas face major problems concerning transport in order to access health and other services and employment. These are exacerbated for those with limited or no access to cars, due to factors such as income, infirmity or (young or old) age. The ageing of the population in rural areas of the UK make transport access a major growing issue. This paper briefly identifies some means to improve access to health and other public services for the residents of Argyll and Bute. It particularly considers those who need an effective and integrated transport system to enable them to access non-emergency health and other services both locally and out-with the area. The study was commissioned by Argyll and Clyde Health Council and Argyll and Bute Council, on behalf of the Argyll and Bute Association of Community Councils (see McQuaid et al., 2003 for the full report).

Argyll and Bute is geographically one of the largest and most sparsely populated local authority areas in Scotland. The mountainous geography of the area combined with long sea lochs, islands and more than 3,000 miles of coastline makes transport and communications difficult. When combined with low population densities, this leaves many individuals and communities isolated. Two thirds of the population live in settlements with a population of less than 1,000, with much of the population being remote from key services.

The 2001 resident population of Argyll and Bute was 92,025, a fall of 0.8% from 1991. The population is also ageing with 24.6% of its population aged 60 or over, compared to 21% for Scotland as a whole. 9.9% (8.0% in Scotland) of households were made up only of pensioners. Those aged over 75 account for 8.4% of the population (7.1% for whole of Scotland). This ageing population, together with the effects of increased specialisation and centralisation of medical services, clearly have implications for current and future access to and provision of healthcare in the area. Public transport is relatively limited. Dependence on private cars, especially in the most remote areas, is far higher in Argyll and Bute than the rest of the UK.

The study was made up of three main stages. The first stage of the research was to map the existing transport services supported by public agencies and the voluntary agencies; and to ascertain the costs of providing these services. The second stage compared existing transport provision with the needs of service users in three case study areas: the island of Islay; Dalmally; and the Isle of Bute. These were selected to represent three distinct types of area: one remote island location, Islay; one remote village location on the mainland, Dalmally; and Bute, a more accessible larger island town. This was done through a variety of means. A postal survey sent out to 2400 households in Islay, Dalmally and the Isle of Bute, with 435 returned and supplemented by detailed face-to-face interviews with residents of each of three areas. A web survey was also open to all residents of Argyll and Bute. Face-to-face were carried out with representatives of key agencies and service providers in each of the areas and telephone and face-to-face interviews with service providers when appropriate. Finally, a range of focus groups was carried out with residents and service providers. From this it was possible to obtain an in-depth knowledge of key transport use and issues for each of the three areas. The final stage recommended models for improving the provision of publicly

funded and voluntary transport, within existing resources, which better meets the needs of the community and vulnerable groups (unemployed, elderly, young families and people using maternity services, young adults, and people with disabilities).

Section 2 then considers transport use in Argyll and Bute and three smaller case study areas. Section 3 sets out some potential areas for savings and improvement in transport related access to services and Section 4 discusses potential areas for savings and improvement in transport related access to services. Finally, section 5 sets out some broad conclusion.

2 Transport use

Argyll and Bute Transport Patterns

Figures from the 2001 Census provide a useful picture of travel to work patterns in Argyll and Bute (figures for Scotland in brackets). Compared to the Scottish averages, more people in Argyll and Bute work or study from home or walk to work. Fewer travel to work by bus or car/van. Due partly to the necessity for rural dwellers to use cars, fewer Argyll and Bute households are without one.

- 10.1% (6% in Scotland) work or study mainly from home
- 5.5% (14.0%) take a bus, minibus or coach to work
- 48.2% (50.0%) drive a car or van to work
- 19.4% (14.1%) walk to work
- 27.9% (34.2%) of households had no car

Figures from the Argyll and Bute Citizen's Panel also provide interesting data on transport use. The Panel consists of a representative cross section of 1,000 local residents and asks questions on a number of issues including transport. It shows that the car or van is the most popular from of transport for nearly all uses, with those going shopping being most likely to use the car at 68%. For those who are employed, 48% stated that they need a car to carry out their work. In relation to public transport the Panel data show that very few people use any form of public transport on a regular basis (at least 2-3 times a week). The most common mode of public transport was the bus, with 9% of respondents using it on a regular weekly basis. The most popular reason given for not using public transport was ownership of a car, with 84% of respondents having a car. The next two most popular reasons given were public transport being inconvenient and the service being infrequent. Dissatisfaction with public transport services is highest for bus services (25%).

Results from the Citizen's Panel showed that travelling to health services was generally by car as either a passenger or driver. Island respondents were most reliant on the ferry to transport them to hospital. Of those respondents

who did have a medical appointment in the last 12 months, 11% stated that they had difficulty getting there. This increased to 23% for those on Islay and 22% for those on Bute. The main difficulties were inconvenient public transport and long and uncomfortable journeys. Cancellation of hospital appointments is a significant cost to the NHS and 12% of respondents said they had to cancel a health service appointment in the last 12 months, reasons included public transport being too inconvenient and the journey being too expensive - 46% of those people stating that the journey was too expensive did not own a car and therefore would have to travel by public transport. So a much higher proportion of non-car owners had cancelled an appointment. Improved transport for people without cars may thus generate cost savings for the NHS.

Survey results for the three areas

Information on transport use and opinions on transport for the three case study areas is outlined in Appendix 5. 435 households completed the survey, including a total of 906 individuals (2.1 individuals per household). In brief, respondents in Dalmally were the most dependent on car use and had highest car ownership. While some 54% of respondents in Dalmally 'never used a bus', only 28% on Islay and 28% on Bute never do so. Isle of Bute residents were more likely to use the train (unsurprisingly given the good service from Wemyss Bay) While 81% in Dalmally 'never used a taxi' (the nearest taxi service is over 10 miles from the village), 33% on Islay said they never used one and 18% on Bute. Only 4% on Islay and none on Bute said ferries were never used (48% in landlocked Dalmally). While 40% in Dalmally and 41% in Bute 'never used an airplane', only 14.5% on Islay never used one. There was a lower frequency of walking as a form of transport in Dalmally with only 54% walking daily, compared to 70% on Islay and 74% on Bute.

A higher proportion of respondents on Bute had 'not visited their GP in the last year' (15%) compared to those in Dalmally (7%) and in Islay (7%), whereas a relatively high proportion on Islay (22%) had visited their GP 10 or more times in that period. Only 8% on Bute and 10% in Dalmally had done so. The levels of cancellations of healthcare appointments were similar among respondents in the three case study areas with no statistically significant difference between them. Between 9% and 13% had cancelled an appointment because of transport problems and between 9% and 13% had cancelled because of other reasons. Respondents were asked to describe "any difficulties or inconveniences you and your household have in attending any of the above [healthcare services]". Responses differed by each area, although bad weather was mentioned a number of times on both Bute and Islay (both being islands). In Dalmally, reasons for difficulties in attending healthcare centred around the lack of public transport and reliance on car use or lifts from other people.

A number of results on views concerning public transport costs, frequencies, reliability and weekend/evening services are provided in Appendix 5. Often these were rated relatively poorly (Tables 4-17). However, peoples' attitudes towards public transport generally varied according to how often they used it. Those who seldom or never used public transport were usually much more

critical and less positive of it than those who used it more regularly. The exception was in the case of air service users on Islay, where users were often critical.

Further Issues

It is worth noting that in general there are also gender issues, especially as many older people are women who survive their husbands and many non-working partners (often female carers) have limited access to cars. For example, for elderly people, after the death of a spouse the survivor often becomes reluctant to drive, and hence becomes more dependant on lifts or public transport or is forced to move to a larger settlement. On average single elderly people are more likely to be female.

Finally, there are many barriers to travel that should be systematically reviewed and tackled where possible in each area (see some of the recommendations discussed later). These include: personal barriers (e.g. the physical condition and health of the person, their motivation to travel, knowledge of transport, fear of using public transport, ability to afford travel, social network for lifts etc. etc.); trip barriers (e.g. the timetable, origin and destination and how far the nearest bus stop is, is the vehicle designed appropriately such as easy access for the elderly or frail, are staff helpful, is there a need to change vehicles or modes and how easy is this etc. etc.); outside conditions or environmental barriers (e.g. the weather, footpaths, kerbs, is there a bus shelter, can people sit down there or on the way etc.).

3 Potential areas for savings and improvement in transport related access to services

Most transport is subsidised already

With few exceptions, public and specialist transport in the three case study areas, and indeed the whole of Argyll and Bute, are fully or partly paid for through public funds. The air link to Islay (and Campbeltown) is a Public Service Order link with Scottish Executive subsidy, but also a large proportion of passengers are patients or staff paid for by the NHS. The ferries to Islay, Jura and Bute are also subsidised (by the Scottish Executive in the case of Caledonian MacBrayne, or by Argyll and Bute Council). The rail links also receive subsidy from the relevant bodies. Nearly all buses are operated following tendering by the Council (both school and public transport routes, including Dial-a-Ride), there being only a few exceptions such as the Glasgow/Inverness to Oban (via Dalmally) and Campbeltown (via Kennacraig) routes. The specialist transport is paid by the Council (education, social work), or NHS (e.g. Scottish Ambulance Service). There are some subsidies for individual travel (e.g. the Highland Travel Scheme and bus travel for older people funded indirectly by the Scottish Executive). Finally, community transport schemes are largely funded by the Scottish Executive, but they often also request Council funding, particularly for revenue costs. Taxis generally

receive no direct subsidy from the public sector, except in a few specific cases.

Increased efficiencies benefit almost everyone

Given that most bus, ferry, air and rail transport receives public funding, usually at very high levels, increased efficiencies and effectiveness will contribute to better overall public value for money. For example, they may reduce the total cost of the current level of service or reduce cost per passenger journey or passenger-kilometre, or increase demand for existing journeys, vehicle and other resources. Such efficiencies may help release `funding for improved services and an improved quality of life for people.

An effective collaborative approach is needed

Hence a multi-agency, and intra-agency, co-operative approach is essential, particularly in rural areas where there is a lack of economies of scale and dispersed travel demand in terms of location and timing. It is important that institutional boundaries do not prevent the development and improvement of co-ordinated, efficient, user focused services. Key agencies and departments need to escape 'silo mentalities' and co-operate to provide appropriate services for different types of transport users across each community. For each are we need to think who needs to get to where and how can we collectively do that better.

Transport funders need to work together to identify the local transport demand and to co-operate to provide the most efficient and effective ways of addressing this total demand, rather than just focusing upon their own clients. For example, planning different kinds of trips in a locality (e.g. those requiring wheel chair access or other assistance) should ideally be based upon overall travel requirements in an area, rather than, for example, Social Services and the Scottish Ambulance Service each providing separately for their own clients. In some cases this may be through collaboratively providing services. This requires co-operation between the agencies providing services (health, education, social services etc.) in terms of: transport provision or supply; information on users; costs; the timings and other characteristics of services provided (e.g. times of hospital or GP appointments, school times etc.).

For example

For instance, in one area a wheel-chair access vehicle with driver and helper may be able to transport people from one village or area going to different health, education, social work etc. service locations, rather than having different vehicles almost duplicating routes. Similarly those not requiring physical assistance may be able to use volunteer based services, education minibuses or flexible public transport rather than transport supplied by the a Social Services. In another area it may be appropriate for all users to be on the same vehicle going to and from different health, education, social work etc. service locations (with suitable safeguards for vulnerable passengers). In the longer term, the grouping together of different services should generally

be beneficial (especially where the marginal cost of an additional passenger is minimal). Such initiatives could possible be extended to other regular vehicle journeys such as water testing sample collection vehicles who may be going to and from a reservoir in a remote area daily.

Incentives need to be right

It is important that change be supported throughout the various organisations, and incentive structures are appropriate. For instance, those 'giving up' resources or having to change their operations should receive some form of compensation (e.g. a school changing its hours of operation could be 'rewarded' with a larger library budget from some of the savings engendered).

4 General Improvements to effectiveness and efficiency of transport services

Some general possibilities are listed below for improving efficiency and effectiveness, but these are not necessarily recommended (see Section 5 for specific recommendations that are based upon not increasing the public subsidy on transport). The possibilities are listed according to: improved co-ordination and organisation; transport service providers; transport services and funding; and changing the way non-transport services are provided. Examples from elsewhere are set out in Appendix 6, and it is hoped that these examples might suggest further initiatives both in Argyll and Bute and elsewhere.

Improved co-ordination and organisation.

1. Co-ordination *between* different organisations to make better use of transport resources.

   For example: through co-ordinating social services, Scottish Ambulance Service, education and passenger transport at both Argyll and Bute level and local community level. At a local level this might be through identifying transport demand and supply and using a transport co-ordinator and through local user and provider forums, while at an Argyll and Bute level co-ordination can be aided through the Community Planning process and through support from key decision makers in various organisations. Consideration could also be given to opening goods transfers to passengers, e.g. collection of specimens from GPs clinic to local hospitals could potentially be made available to passengers, and school equipment and meals trips also. Travel plans in rural areas should often consider plans for all major public (and other) bodies in an area, rather than, say, a single organisation.

2. Co-ordination *within* an organisation to make better use of transport resources.

For example: through combining Council vehicles, especially social services and education; or better co-ordination of ambulances (e.g. going to Glasgow from Bute or when arriving at Glasgow airport from Islay).

3. Local transport co-ordinators to bring together different transport providers and passengers at a local level.

   This may be through a local co-ordinator who can generate local initiatives to improve transportation co-ordination, and, having set up major improvements, can move onto another of the areas.

4. Better co-ordination and integration of timetables.

   For example: through improving transfer arrangements, reducing overlap and upgrading services for similar cost (e.g. Dalmally and Islay). Timetables for tendered services on Islay could possibly be changed in some cases to co-ordinate better with Post Bus services.

Transport service providers.

5. Expansion of Volunteer drivers for patients (generally co-ordinated by Scottish Ambulance Service) and associated diversity of vehicle types (e.g. smaller vehicles).

   The Council should work with the Scottish Ambulance Service to consider improving volunteer type driver services and co-ordinating social services and education vehicles. An application to the Rural Challenge Fund to support this should be considered. Consideration may also be given to more organised lift sharing schemes (e.g. where people can use the internet to identify potential lifts to work or to hospital appointments).

6. Development of Volunteer driver schemes for the 'general public' and special groups (such as the elderly or disabled).

   The Council should consider applications to the Scottish Executive for greater use of general volunteer car schemes, especially on Islay. This could combine local and Argyll and Bute wide initiatives to increase the number of drivers and to ensure their efficient use.

7. Greater use of community transport and alternative vehicles, such as minibuses or subsidised taxis, where demand is very low.

   The Council should consider the use of subsided taxis, in appropriate remote parts of each area. Can Education Department contracts allow transport firms to use smaller vehicles, so that empty 50-seater buses are not used for daytime public transport (although in practice this in influenced by many factors)?

8. Improved use of social services and education vehicles out-of-hours.

   In each area the Council should consider the greater use of vehicles for out-of-hours community use and the cost of this (e.g. particularly the cost of minibuses on Sundays for assisting church attendance by elderly and disabled and others).

Transport services and funding.

9. Better services.

   For example: through more frequent timetable, evening services (although this would often increase costs). Particular consideration should be given to Weymss Bay to the hospital at Inverclyde.

10. Improved information and marketing.

    For example: improved information and marketing would be useful, as evidence suggests that actual users of most public transport have a more positive view of it than car drivers who rarely use it. This would increase use at virtually the same operating costs (although there may be marketing costs). Better publicity for services and eligibility for some services (e.g. Dial-a-bus on Bute).

11. Improved physical access to public transport.

    For example: through improved ticket purchase at Bute ferry and road crossings at Weymss Bay.

12. Demand responsive travel (DRT).

    There is scope for investigating more fully Demand Responsive Transport (perhaps 'wiggly bus') on Islay (and the other areas). Similar to Dial-a-Bus but open to all, e.g. 'fixed' times but will move off the route to pick up pre-booked people and leave them at their destination (e.g. the hospital, GP etc.). This would require a careful, detailed study of potential and costs etc.

13. Improving the experience when using air travel.

    For example: through improving timings for patients returning to Glasgow airport after treatment. A more transparent view of the contribution of the public sector and NHS to the air services is required and alternative costing models considered. Given the major expenditure by the NHS (and other public bodies) on this, it is an area of expenditure that could be linked to other government policies.

14. Promotion of Highland Travel Scheme and a general feedback system.

There should be a clear point of contact for suggestions, complaints etc. about the Scheme, but also about health related transport in general, so that there is a feedback to improving the transport system for patients. There needs to be continued publicity for this (especially on the Isle of Bute) and a feedback system so that problems or comments on travel can be identified and fed back to the relevant agencies.

15. Changing charging schemes.

    This could involve charging for school children that live within 2 or 3 - mile cordon and so increasing income. This is not recommended currently and potential revenue increases are likely to be small.

16. Changing fares on public transport.

    This would need to be part of a wider review. A full review of the free travel scheme for over 60s and the disabled is needed.

Changing the way non-transport services are provided.

17. Changing timings for existing activities etc., so as to allow more efficient use of transport resources.

    For example: through staggering school hours so that the same vehicle could serve different schools or through green travel plans for major employers. Given the limited size and sparse population in most of the areas, this would need to be considered on a school by school basis, in conjunction with the use of other Council vehicles.

18. Taking services to people.

    For example: through medical clinics served by nurse practitioners in villages or consultants travelling to Islands. This would require action from the Health Board, who are active in considering the issue of transport for patients.

19. Integrating medical appointments with public transport.

    This includes ensuring that discharge and transfer procedures at city hospitals are adequate and operated effectively. It could be considered in conjunction with the Demand Responsive Transport issue.

20. Improved passenger waiting conditions.

    GPs and local hospitals should consider improving passenger waiting areas so that people using public transport may be more comfortable. For example: the café run by WRVS at Connel Bridge provides an internet café and comfortable waiting area for people waiting for public transport after their GP appointments. In addition the access of patients

to cafés etc. after their appointment at city hospitals should be considered (as some must wait for a long period at the clinic before being picked up by home bound transport).

21. Using telemedicine and teleconferencing for services and for people visiting hospital/ care patients.

These are developing rapidly and are largely beyond the scope of this report. However, they do offer significant opportunities for the hospitals and Health Board to reduce travel needs. NHS Direct should also cover Argyll and Bute over time and perhaps reduce the need for some GP visits, especially out-of-hours.

5 Conclusions

Each area needs distinctive locally focussed transport solutions that work with wider Argyll and Scottish wide policy changes. Although much good collaborative work is underway in Argyll and Bute (both between and within organisations), there is a need to continue to change attitudes of policy actors from narrow 'departmental' or 'organisational' perspectives, on people's or organisation's role in improving accessibility to services, towards collaborative supply of transport services to meet changing needs. We need increasingly to try to identify who needs to go from where to where at certain times and then how can these travel needs best be met.

For instance, rather than Social Work, Scottish Ambulance Service, Education Service (SAS) and Public Transport vehicles all taking people from one village to different places in a town, can these trips be co-ordinated with the same vehicle being used for all or most of the trips? Serious consideration should be given to such a many-to-many destination based service rather than a many-to-one or one-to-many service. Indeed the Audit Commission in 2001 identified that many Patient Transport Service users could use public transport if it were available at suitable times and it is likely that wheel chair accessible vehicles (with suitable trained staff) may be able to transport many social work and SAS clients, as well as other groups of people. What is often needed is flexibility, will, co-operation, high quality support and co-ordination. It is essential that every relevant organisation contributes and actively seeks involvement rather than waiting for others to take the lead.

One particular issue is the need for better co-ordination and use of existing resources. In many cases we found that vehicles were available, such as minibuses, but were not being used to their full potential. One way around this problem would be for a greater co-ordinated use of vehicles between the various organisations that would benefit from them. A further issue identified was the need for the greater sharing of information, as it arose during discussions that a number of organisations and individuals were not fully aware of the transport options available to them. Examples included the Patient Transport Service and the Highland and Islands Patient Travel Scheme. Finally, we identified the potential for a greater use of community

transport in the three areas. Travel demand in the areas tended to be small scale and sporadic which would often be most easily addressed by more community based transport provision and/or more flexible, possibly demand responsive transport, solutions.

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