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Te Pūtahi Rangahau i te Pakeke Haere

Coping without a car

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1 Introduction

Background to the research

The New Zealand Positive Ageing Strategy includes the goal of *Affordable and Accessible Transport for Older People*. This goal lies within the overall aim of improving the opportunities for older people to participate in the community in the ways that they choose. Research in New Zealand and overseas indicates that older people hold strong preferences for private transport.[1] Clearly, access to private transport is an important element in quality of life and it contributes to the community participation envisaged in the Positive Ageing Strategy.

In 2003, the New Zealand Institute for Research on Ageing (NZiRA) produced two reports on transport and older people. These conclude that private transport plays a central role in the lives of older people in New Zealand. Over half of their trips are as drivers of private cars. The vast majority of people enter their retirement years having access to a car and two-thirds of people under the age of 80 hold driver licences (Davey and Nimmo 2003). Similar patterns apply in countries similar to New Zealand.

Without access to suitable transport, older people may become "prisoners of space" (Dwyer, Gray and Renwick 1999:39). Similarly, a major British study, *Extending Quality of Life for Older People via Public and Private Transport*, found that car ownership and access to private transport was associated with a higher perceived quality of life (Gilhooly et al. 2003). Given their very high dependence on private transport, when older people lose access to a private car, their lifestyle and wellbeing may be threatened.

Coping without a car represents a development from the earlier work, seeking first-hand information from older people themselves as they face life without private transport and experience the effects of this major change in their lives. The questions that form the focus for this study are therefore:

- How does lack of private transport affect the lifestyle and quality of life of older people?
- How do older people who do not have access to private transport meet their transport needs?

The Office for Senior Citizens intends to develop an information booklet as a way of stimulating discussion and providing information about this issue so that decisions can be made. This recognises that ceasing to drive can be an important and life-changing event for older people. It is important that families, older people's groups and organisations working with older people begin this discussion, so that this situation can be planned for and given serious consideration when older people are making decisions about their future. Planning for future transport needs, once driving is no longer an option, should ideally be considered when other major lifestyle decisions are being made. The ability to remain active in the community may hinge not only on where a person lives in relation to services, but also on how they meet their transport needs in relation to continuing participation in the community.

[1] Private transport is defined as a motor vehicle or vehicles owned by an individual or couple, kept at their residence and available at all times for personal transport.

Research method

The research was aimed at people over the age of 75 who no longer have access to private transport, because they have no car, because they have chosen to give up driving or because they can no longer drive legally. The information was collected through personal interviews with individuals and couples recruited by the Volunteer Community Coordinators (VCCs) who work with the Office for Senior Citizens.

The respondents to the survey come from metropolitan centres, large and small cities and towns, and rural areas, throughout the country (Appendix 2). They comprise 43 single people – 14 men and 29 women – and 28 couples, a total of 71 interviews. Counting both partners in a couple gives a total of 99 respondents. The average age of the men was 84.5 years and of the women was 81.4 years. They include Māori, Pacific and Indian respondents.

Detailed information about how the research was designed and carried out, and data on the characteristics of the respondents, is included in Appendix 2.

Outline of the report

The following chapters encompass three themes – situations, strategies and solutions.

- Chapter 2 looks at the lives of the *Coping without a car* survey respondents – how they come to be without private transport, the impacts that this has had and how well they are managing.
- Chapter 3 is about the strategies that the respondents are using to meet their transport needs. These include the use of modes other than their own private transport – getting lifts in other people's cars, public and community transport, taxis, mobility scooters and walking. It also covers strategies such as moving house and staying at home more.
- Chapter 4 moves on to solutions, defined as "what would help" – actions to be taken by people other than the respondents themselves and suggestions for change. These ideas have been derived from interview information, but range rather more widely.

Acknowledgements

The success of the interview stage owes much firstly to the participants, who willingly gave of their time and experience and welcomed the interviewers into their homes. Secondly, we acknowledge the ability of Jane Yoong, the national VCC Coordinator, in liaising with the VCCs, and the cooperation of the VCCs themselves. Many went well out of their way to assist the interviewers. The research could not have been conducted without Jane and the VCCs and the research team would like to express their thanks. The Office for Senior Citizens manages the Volunteer Community Coordinators Programme.

The interview team consisted of Sue Missen, Margaret Connor and Judith Davey. Their skill and fortitude in the face of weather-related and other difficulties must also be acknowledged.

Rebecca Gray assisted with the data analysis for the survey and Kirsty Fraser helped with setting up the SPSS database.

The Office for Senior Citizen manages the Volunteer Community Coordinators Programme.

2 Situations – life without a car

Key points

- More women than men have never driven and women tend to give up driving earlier.
- Ceasing to drive has a considerable impact on social networks and travel patterns, but many people adjust to it. The impact seems to be higher on men than on women, relating to differences in gender expectations.
- Most respondents have adult children living in the same centre and see them at least once a week, but this does not guarantee assistance with transport.
- Many people have lost contact with their friends, either through death or transport problems.
- The activities most likely to generate transport needs are food shopping, other types of shopping, medical appointments and seeing family.
- Specific transport problems relate to working around the available options, medical emergencies, missed opportunities for activities and not being able to get to special events.
- Whether or not people cope well without a car depends on location and the availability of transport options, but also on personal health and mobility levels, outlook on life and the extent to which people feel dependent.

This chapter looks at the lives of the *Coping without a car* survey respondents – the circumstances around giving up driving, the impact of this on social networks and travel patterns, and what influences how well they are managing.

Giving up driving

Giving up driving is the starting point for life without a car. This may come about through voluntary cessation, as a result of medical problems (often on the advice of a health professional such as a general practitioner, specialist or optometrist), or through failing a medical test at age 75 or a practical driving test at age 80 (which is then repeated every two years). The driving test can be problematic for older people because it may be the first assessment they have experienced for many years (Davey and Nimmo 2003). While there is assistance available for older people in approaching the test, none of the interviewees mentioned refresher or *Safe with Age* courses or written material for older drivers.

Out of 42 men in the survey, only one had never driven, but this was the case for 12 out of the 57 women. A further two men had been drivers, but gave up earlier in life, as did 11 women. Women in the study usually stopped driving earlier than men. Women in couples may have given up earlier than women who are now single. Perhaps there is more incentive for women who are widowed to keep on driving.

This means that seven percent of the men, but 38 percent of the women, have not been drivers in recent years (Table 1). This illustrates attitudes towards women driving that were prevalent through the adult lives of this cohort. The men are much more likely to have given up recently. Around 60 percent of the respondents stopped

driving more than two years ago and all ceased at least six months before the survey took place.

Table 1: Driving experience of male and female respondents

	Male	Female	Male %	Female %
Never driven	1	12	2	21
Stopped before age 65	2	10	5	17
Gave up at age 65–79	13	18	31	32
Gave up from age 80	26	17	62	30
Total	42	57	100	100

The cost of private transport was not cited as a reason for giving up driving except in the case of one man. Sometimes it was difficult to ascertain whether people had ceased driving voluntarily or not, as some respondents were unwilling to admit to having failed a test. From the information offered, nine men and four women confessed to failing the test, but 28 men (40 percent of the men) and 25 women (36 percent of the women) gave up driving voluntarily, sometimes on advice from a doctor or health professional (usually an optometrist). Eyesight is mentioned as a limiting factor for many older people, although the survey did not record the specific conditions involved. No one mentioned attempts to rectify eyesight problems. Eight men (11 percent) and 13 women (19 percent) stopped purely on their own initiative, while one man and four women gave up after accidents and two men gave up after family advice. This suggests that women are more likely than men to stop driving on their own initiative.

Comments from men

> I had a stroke four years ago and now can have mini strokes, so it's unsafe. I gave up voluntarily with family advice.
>
> My doctor said I was not allowed to because of my heart, I might have an attack and cause an accident.
>
> I failed my test at 88 – I was a bit unhappy but knew about my neck problem.

Comments from women

> I passed the test but then decided not to continue. I didn't feel safe. I just decided at my age [81] I was better off the road.
>
> I didn't pass the test at 80. I felt I was not fairly treated and objected to the test.
>
> I passed the test at 80 but at 82 my eyesight had deteriorated and I decided not to go. The tester said I was an excellent driver – but I didn't want to kill anyone, such as a jogger.

More women than men also expressed discomfort with driving, lack of confidence and relief when they stopped.

> I gave up at 86. It was too stressful having to deal with petrol, WOF [warrant of fitness] and so on.
>
> I lost my bottle five years ago at 75. I never liked driving and never had a lot of confidence.

The effect of giving up driving appears to be higher among men than among women – 30 percent of the women, but only 13 percent of the men, said it had little or no effect. Table 2 shows the percentages of men and women who said that they experienced negative effects, of the type mentioned in the comments below, after giving up driving. Overall, 81 percent of the men and 55 percent of the women mentioned negative effects and these effects appear to increase in their incidence with the age of the respondent. Those who gave up driving after the age of 80 are the most likely to have felt untoward effects, both men and women.

Table 2: Incidence of negative effects felt after driving cessation

	Male %	Female %	Total %
Never driven	0	38*	36
Stopped before age 65	50	50	50
Gave up at age 65–79	77	56	65
Gave up from age 80 onwards	89	71	82
Total	81	55	66

* relates to husband's driving cessation

Some respondents became quite emotional when they talked about how their life had changed when they lost their cars or ceased driving, supporting the findings of the earlier studies that this is indeed a life-changing event (Davey and Nimmo 2003; Davey and Fraser 2003). The greatest effect was loss of independence, felt by both men and women, and this seems to be greater the later in life they give up driving. This effect was also evident with respect to specific activities. People who gave up driving after the age of 80 reported more transport difficulties with shopping and medical appointments than those who gave up earlier in their lives. This may be related to the ability to adjust.

Comments from men

> It knocked me back in every way.
>
> It was like cutting off an arm or a leg.
>
> I couldn't go fishing, or anything really and had to take a taxi to the RSA.
>
> It made me a total prisoner in here. I can't go out and I can't do anything.

Comments from women

> You feel life comes to an end. I can feel depressed sitting there on a Sunday afternoon [unable to go out]. If you tended to be depressed it would make you worse.
>
> I couldn't do things with my grandchildren – drive them to school and pick them up – and go to see people.
>
> I cry every time I think about it. You just can't go anywhere. I can't walk. I have to get everybody to do everything for me. I have become totally housebound.

However, a considerable proportion of respondents say they have adjusted.

Comments from men

> [ceasing to drive] had quite an effect but you get over it. It would have been harder if I did not have my family close and didn't live in this [convenient] location.
>
> I don't miss it really, only for out of town trips.
>
> It was difficult but you just make up your mind and live with it.

Comments from women

> I worked myself into getting the help I needed. It was no hardship. I was relieved, pleased to have family and friends around.
>
> No effect really, once you get used to having to ask [for lifts], and we get more taxis.
>
> I manage all right, but I can walk. When my husband was alive I was dependent on him for going out. I didn't really enjoy driving.

As the comments show, there are clear gender differences in attitudes to driving and to giving it up. Often women see giving up as a relief. They "never liked it" and were "never confident". The impact of giving up driving may be greater on men because women generally have better social networks, are more home-oriented and have more home-based hobbies. They are also more used to being driven. At all ages, males drive longer distances than females and females travel longer distances as passengers (Davey and Nimmo 2003). Women tend to have more knowledge of public transport from earlier in their lives when they were involved in children's transport or were left without transport when their husbands took the car to work.

Other attitudes may affect the impact of driving cessation. Women are often considered to be worse drivers than men and some accept this stereotype. On the other hand, many older men have been brought up to expect to take charge and may consider it demeaning to be driven or to use public transport. It may be more acceptable for women to admit to not coping. A number of informants in the scoping study observed that men seem to place a higher value than women on owning and driving a private vehicle and frequently associate vehicle ownership and use with a strong sense of individuality, independence and status. Thus men may feel a greater loss when they no longer have access to private transport.

The responses show that giving up driving has a considerable effect on older people's lives. The impacts show through in networks of social contact and patterns of travel.

Transport and social networks

Family

Less than 10 percent of respondents have no children, half have one, two or three and 40 percent have four or more. So, in general, their families are large by current standards. These are the parents of the "baby boom" generation, most of them having had their children in the 1950s. Among the couples and individuals interviewed, two-thirds have adult children (or other close relatives like nieces or nephews) living within the same city or town, and for 85 percent, they are within two

hours' travel. Over 60 percent see their close relatives at least once a week and 30 percent see them daily or several times a week. However, having adult children living close by does not always guarantee regular contact or assistance with transport.

> They are all busy – but there's always the phone.
>
> Our son is wrapped up in his own affairs and work. We only go there for birthdays and Xmas, we don't like to ask for more [visits].

The situation of Mr AA further illustrates this point.

Mr AA is a 76-year-old Pacific person who moved to live with his daughter, her husband and her two children four years ago. His friends are mainly in another part of the city and his English is limited. Mr AA has not driven since he came to New Zealand, as he was a bit afraid of the traffic and now wishes he had, although his eyesight would prevent him from driving now. He mostly depends on his family for lifts, but sometimes he can't get where he wants to go if it does not fit in with their schedules. If they are at work and he is alone but wants to go out, it can make them feel guilty and him feel grumpy.

He can walk to the shops and sometimes brings the shopping trolley home. But he has breathing difficulties and counts his health as poor. His children do not want him to go on the bus or use community transport and he doesn't use taxis because of the cost. He would like a mobility scooter, but the family are not supportive because it would mean he wouldn't exercise.

Most of the contact with family takes the form of visits to the older people or visits in both directions – very few people say that trips to visit family are more common than trips to see them. So one way in which older people without transport cope is to stay at home and be visited.

Friends

Contact with friends is less likely to take place several times a week, often falling into the "once a week" category. A number of respondents mentioned diminished contact with friends. Many had lost most of their friends through death. Some respondents say that not having a car means that they see less of their friends and they now mainly keep in touch by telephone. Loss of private transport therefore appears to impact more on friendship networks than on contact with family.

> They [my friends] are all in their 80s and they also have lost their licences – so I rarely see them.
>
> My closest friend lives too far away now. She doesn't come as she is in a wheelchair and I have no transport to see her.

The falling-off of friendship networks is common, but not, however, universal. One respondent, with very limited mobility, has an extremely active network:

> I have a huge bank of friendship – every day someone calls in.

Where contact with friends occurs, it is similar to family contact in that the older people tend to be visited by friends or the visits take place in either direction.

> You don't go visiting when you are as old as this – you just stay put.

However, a fair amount of contact with friends or acquaintances takes place elsewhere – other than in the respondents' or the friends' homes. Neutral territory, such as the bowling club, church functions, the RSA or other club premises, is an important venue for older people to meet others, emphasising the importance of transport for these purposes.

Neighbours

Most of the respondents have regular contact with at least some of their neighbours, who would be able to help in an emergency. Many count neighbours as friends, which facilitates social contact without incurring transport problems. This applies especially to people who live in retirement villages or multi-unit developments.

> Neighbour pops in every afternoon for the newspaper.

However, contact with neighbours can be reduced by the layout of houses and sections and by steep terrain. High levels of workforce participation nowadays cut down the opportunities that older people have to be neighbourly with younger people.

> A family across the street I see most days and I can ring them [if I need help]. They work and so are not at home during the day, but they look out for me.

Summary of social networks

In order to summarise contact networks, respondents are classified into four groups, as shown in Table 3, on the basis of the extent of their weekly or more frequent contact.

Table 3: Classification of respondents' social networks

	Frequency	Percent
High contact with family and friends	27	38
High contact with family only	18	25
High contact with friends only	17	24
No high contact with either	9	13
Total	71	100

Some people with low levels of social contact are also restricted by health problems, and, if they also lack access to alternative transport, losing a car may put them at risk of social isolation – as the situation of Mrs CI shows. However, having restricted social networks does not necessarily lead to transport problems where people are mobile, like Mr and Mrs RO.

Mrs CI is 91 and has lived in her rambling house with quite a bit of land for 40 years. She has a gardener, a housekeeper and home care. She likes the view, the climate and the people, but the narrow, steep and meandering roads make it hard for her to get out and she could not use a scooter. There are no buses or community transport in her area.

Mrs CI has no children and most of her friends have died, but she still goes to church and plays bridge. She relies on a taxi or friends for transport and a neighbour will take her to medical appointments in Mrs CI's car (but the neighbour is moving soon). She hates being dependent so doesn't ask for lifts except from this neighbour. Mrs CI's housekeeper does all the food shopping but doesn't do personal shopping.

Mrs CI gave up driving about three years ago when her husband died and her eyesight deteriorated. This is obviously distressing to her. Mrs CI's mobility is very restricted; she uses a walking frame in the house and sticks when going out. Despite her disabilities she considers her health to be good, but her transport situation to be poor, in fact "jolly hopeless".

Mr and Mrs RO are in their 80s and live in a city council flat, having moved from a Housing New Zealand house nearby 11 years ago. They have had quite a few financial setbacks and gave their car up 10 years ago after an accident, because of the cost. They were pleased to see it go and feel they have adjusted.

The couple have only one son living in the South Island whom they rarely see, and a niece in a nearby town. They have a lot of "acquaintances" and friendly neighbours but "don't bother with a lot of people". Mr and Mrs RO go out almost every day using the bus or walking and are involved in several clubs. Sometimes they get a lift with people from the clubs, but they would never ask for one. Dependence on the bus means they can't get out on public holidays, nights and weekends, but their only complaint about the buses is that some drivers don't come into the kerb, making access difficult. Their use of taxis is sometimes quite frequent, but they are not eligible for Total Mobility fares as they can use the bus. Both can walk considerable distances, at their own pace and in suitable weather.

Transport patterns

Respondents were asked about their weekly pattern of trips, thus linking social networks with transport. Over half have a pattern of several regular trips per week. Regularity of travel is important in terms of finding suitable transport when the flexibility of private transport is no longer available. Most commonly, these regular trips are for shopping and church, but also include regular club meetings or recreational activities, such as bowls or cards. Others tend to have only one regular trip per week, again often for shopping or church. There were examples of people with serious health problems who go out only once a week to a Stroke Club or day care for Alzheimer's patients. The following example is at the other end of the scale – a busy 85-year-old lady using a variety of transport modes. In addition to her weekly appointments, Mrs KW has her hair done every fortnight, taking a taxi there (in order to be on time) and then walking to the bus to come home.

Mrs KW's weekly schedule

	Purpose of travel	Mode
Monday	Embroidery class	Walk
Tuesday	Help at Care and Craft in church hall	Lift
Wednesday	Visit friends in rest home and take them home-made baking	Walk
Thursday	Craft class	Lift
Friday	Shopping	Community bus
Saturday	Home in the morning, walk in the afternoon with friends, or play petanque	Walk
Sunday	Church	Lift

Others have regular outings every day to the same destinations, like church or the local shopping mall. For some people, their trips are regular but not necessarily weekly. Many organisations have monthly meetings, such as Probus, historical societies and adult education activities. Only a few respondents say that they do not have any regular trips. This is not to say, however, that they did not go out.

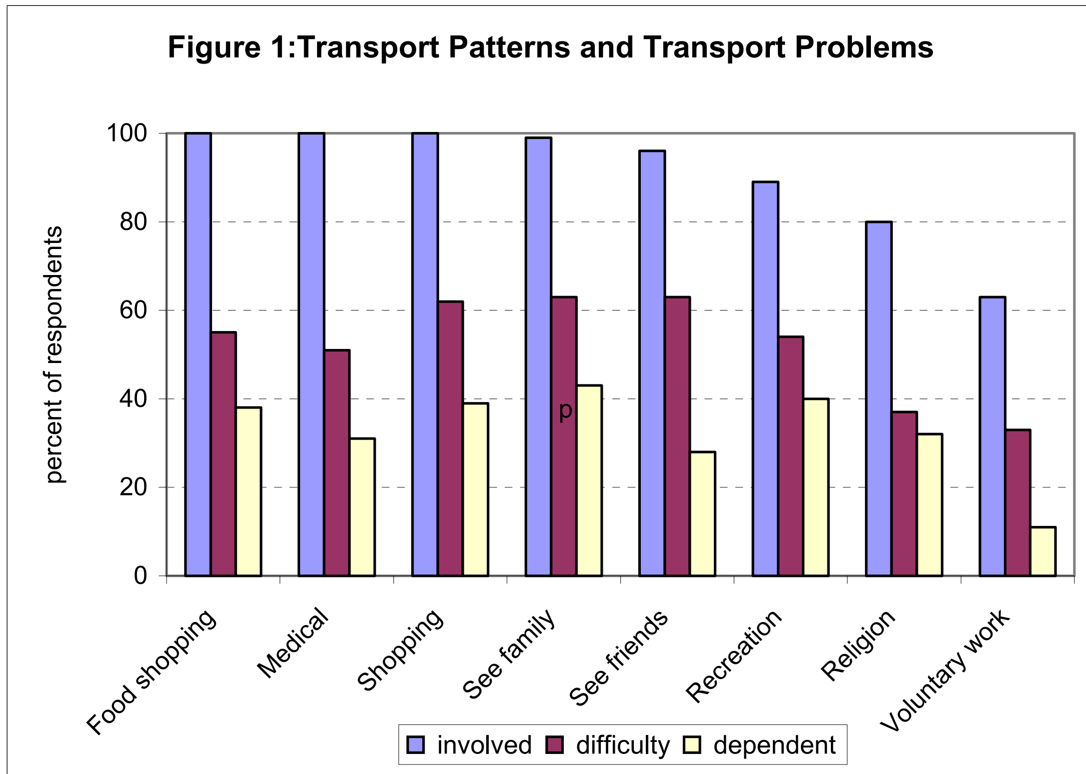
Activities

All, or virtually all, the respondents participate in food shopping, other types of shopping, seeing a doctor/medical appointments, and seeing family. These are the activities most likely to generate transport needs. In addition, 90 percent make trips to see friends and for entertainment or recreational activities, and 80 percent go to church or religious observances. Much fewer are now involved in voluntary work, although many have done such work in the past. It is not always clear whether they gave up because of transport problems or because they now suffer from health problems or lack the stamina. The same is true for entertainment and recreation. For older people generally, social or recreational travel represents a high proportion of trips, and trips as a driver in private transport are the leading mode for all purposes (Davey and Nimmo 2003). Such trips are clearly curtailed when access to private transport is no longer easily available.

Table 4: Transport patterns and transport problems

Activity	Participation %	Difficulty %	Dependence %	Comment
Food shopping	100	55	38	Moderate dependence and comparatively low difficulty
Medical	100	51	31	Low dependence and comparatively low difficulty
Other shopping	100	62	39	More difficulty than for food shopping, perhaps seen as less essential
See family	99	63	43	High dependence and difficulty
See friends	96	63	28	Difficulty but less dependence, perhaps friends come to them
Recreation	89	54	40	High dependence, this may discourage involvement
Religious observance	80	37	32	Less dependence and difficulty perhaps because people help
Voluntary work	63	33	11	Not much involvement and what there is receives help

In Table 4, the activities are listed in order of level of involvement, from those in which almost all the respondents participate to those that are less frequently taken up. The second column shows the percentage of respondents who experience difficulty in meeting their transport needs in relation to the activity, given that they do not have private transport (including only the respondents who participate in the activity). Clearly, shopping (other than food shopping), seeing friends and seeing family produce more difficulty than other activities. However, transport difficulty and level of dependence for transport do not always coincide. The third column in Table 4 shows the extent of dependence that people express (again including only people who were involved) – in other words, the extent to which they cannot meet their transport needs through their own efforts, like walking or using public transport. The highest levels of dependence were in relation to seeing family. They were also high for food and other shopping and recreation, but much less for seeing friends (even though this produced considerable difficulty). These differences are pointed out in the comments on Table 4 and again illustrated in Figure 1.



Overall, the activities that cause the highest levels of difficulty and dependence, and in which almost all the respondents participate, are shopping (other than food shopping) and seeing their families. Many people are dependent for food shopping, but it causes less difficulty than some other activities, perhaps because it is seen as essential and thus help is more forthcoming, or perhaps because people are more willing to ask for help in this area. This links with later remarks about "serious" and "discretionary" travel. Religious observances and recreation are the areas where difficulty is less high but dependence is moderate to high. People can get to such activities but they are dependent on others. This is probably because they are group activities and therefore people may be offered lifts by others who are attending. Given that others are going to the same destination, the respondents may also be more willing to ask for lifts.

Transport problems

In order to illustrate transport difficulties, respondents were asked to cite an example of a recent situation in which transport was a problem. A third could not think of anything specific. The others brought up numerous issues.

- Having to arrange travel around the availability of transport, especially buses and lifts (nine respondents). Travelling in other people's cars may not be convenient because of access, eg getting into the back of a two-door car, or other reasons.

> My husband has to go to hospital every six months for a bladder check and they fill him full of water. He can't use a bottle in someone else's car.
>
> A fortnight ago, after cards, I was offered a ride coming home. I was only part of the way out of the car when the driver took off. I was jammed and ended up bruised with two stitches in my head. It was a male driver whose hearing was not very good. Men won't give up driving until they really have to.

A lady whose husband has dementia has to synchronise two people when she goes out – one to remain with him and another to take her. In addition, he will not go in a car unless his wife is with him.

- Medical or health emergencies presented problems for nine respondents. The cost of travelling to hospital by taxi can be considerable. Even if an ambulance takes the patient one way, there is always the cost of the return trip. In the case of medical need, usual sources of lifts may not be available.

  > On Monday I had a problem with my leg. The doctor said come at noon. I knew it would not be convenient at that time for my friend because she has a handicapped child and would be cooking a meal. So I had the district nurse to come around [to look at my leg] instead.

- Missed opportunities for spontaneous outings, for pleasure, were mentioned by eight respondents. Examples included going for a drive around the coast, to see the spring flowers, or to have fish and chips on a Friday night.

- Eight respondents mentioned not being able to get to special occasions such as reunions, funerals/tangi, or special events that were not of interest to the people who usually gave them lifts.

  > Could not go to a reunion in H because I would have had to take all my own bedding [can't do this on public transport].

- Reliability of transport (five respondents) was also of concern, such as taxis not arriving, even when booked, and problems with swipe cards (for Total Mobility taxis, see below).

- Some people missed out on seeing friends or family.

  > Every week I used to go to my sister's [10–15 kilometres away] – now I don't get a Sunday ride in the country and I can't expect her to come here regularly.

- Others missed shopping opportunities, such as sales, seasonal fruit and vegetables, and the opportunity to shop at a leisurely pace.

  > My son is always in a hurry and just grabs things off the shelf.

These represent a mixture of what might be seen as problems relating to "serious" transport needs, such as for medical emergencies, but also to optional or discretionary trips, including pleasure outings, spontaneous trips and visits to friends. These may be seen as less vital, despite their importance in terms of quality of life for older people. As such, once private transport is no longer available, discretionary trips may be curtailed or cease altogether. This distinction, between "serious" and "discretionary" travel, is significant, and will be returned to later in discussing how people use lifts for transport.

People were asked: "What would improve your transport situation?" – which came directly after the questions on activities. Some of these were fairly impractical – nine people want their cars/licences back and four want better health or the ability to walk or see well again. Other suggestions related to better public transport (eight respondents); easier availability of lifts (six respondents); more community transport (five respondents); and getting a scooter (two respondents). But 30 out of the 71 respondents have no suggestions and six say that you just have to get used to it, showing a high degree of resignation to their car-less situation.

Coping or not coping?

The following set of vignettes, drawn from the interviews, depict people at different levels of coping without private transport – those who are doing well, those managing, those barely managing, and those for whom life has become difficult. For the last group, transport may be only one of the problems that confront them in trying to maintain a good quality of life.

Coping well

Mr and Mrs TO, aged 82 and 77, live in a detached house off a main road. They have been there for 18 years and find it handy for everything. They see their neighbours as also their friends. This is a second marriage for both and between them they have 10 children, several in the area, so they see a lot of them.

They live close to a supermarket and their doctor, so they can walk or go by scooter. Friends visit them and the family often provides transport to family occasions. Mrs TO has never driven, but Mr TO stopped three years ago on the advice of his optician. He misses driving and his independence, but has substituted other activities and has a "machine for reading". Mrs TO says she was "never a gadabout". They get lifts with friends to go to play cards (Mrs TO) and to bowls and the RSA (Mr TO). Buses are hard for both because of eyesight (Mr TO) and arthritis (Mrs TO). They don't use community transport but go by taxi into town and to clubs, using Total Mobility vouchers from the Arthritis Society.

They bought a mobility scooter for Mrs TO to use while her husband was playing bowls but now Mr TO uses it more – taking along a mobile phone and a magnifying glass. He can take trips of up to 20 kilometres and finds it wonderful. Mrs TO is restricted in her walking and describes her health is poor, with her arthritis and Parkinson's disease. But Mr TO says his health as good and both think their transport situation is excellent. They are very happy and content and enjoy their large family who all get on well.

Mrs MZ is 90, and 20 years ago she moved into a new unit in a group of nine pensioner units built by a church organisation. She is now the oldest resident. She stopped driving only two years ago, as she was getting nervous about increased traffic and sold the car to her granddaughter.

Mrs MZ has children and stepchildren, but none in the same city. Her neighbours come to see her frequently and the housing development is very convenient (two blocks from town) and has good security. Many of her activities centre on the church and she walks there to services on most days. She can also walk to the shops, with a shopping trolley, and to the GP, but gets a taxi home, using her Total Mobility vouchers. After about 10 minutes walking her legs begin to ache. She also takes a taxi to visit friends if it is too far to walk, gets lifts from her neighbour, but hardly ever gets a bus except for long distance travel. At the moment Mrs MZ would not be seen on a mobility scooter and would have to be much worse to consider one. Although her health is fair – she has angina and circulation problems – Mrs MZ thinks her transport situation is very good.

Coping

Mr and Mrs AE have lived in the same small bungalow for 20 years and love the area even though their daughter wants them to go into a “home” – both are over 90. Both drove until three years ago when Mr AE lost his licence and his wife stopped driving because of her eyesight. They felt that this really took away their independence and upset their routine.

Their daughter lives in the same city but she goes away a lot and they see her about fortnightly. They don’t see many of the neighbours because they are working but they have good friends across the road who take them to bowls twice a week. This is their main outing apart from shopping. The AEs get lifts from their cleaner to go food shopping and from friends and their daughter for most other things, but they feel uncomfortable about asking. Mrs AE says “I have not really looked at the shops for years”.

They used to enjoy going in the car but now they have to depend on family to take them to places and they don’t visit much. They would like to go to the hot pools more and visit the Bay of Islands and Wellington. Mobility and eyesight problems would make using public transport a problem even if there was a service. Similar problems mean they can’t use the RSA van and they have not been to their functions for years. They use taxis for doctor’s appointments when their daughter is not available, using Total Mobility chits. A mobility scooter is not an option because of steep streets. Both have reduced walking ability and use sticks, but still play bowls. They feel getting rides is the best option for them, but consider their transport situation is only fair.

Mrs JJ is a widow, aged 75. She lives in the outer suburbs of a medium-sized city. She has three children but none of them live in the same city. She used to drive to see them up to a year ago, when she had a blackout while driving and wrote her car off. Now her doctor will not let her drive until she has had more tests.

Mrs JJ has a brother living nearby but does not see him very frequently. Two friends come to see her about once a week and three times a week she goes out, with a friend, to group meetings – housie and a senior citizen’s group – mainly for the company. She is reliant on friends to get to these and can only go if they are also going. Mrs JJ also has problems with shopping because she has to wait until her brother and sister-in-law are going and will take her, as there are no local shops. He is not very reliable because he puts his bowls first in his priorities. Other activities also cause problems because of having to rely on others, although her hairdresser will come and get her (she has to pay for this). She hates having to ask for lifts and be reliant on others and finds that getting lifts costs more than running a car. The car cost her $20 a fortnight and she gives more than that to have rides. Having the car back would be the best thing to improve her situation.

Mrs JJ doesn’t use public transport, which in any case would be over a kilometre away. As well as the distance she has poor eyesight and wouldn’t feel safe. The pavements are uneven and there are not many pedestrian crossings. She is scared of falling, as she can’t see the steps well. She doesn’t use taxis because they are too dear.

> I don’t like asking people to help but probably will have to – I feel I am tied down but would like to get out more. It would be better if my kids were handy.

Coping marginally

Mr and Mrs NO, both in their early 80s, live in a retirement village. They have been there for three years having moved from not too far away. They do not seem to be happy with the move. They have six children who ring daily, but don't visit very frequently. They see quite a bit of their neighbours, who visit them, but they hardly ever leave the house. A friend does their shopping – they give her a list over the phone and they seldom visit the shops unless a neighbour/friend takes them. They use taxis for medical appointments, using vouchers, but find the charges vary for the same trip. If they go out for entertainment it is with friends or family members. This is only on special occasions.

They would like to go for a drive sometimes or be able to drive again. Mrs NO has never driven, but her husband did until two years ago when he had a stroke. He finds not driving hard to accept. He has kept the car.

They don't use buses as the route is 10 minutes walk and neither can walk far. They both would consider a mobility scooter but they are too expensive. Mr NO says his health is good despite having had three strokes, but his transport situation is very poor. Mrs NO has poor health and a poor transport situation – in fact "terrible".

Mr GM lives in a large detached house on a corner section. He has a daughter who brings him his evening meal every day and friends he can walk to see, but doesn't see much of neighbours. His main social life is through a community centre where he plays cards and bowls and goes for exercises and meals. He doesn't do much shopping; his daughter and granddaughter see to most things and will take him for medical appointments. He can only go to church when friends take him and his social life also depends on friends and family. However, he doesn't consider he has transport problems as he could use a taxi in the case of sudden need. He doesn't see getting lifts with family as really being lifts, "just part of family".

He is disappointed that he cannot drive now as "it was handy to go out when you wanted to". Mr GM never uses public transport and rarely taxis (because of the cost). He thinks that a mobility scooter would be handy to go to the corner shop or for haircuts but doesn't know why he has not pursued this – possibly because of the cost. He can walk short distances with a crutch – he has two but doesn't like to be seen with two. Mr GM is a bit forgetful, at age 91, but thinks his health is very good and his transport situation is fair. He doesn't really want to go to many places now. But "if you can't get around what the heck do you do".

Not coping well

Mr SV is 90 and his wife has recently had a stroke that has changed everything for them. They have lived in the same house for 30 years and feel they can't go anywhere else at present even though the garden is too big. They have a daughter close by whom they see daily and "will do anything for us", and a son fairly near. Their friendship network is not large. Before the stroke they used to go out, but not a lot. Now they rely on their daughter or friends for all their shopping and she takes them, with help from their son, to medical appointments. Family comes to them for visits. Other outings and activities are very restricted.

Mrs SV never drove and Mr SV gave up in the last year because of his eyesight. He now feels he can't look after his wife because of this. There are no buses or trains locally and no community transport. They do not use taxis, although there is a service, because "someone always takes us". Mr SV thinks he is too old and deaf for a scooter and is not keen on the idea. He doesn't walk much apart from around the house and garden. Nevertheless he says his health is good and his transport situation fair.

Mr FS is 89 and lives alone in a large house where he has been since 1960. He has a son and a daughter who live near and he sees his daughter every day. His children take him out and he doesn't see this as getting lifts as they ask him where he wants to go. His daughter does his shopping and he does not get out to do this himself, so he can't browse the shops for what he wants. All his friends are "gone" and he doesn't see much of his neighbours. Not being able to drive makes it difficult for him to visit and go to the doctor and he has had to give up his dancing. He even has problems getting to have a haircut. Mr FS still has his car registered and warranted but ceased driving about six months ago when he had the stroke. He feels this has made him a "total prisoner".

He doesn't use the bus as he needs someone with him all the time and he doesn't use taxis, but might if they were cheaper. Mr FS also needs other people with him if he goes out walking as he has balance problems after a recent stroke. He has a poor impression of mobility scooters from other people – he heard they were more dangerous than cars.

Overall Mr FS sees his health and his transport situation as fair only. He feels very restricted and gets stressed easily (he needs frequent toilet visits). He emphasises the importance of being able to talk to someone about health issues.

What are the factors that appear to assist older people to cope without a car? The examples show that it is hard to be unequivocal about how certain factors operate. Location with easy access to public transport and services (church, shops) certainly benefits Mr and Mrs TO and Mrs MZ. However, being in a retirement village – where many people go for services and social contact – has not helped Mr and Mrs NO. Living alone, especially in an isolated situation away from services (like Mrs CI – whose story was included earlier), certainly does not help. The section on social networks showed that having family nearby does not necessarily mean that transport problems are solved. Mr and Mrs SV, Mr FS and Mr GM have frequent family visits, but still feel restricted. Ready assistance from family can be helpful when private transport is no longer available, but friends are sometimes the preferred sources,

given the busyness of most adult children. The people who are coping well tend to have good friendship networks, and friends who are able to offer lifts.

It appears that personal factors, as well as location or external factors, are important in coping. Foremost among these are good health and mobility. If older people are able to walk with ease and use public transport, this can compensate for a lack of private transport, provided bus services are available and accessible. Mr and Mrs RO, quoted above, are an example of this. The people who do not cope well, in the examples quoted in this chapter, often have serious health problems (especially affecting mobility and eyesight) or, like Mr SV, are restricted by their spouse's condition. This may lead people to see themselves as "housebound", as is the case for Mr and Mrs NO. Given higher levels of health problems and disabilities among very old people, public transport is not always an easy substitute for a private car.

An important factor seems to be the extent to which people feel dependent on others for transport. This is mentioned in several of the examples where people are not coping well, and works against the values of independence and autonomy that are so important for quality of life in old age. General outlook on life and attitudinal factors also play a part. Several respondents who had multiple health problems still declared that their health was good (Appendix 2) and many thought their transport situation was equally good, even though they may have appeared restricted to an outside observer. Self-perceptions such as these reflect attitudes that people may have carried throughout their lives. Outlook on life may also influence the extent to which people are willing to try new things – such as alternative transport choices. Mr and Mrs NO embraced the opportunity offered by a mobility scooter, whereas Mr SV and Mrs FS have not taken this up or have actively put aside the idea. To conclude this chapter, here is the story of Mrs FW, who has many of the attributes associated with not coping, but whose outlook is bright and positive.

Mrs FW lives in a low maintenance unit, in a quiet street in a small town where she has been all her life – she is now 79. None of her six children live close. However, she has lots of friends, so that people drop in very regularly. Mrs FW doesn't go out much but has a very active life in the community, fund-raising, letter-writing and phoning.

Once every two or three weeks someone takes her shopping to a nearby town but she always pays her petrol money. Otherwise she doesn't go shopping but gets things through mail order. Friends give her lifts to the hospital and to see the specialist, but she can go by scooter to the local doctor. There can be problems when friends are not available or it would be inconvenient for them. There are no taxis in the area and only infrequent long-distance buses pass through. Mrs FW used to drive but gave up because she thought her reactions were slow and she needed the garage for her scooter. She didn't want to become a bad driver. However, it was a wrench to part with her car after 31 years and she made sure it went to a friend who would look after it.

Mrs FW manages her lifts so as not to use friends too much and always gives cash or coupons, saying they are "a shout" for their car. However, she can't just "hop out and go and see the kowhai blooming" now. Mrs FW is still getting used to her scooter, but it is wonderful as it makes her feel she is not shut in. She can't walk a lot now like she used to. Her health is "fair" but her transport situation "very good".

3 Strategies – how do people cope?

Key points

- Some people keep their cars even when they no longer drive.
- All the respondents use lifts as a means of transport and one in five has them almost every day. Lifts in other people's cars are by far the most common transport mode, but they represent a lack of independence and there is often a feeling of imposing on other people.
- Less then half of the respondents use public transport. The main barrier to its use is access – getting on and off the buses.
- Only a minority of respondents know about community transport.
- Eighty percent of respondents take taxis, and 25 percent use them weekly or more frequently. The cost of taxis is much more of an issue than the cost of public or community transport.
- Most respondents know about the Total Mobility taxi scheme and just over half use it.
- Less than 20 percent of the interviewees have a mobility scooter, but a higher proportion would give favourable consideration to this means of transport.
- The ability to walk is associated with health status. Uneven footpaths and difficult road crossings are obstacles to safe and easy walking.
- One way in which older people without transport cope is to stay at home more.

This chapter looks at what people do to meet their transport needs when they no longer have a car to use. It covers the main transport modes: getting lifts with family, friends or acquaintances, using public transport or community transport, taking taxis or walking. But there are also other strategies, such as moving house, staying at home more and keeping the car.

Keeping the car

As the title of the project implies, the assumption was that the respondents would no longer have access to a car. However, it was discovered that 10 out of the 71 had retained their car, even though there was no one in the household who was licensed to drive. They thought others would use it and drive them to where they wanted to go, sometimes out-of-town family, sometimes home care workers or friends.

> We still have a car so we can ask them to use our car and they are not using their benzene [sic].

> The car is in the garage still. A friend gives it a run now and again and our daughter used it to help us shift.

This strategy may work well, eg in a retirement village setting where there is a pool of drivers nearby. However, in several cases, it seems as though the cars are rarely used. Keeping the car is linked with the concept of a car as a symbol of independence and with feelings about become "beholden" when seeking or accepting lifts.

Relying on family and friends for lifts in private cars

All the respondents say that they sometimes get lifts (as opposed to high proportions who never use public or community transport). In fact, two-thirds have lifts at least weekly and 20 percent have them almost every day. This applies to people at all levels of self-perceived health, from poor to very good. So, people in poor health are not more likely to have lifts than those who think their health is good.

Lifts are most commonly used for shopping – food and general – and for travel to recreation and entertainment (around 60 percent of respondents say they use lifts for these three activities). Lifts are least likely to be used for going to religious services, to the doctor or for medical appointments, and for seeing friends. There are a variety of sources of lifts and half the respondents cite a combination of family, friends and neighbours: a quarter says friends only, 20 percent say family only and four people say neighbours only. The people who have lifts most regularly – weekly or more frequently – tend to get them from a variety of sources.

The respondents are fairly evenly distributed between those who say that people always offer them lifts and those who have combination of being offered and asking. Only 10 out of 71 say they always ask for lifts. Sometimes it may be easier to ask family than friends – in fact, one man suggested that going with family is not a "lift" at all, it is just part of family life. However, in the analysis of responses, it appears that friends and neighbours were more likely to offer lifts than family. Half of the people who mainly get lifts from friends and neighbours say that these are always offered, compared with a third of those who mainly get lifts from family. This is summarised in Table 5. The table also shows that few people always ask friends for lifts and that lifts from family tend to be a mixture of offering and asking.

Table 5: Sources of lifts by whether people offer or are asked for them

	People offer %	Respondents ask %	Combination of asking and offering %	Total %
Mainly family	31	23	46	100
Mainly friends	53	6	41	100
Mainly neighbours	50	25	25	100
Combination	42	13	45	100
Total	43	15	42	100

> People offer – I never have to ask. I don't make a habit of asking anyone other than family.
>
> The family give me lifts. I get to see them and I am not taking advantage of people.
>
> I wouldn't ask neighbours. They don't offer except once or twice someone brought me back from the shop if they met me there.

These patterns and attitudes link with earlier observations about "serious" or "discretionary" travel. Older people may feel less reticent about asking family and friends for lifts if the purpose is clearly necessary and serious. Lifts to recreational activities may not be seen as serious travel, but often friends are going in the same direction. Visiting friends is also discretionary and thus people are less likely to ask for lifts to do this.

There are various advantages and disadvantages in using lifts as a means of transport. Fifteen people did not respond when asked about advantages, but of those who did, most people say that it is how they travel to places that otherwise they would not be able to reach. Others cited multiple advantages, including people offering transport, lower costs, getting transport right to the gate and the opportunity to have contact with other people.

> Saves you money on taxis.
>
> You don't have to worry about traffic.
>
> If I didn't have a lift I would have to walk and don't think I would get out, especially if it's raining.
>
> You don't have to tear away down and then miss the bus.
>
> To get from A to B. It's enjoyable going with whānau. You can catch up on titbits [of news].

Twenty people did not list any disadvantages of lifts, but those who did made very explicit comments, suggesting that using lifts means a lack of independence and that there is an unwillingness to impose on other people or "put them out".

> It's OK if they are coming past but I hate taking people put of their way. I want to be independent.
>
> It makes me obliged to them, I don't like to impose, I would rather say nothing.
>
> Three [disadvantages] – you can't be relying on people and losing your independence. The others don't drive like I used to do, and, thirdly, having to be ready for people to come for you.

Several people mention how they try to repay people who gave them lifts, offering cash or petrol vouchers or responding with gifts.

Using public transport

Thirty out of 71 respondents (42 percent) use public transport – 34 percent of the men and 47 percent of the women. The rest say either that they do not need to (their transport needs were fulfilled in other ways) or that none is available in their areas. But others – 22 out of 71 – cite aspects of public transport (almost exclusively buses – only three people mentioned use of trains) that deter them from using it. By far the most important deterrent was access – getting on and off the buses. The following two quotations are both from women.

> I am too frightened I will fall. My physio told me not to and haven't been on a bus for five years. The buses kneel but it's getting off, I would be a bit slow.
>
> One bus driver comes too far out from the kerb. I have told him and had a few arguments. He pulled me up roughly once. Lately he has been a bit better.

More than half of the public transport users also complain about physical access to the buses, especially the women. Sixty-four percent of women users and 54 percent of male users have access problems. Nevertheless, public transport does come in for some appreciative comments.

> Great service, lovely drivers, they can't do enough.
> (man who has an artificial leg and uses a crutch)

> If I catch a late bus the driver makes a special stop outside my house.
> (Pacific woman, living in Auckland)

Respondents were asked what would encourage them to use public transport or use it more. Half had no comment. Only one person mentioned cheaper public transport, suggesting that cost is not generally a barrier. Access, more broadly defined, was the main improvement that the people looked for in public transport – having a closer service (or any service at all) and more physically accessible vehicles. The following quotations all come from women.

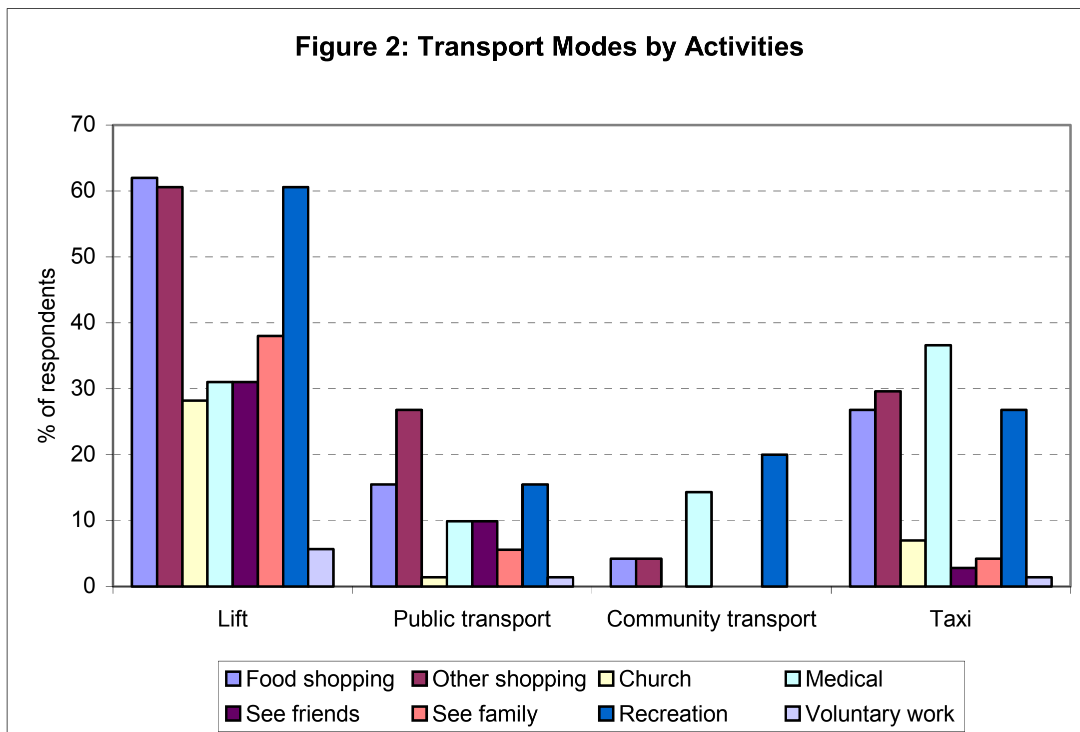
> Buses are not at a convenient time and with a taxi chit there is not much difference in cost.

> I would sooner travel with someone I know to help me – I use walking sticks.

> I would use buses more if they were more comfortable, more regular and more reliable.

Compared to lifts, fewer respondents use public transport for all the activities listed (Figure 2). It is used most frequently for shopping (other than food shopping) and then food shopping and entertainment/recreation. Bear in mind, however, that less than half the respondents use public transport at all and those who do have higher levels of mobility. Only a quarter of people who say their health is poor or fair use public transport as opposed to half of those in good health. This links back to access problems.

Figure 2: Transport Modes by Activities



Access is not only based on personal mobility, but also on the availability of public transport services. There is a correlation between public transport use and location.

The proportion of respondents who use public transport decreases from 54 percent in metropolitan centres to 50 percent in main urban centres and 19 percent in small towns and rural areas. People who have access to public transport within a five-minute walk use it the most. Frequency of services does not appear to be a factor. Services are reported to be much more frequent in metropolitan areas than elsewhere. Perhaps access, in all its forms, is more important than frequency for retired people.

The group of people interviewed for this survey are not well served by public transport outside of weekdays. Only 20 percent have services at weekends and only 10 percent say there are services in the evenings, although many would not go out at night by bus anyhow.

Davey and Nimmo (2003) noted that willingness to use public transport is sometimes related to a perception that this is the domain of "poor people" and travelling on a bus is an indicator of low socio-economic status. Conversely, owning and using a private car is associated with affluence and independence. This was not mentioned by *Coping without a car* respondents, who have already lost access to a car. For these people, access was the key factor.

Using community transport

Community transport is defined as kerb-to-kerb or door-to-door transport run by community and voluntary groups (Davey and Nimmo 2003). This could be seen as matching many of the advantages of private transport. However, only a minority of respondents know about community transport and can name a service (Table 6). Out of 71, only 25 percent know about services provided by hospitals and few had used them. More know about service-club or voluntary agency transport, of which the RSA's is the most often cited, but transport is also provided by Age Concern, Rotary, St John, kaumātua and women's groups. Retirement villages and rest homes often provide transport, but not all the respondents actually living there use it, finding other ways to meet their needs.

Table 6: Knowledge and use of community transport

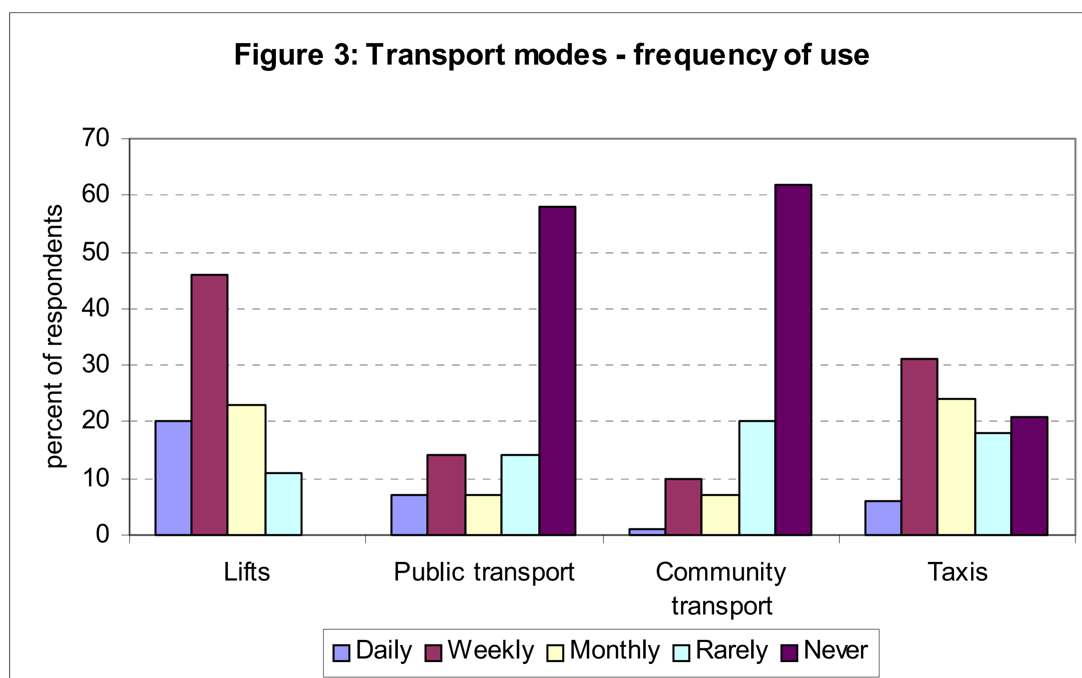
Service provider	Number who know of the service	Number who had used the service
Bus/ambulance provided by hospital/medical authorities	17	6
Transport provided by social/service club (Rotary, RSA)	12	9
Retirement village transport	10	5
Age Concern services	10	5
Transport provided by health-related voluntary organisations (Cancer Society, Blind Foundation, Stroke Club)	6	1
Transport provided by religious organisations	5	2
Other	3	1

Community transport is the least-used of the four transport modes illustrated in Figures 2 and 3. Less than 20 percent of respondents use it more than rarely and 62 percent never use it. The reasons for not using community transport are either because people have not heard of any services (32 percent) or because they do not

need to (22 percent). Lesser reasons are that these services are not convenient, they prefer not to, or because the service is not physically accessible. Only one person said it was because of the cost. Generally speaking, however, the costs reported are not high. Of the 25 people who use community transport, 11 say they pay nothing (including all who use retirement village transport), 10 pay under $5 per trip and four pay $5 or more. The higher costs are in relation to transport organised by clubs and religious groups.

Community transport is mainly used for recreational travel – typically outings from retirement villages, by Age Concern branches or other clubs (Figure 2). Medical appointments are second in importance, linked to hospital and medical practice transport. Very little use of community transport is made in relation to shopping. Here again retirement villages often provide regular shopping trips. Community transport is not recorded as assisting respondents to meet their needs in relation to religious observance, voluntary work, or seeing friends or family.

Chapter 4 will suggest that community transport, as it stands now, is not fulfilling its potential as a means of coping without a car, certainly not for this group of older people.



Using taxis

Eighty percent of respondents say that they take taxis, and 25 percent use them weekly or more frequently. Where people do not use taxis, this is because they are not needed or because of cost. Cost is much more of an issue here than with respect to public or community transport. In some smaller centres and rural areas, however, there are either no taxi services or problems with availability.

Lower fares are most frequently mentioned when respondents are asked what would encourage them to use taxis more. Others suggest they would use taxis more if their present transport options were no longer available, or if their health or physical

condition worsened. A few mention improved availability of taxis or better service by the drivers.

The most common reason for using taxis, reported by over a third of respondents, is to get to medical appointments, with the doctor or specialists or at hospitals, ie “serious” travel, as earlier defined (Figure 2). Almost as important are trips for shopping, including food shopping, and for entertainment/recreation. Very little use is made of taxis to go to see friends or family or to go to religious services, which may be seen as discretionary travel. However, several people mention that taxis are more likely to be used during bad weather, late at night or when returning from outings when they might be tired. For these activities, except for medical visits, people who used taxis at all tend to use them frequently.

> I only use taxis when I am desperate to get somewhere [because of cost] – sometimes to get home from town.

> I use taxis much much more since I have been without a car. I scorned them before as a waste of money.

Taxis were used by around 70 percent of respondents in urban centres and by 50 percent of respondents in small towns and rural areas. High levels of taxi use (weekly or more frequently) are recorded for people in metropolitan and main urban centres and for Pacific respondents (this links to common use of taxis in the Pacific Islands). None of the interviewees in secondary urban centres take taxis more than once or twice a month. A few people in small/rural towns use taxis more often, but more of them never take taxis at all. However, many respondents in Auckland talk about having to wait a long time for taxis and report problems with the Total Mobility scheme. The following quotation is from a couple living in Auckland.

> We can walk to shops but usually take a taxi back, in fact we use taxis a lot and sometimes don’t go to things because of the cost of them. Going to the doctor costs $9 and it is $12 each way for my wife to do her voluntary service for the church. There can be problems if the taxis don’t turn up or baulk at short trips – like going to the local cinema. The driver makes a face. The costs of getting across Auckland can be very high even with Total Mobility and there are problems because not all companies have put in swipe card facilities.

Total Mobility scheme

The Total Mobility (TM) scheme started in 1981 and provides taxi vouchers, representing a discount of 50 percent in most regions, for people with serious mobility constraints (Transfund 2003). Almost three-quarters of respondents know about the TM scheme and just over half use it. The extent of taxi use is certainly higher among people who are eligible for TM subsidies (Table 7).

Use of the TM scheme is higher in large cities, compared with smaller centres, and among people with lower health status – 78 percent of respondents who said their health is poor used TM subsidies, but only 30 percent of people who said their health is very good used them. In some cases, people used the scheme through the eligibility of their spouse.

Table 7: Frequency of taking taxis by TM and non-TM users

Frequency of taxi use	TM-users %	Non-TM users %
Every or almost every day	8	3
About once a week	43	18
About once or twice a month	32	15
Very rarely/hardly ever	14	24
Never	3	41
	100	100

Some problems with the schemes were pointed out, although most of the users appreciated the financial assistance.

> We have vouchers, but still find taxis costly and use them not for just anything but for what we really need.

Using mobility scooters

Less than 20 percent of the interviewees have a mobility scooter in their household, but a higher proportion (40 percent) say they would give favourable consideration to this means of transport. There are differences by gender. Out of 42 men, a third already have a scooter, but less than a quarter of the 57 women do. Twenty-six percent of the men and 35 percent of the women say they would not consider having a scooter.

Many prospective users have positive comments about scooters, thinking they would be handy, especially if they experience a worsening of their health or mobility, although some have concerns about the cost. The following comments illustrate views from male respondents.

> I am getting loss of balance now, that might tempt me to get one. I think they're good. I know others who are pleased with them.

> I would like one, I think they are fine, like motorised transport.

> Yes, I think about it, I don't know why I haven't taken it up. It would be handy; you don't have to go far, just to corner shop and for haircuts. But cost – I could get one second hand. Would the doctor allow me to use a scooter? I get lonely, it would be handy to have something to get on and go.

People who already use scooters point out their benefits, especially in widening their horizons. The following are positive comments from women.

> They are wonderful in a small town. It makes me feel I am not shut in, but I don't go out in bad weather.

> I use it on good days. It cost $4000 second hand and $500 to replace the batteries. I did have a problem finding someone to do repairs, but it's the way to go if you are having trouble walking. It's better than staying at home.

People who would not consider using a scooter suggest that this would be acknowledging loss of mobility. Two female respondents expressed this as follows:

> I might use one if I got bad enough. Our son wanted us to have one. But I felt like to would be the first nail in the coffin.

> I would have to be really unable to function because at the moment I wouldn't be seen on one.

Some think that having a scooter will make them lazy and reduce the amount they walk. Others see limitations on scooters or feel they would not have the confidence to use them. Women more often expressed this view, as in the following quotations.

> No, I wouldn't have the nerve – the thought of being on the road after 20 years!

> No way, I would have to learn to drive.

> No, I am not very good at mechanical things, I prefer the walker. It's a responsibility and I don't want the worry of it.

Then there are those who have a negative view of mobility scooters – only one person can ride at once, it is difficult to carry a lot of shopping on them, and they do not give protection in bad weather.

> Too old and deaf, not keen on it. There is enough junk in the shed.
> (male respondent, aged 90)

And finally there are those who tried mobility scooters but found they did not suit their requirements. These were often women, as shown in the following two quotations.

> I had one brought up, but the company and I agreed it would be dangerous. The road is too narrow, steep, and has no footpaths.

> I had one when I thought I would be bad [health], but it squashed my legs up and I knew I needed to walk.

Information from 14 scooter users gives a picture of their use by older people. Most of them began to use their scooter after they had stopped driving; in fact, acquiring a scooter was in one case the trigger to get rid of the car, to free up garage space. Few travel more than 3 km (a journey of up to 45 minutes) on them. Scooters are helpful for people reaching services, but more generally for recreational travel and just "getting out". Most people report no problems with their scooters, but one lady did $900 damage to hers by going over a judder bar too fast and another was once stranded with a flat battery.

Rates of scooter ownership are fairly similar by size of centre and use of scooters is not correlated with poor health status among the respondents. Sixty percent of users say they can walk less than 500 metres, but 40 percent could, in fact, walk further. Using a scooter does not necessarily mean that people walk less, as the following examples show.

Mr NV is 82 and his wife is in a rest home. He lives in a two-bedroom unit, but expects to move into a studio or rest home soon. He has four children but only sees his two daughters regularly. Family members take him out for visits or to the hospital when he needs it and he has a friend who will “take him anywhere”. He used to get lifts even when he had his car.

Every day he visits his wife on his scooter. He says “I have dedicated the rest of my life to keeping her happy”, and walks to the shops, which he did even when he had his car. Mr NV gave up driving less than a year ago when his eyesight failed. After he stopped driving he acquired a scooter and uses it regularly. It is good for going up hills, as he gets breathless. Mr NV walks 30 minutes – up to two kilometres – at 7 am every day for health and fitness. He considers his health to be good and his transport situation fair.

Mr and Mrs YE, both in their late 80s, have no children but keep in touch with a niece and nephew. Their neighbours are friendly and often come to see them as both are limited in their mobility and Mr YE is very deaf. They don’t have any regular social appointments – “We are home people” – and never did go out much. They use taxis for medical appointments and special shopping.

Mrs YE never drove and Mr YE gave up over a year ago when he failed his test twice. He is glad to be off the road although sad not to be driving and misses his trout fishing. They get lifts with their home carer and with friends and feel they are trading off independence for less responsibility. They like to go with people they know, but don’t like to impose. They don’t use public transport, but occasionally use Age Concern transport for medical appointments. Mr YE got a mobility scooter after he stopped driving and “It’s been absolutely marvellous”. He goes to the shops and to the rose garden and then he walks there with his stick for up to an hour. Mrs YE doesn’t walk because of her legs.

Mrs RT has lived in the same suburb for 55 years. She has two daughters, one of whom visits weekly and the other is overseas. She has fairly regular visits from friends and sees quite a bit of her neighbours. Her poor eyesight restricts shopping but she goes on her scooter and the people in the shops are helpful. Her daughter brings her frozen dinners and she uses mail order for clothes. She has no problems with her regular trips to the Arthritis Club, health centre and to local museum duty, as she uses her scooter, taxis or lifts with her daughter. She thinks she “couldn’t do better”.

Mrs RT (now 77) gave up driving seven years ago. Her doctor thought she should give up because of her eyesight, but gave her the licence. However, soon after she had a shock and lost her confidence, dreading going out in the car – “A bloody nuisance”. However, she decided to get a scooter and sold the car to make room in the garage.

Mrs RT can’t walk far because of an operation on her feet and she doesn’t “like people staring at me as I struggle along”. To Mrs RT her scooter is “the way to go” despite having had problems with repairs and with uneven pavements. She knows she should walk more but she says she is lazy and her feet hurt.

Walking as a means of transport

According to travel survey information (Davey and Nimmo 2003, Chapter 2), walking accounts for 21 percent of trips for people in the "young-old" age range (65–79) and this increases to 27 percent for people aged 80 plus. It may be a substitute for private transport, but its use as a transport mode is subject to health and physical ability. The interviews give several examples of how health problems limit the ability to walk, both indoors and outdoors.

> Mr – I have to rest every 50 metres and I am slow on pedestrian crossings – the lights change before I am over the road. Mrs – I have arthritis and chronic asthma – I don't like crossing on my own, I wait for someone else.

> I am a furniture walker, I walk from one piece of furniture to the next. I have a walking frame but can only use it up and down the lounge, as the garden is steep. I use a walking stick when I am out.

> I had a walking frame from the hospital but can't use it because of the steps and the uneven footpath. I use it in the house. I only go out with a friend who helps me across the road – I am blind in one eye.

Since they ceased to have access to private transport, some of the respondents have walked more and some less. About 30 percent say that they walk more – slightly more men than women. But a higher proportion say they walk less (40 percent of the men and 49 percent of the women) and some cannot walk easily at all. Half a kilometre is a long walk for half of the men and over 60 percent of the women. This suggests that walking is not likely to be a substitute for private transport in most cases. Nevertheless, the respondents include a group who are able to walk easily for more than a kilometre and many take medium to long walks for their health, and as a means of meeting their transport needs. These walkers include a third of the male respondents, but only 13 percent of the women. Amount of walking is clearly associated with self-perceived health status (Table 8).

Table 8 : Health status by what is considered a long walk

	Poor %	Fair %	Good %	Very good or excellent %	Total respondents %
Never walk	44	5	8	0	9
Under 500 m	56	70	30	46	49
Up to 1 km	0	11	28	0	15
Over 1 km	0	14	35	54	26
Total	100	100	100	100	100

Uneven footpaths and difficult road crossings are frequently mentioned as obstacles to safe and easy walking. Two women had taken action on this issue.

> The grades on the crossing are dangerous and I avoid some. I will be telling the mayor because it will help others. I am not afraid to tackle the powers that be. I don't like the location of the pedestrian crossing – it is blocked in by cars, so I use the other one.

> I had a couple of falls and wrote to the mayor. There was a flagstone sticking up and I fell and needed dental work. The mayor came around with a bunch of flowers. Then the works manager came and asked me about it and fixed it. There are quite a few rough stones and tree roots. I have had my eyes fixed but I had a lot of trouble before.

To summarise, respondents who never walk or who walk only short distances tend more frequently to use modes of transport associated with dependence – lifts and taxis – as their predominant ways of getting around. Those who are able to walk further are more likely to use independent modes – walking, public transport and scooters. Thus health status clearly influences choice of transport mode and level of dependence.

Moving house

Over half of the interviewees (39 out of 71) had been at the same address for over 10 years – these have been classified as "stayers" – and more than a third for over 20 years. Half of the people who had moved in the last 10 years – classified as "movers" – came from elsewhere in the same town or city and a quarter had moved from another urban area. The main reasons for moving, as suggested by the respondents, fall into two categories. The first is moving because of the attributes of the house itself, eg to a more easily managed property or a flatter area. The second group is more likely to be associated with transport factors and includes moving to be nearer to family and to be nearer to services, especially medical care. Both categories were mentioned by about the same number of people.

When people were asked what they like about their present location, again there were features of the house or the area, mentioned by about a third of respondents (more men than women), and also proximity (sometimes along with features of the house or area), mentioned by well over half. Proximity was stated as a liked feature rather more by women than by men and included proximity to services, support services and family.

Nearly half of the respondents could not think of anything they disliked about their current location, suggesting a good degree of satisfaction. Most of the disliked features are associated with physical aspects of their location, either the area or the house, and only 15 percent say that they are too far away from family, friends or support services. This is far fewer than the proportions that think proximity is something they like about their location. The pattern for dislikes is the same for men and women. Being close to places they needed to go to was something that many people liked about their present location. Fewer people mentioned being too far away from something as a feature they dislike.

Information on likes and dislikes about their current location was coded separately for movers and stayers. People who moved recently and mention proximity as something they like about their new location may have been prompted by considerations of transport. This seems to be true for women respondents – 80 percent of women who had moved in the last 10 years say proximity is something they like about their new location, but only 59 percent of women who had not moved say this. However, the situation is different for the men in the survey – 44 percent of men who had moved in the last 10 years say proximity is something they like about their new location, but 75 percent of the stayers say this. Have women movers improved their transport situation by moving while men movers had not? Earlier findings show that women appear to care more about proximity than men do and it may be a stronger motive for them to move, especially when they are living alone.

People who had not moved house in the last 10 years – stayers – report more difficulty with shopping and medical visits than those who had moved (Table 9).

Moving house may have improved the situation with respect to these common activities.

Table 9: Difficulty (often or sometimes) with transport to specified activities – movers and stayers

	Food shopping %	Other shopping %	Medical visits %
Movers	44	59	44
Stayers	64	64	56
Total	55	62	51

There were no significant differences between movers and stayers with respect to social networks or health status. People who have moved in the last 10 years may not have specified transport as a reason, but many have achieved a better location with respect to the places they usually go – expressed as proximity. This is especially the case for women, as the example of Mrs MZ shows (see p. 15). Certainly, older people in the survey see proximity to shopping, services, family and friends as a valuable feature of their location. But the features of the house itself are equally important.

Several people had moved from a rural area to an urban area in the last 10 years, but this was mainly for the same reasons as people moved within urban areas. Only one couple mentioned that they specifically wanted to be in an urban area.

Mr and Mrs WE (aged 85 and 80) moved into town from a rural area seven years ago to be handier to the hospital and urban services. They have a son back where they came from and one in Australia whom they rarely see. Mr WE has had a stroke and has home care three times a week. His only regular outing is a day at the rest home “to have men’s company”. About once a week, Mrs WE walks to town and has a taxi back or gets groceries delivered. They have prescriptions delivered too. They never did go out or socialise much and don’t feel they have any transport problems.

They take lifts with neighbours and work in with them, showing their appreciation with petrol vouchers. About once a week they use taxis, mainly for medical appointments, with Total Mobility vouchers but they “never abuse it”. Both think their health is fair, but their transport situation is good. They realise that things would have been worse if they had not moved into town – “You can’t expect your son to do everything”.

Other issues that emerged included the need to think ahead, to plan and not to leave a move too late, when it may be difficult to re-establish social contact. Moving to smaller centres, even in attractive locations, may not be beneficial if transport services are lacking. The impact of losing private transport has already been shown to be severe in many cases and this will be compounded if there are few transport alternatives.

Moving to a retirement village may work well as a planned choice and may improve the transport situation for older people. Among the respondents were examples of where such a move had worked well, as for Mr and Mrs SS. But in other cases, the outcomes were less successful, such as for Mr FR (see p. 33) and also Mr and Mrs NO (see p. 16).

Mr and Mrs SS, both in their early 80s, live in a one-bedroom apartment in a retirement village. They consider there are many advantages and few things to dislike except the institutional food and a tendency to gossip among the residents. Their son and daughter come every week and take them out. They don't see much of their remaining friends but neighbours in the village are always popping in. Their daughter takes them shopping weekly and helps, as Mrs SS has poor eyesight. Their son takes them to the library. They would not ask others for lifts – "It would be an imposition".

Otherwise, they use taxis and the doctor calls at the village on a regular basis. Most of their entertainment centres on the village because Mrs SS cannot see and Mr SS feels too tired for evenings out. There is a bus outside the village, but both would have difficulty using this service and they find the taxis very good. Mr SS would also have difficulty getting in and out of the village's minivan although it is available for shopping and day trips. Their advice to others is to move somewhere suitable while both partners are alive – "Don't leave it too long".

Mr FR is 84 and lives in a villa in a large retirement village. He bought the villa six years ago because his wife needed rest home care and it was available on the site. However, she died before he actually moved in. He doesn't like the village – "It's a dead place" – but he won't move because now he is dependent on care. He walks with a trolley or two sticks.

He has two daughters and sees one monthly and the other about once a year. He has a few close friends and finds the other residents "cliquey". Mr FR's regular outings are to play bridge and for band practice. His approach is – "If they want me they will come and get me". The village has a bus, which will take him shopping and will also drop him at his doctor's on the way. Sometimes a friend will take him to church but "if he can't take me I don't go". He misses seeing friends and he missed the wedding of his "adopted" granddaughter because there was no transport. He wished he had a car or friends who would take him anywhere he wanted to go. Mr FR doesn't use taxis because they are too dear but he has a scooter. He uses it only in fair weather as it makes him lazy and he needs to walk.

Mr FR stopped driving two years ago. He passed one test, but the "nark" said he would not pass again, so he didn't try. Mr FR thinks his health is fair but many people are worse than him. His transport situation is also only fair – he would go without rather than beg for lifts, but he is thankful for help.

In several cases, the respondents were encouraged to move by their families. Sometimes this was resisted – as in the case of one man whose son wanted him to move to Brisbane – but in other cases, family advice was influential. This may lead to a move closer to younger family members and the possibility of support, including help with transport. However, this does not necessarily mean that all transport problems are solved, as the following examples show.

Mrs JT is 85. She moved six years ago to be nearer her children. Her eyesight led her to give up driving two years ago and this was hard to get over – losing her ability to “just hop in and go places.” She has several children and stepchildren but only one comes around regularly. The others are “there when needed”. She has a few friends who live close but says “You don’t go visiting as much when you are old”. Her activities centre on the church, which is within walking distance for her, and she goes for a walk most days, but her knees give her trouble and she has had to give up going with the church walking group. Shopping and visiting friends is a problem now she can’t just pop out in the car, but she does use a taxi to get to the doctor. She is nervous of taxi drivers and this means that she sometimes misses films and plays and also grandchildren’s sports and break-ups – “If the parents forget then I don’t get to go”. She doesn’t find it easy to ask for lifts.

Mrs and Mrs AW (aged 83 and 80) moved 10 years ago to be near family. A son and daughter-in-law live only 10 minutes away and come around daily. They have no close friends locally and still consider themselves new in town. Both were drivers, but Mrs AW didn’t feel the need and gave it up 20 years ago. Mr AW failed his test five years ago. Mr AW is more or less housebound and in poor health. He can only go out if someone picks him up, but Mrs AW has some regular meetings (RSA, Grey Power, housie), for which she usually gets lifts with friends. Without these she probably would not go. She feels very restricted shopping in such a small centre but uses a taxi and tries to do all her business along with shopping. They both use taxis for medical appointments, for shopping and for getting back from meetings, using Total Mobility vouchers. Other activities such as church-going and voluntary work have been curtailed since their move.

Staying at home more

To what extent can people meet their needs without going out and requiring transport? Six people say that their food shopping is delivered to their home, either from supermarkets or family and friends bring them food or prepared meals. Four people have other purchases delivered, eg they buy clothes from a mail order catalogue. Some had tried to avoid having to shop. One Auckland husband commented that his wife had enough in her wardrobe to last forever. Another couple had tried to buy as much as they could prior to retirement and said that now, 20 years later, things were just beginning to wear out! Only one person receives religious services and one receives medical visits in their own homes. These situations are therefore uncommon. People are having their needs met but they are missing the social contact and stimulation that comes when people leave their homes. Shopping is a common form of recreation. When people had cars, they were able to have a day out visiting various shops and making comparisons before purchasing.

As already noted, most of the contact the respondents have with family takes the form of visits to the older people or visits in both directions – very few people say that trips to visit family are more common than visits to them. So one way in which older people without transport cope is to stay put and be visited. In this case, social contact is provided, but not a change of surroundings.

Frequently in the interviews, respondents expressed resignation and acceptance of staying mostly at home – "What can you expect at my age". This attitude probably leads to an understatement of transport difficulties. Often people see no answer to such problems, apart from adjustment to a more confined lifestyle. Many do not want to make a fuss or be a bother and they may not be completely honest about what they really would like to do. "Not thought about it" may cover not only acceptance, but also unwillingness to consider alternatives – possibly ways of travelling that they have not encountered before, when driving a private car was paramount. This is clear in some of the attitudes towards mobility scooters. It also underlies reluctance to ask for or accept lifts, although here the preservation of independence associated with individualism is also influential.

Summary of transport situations and strategies

Respondents were asked how they would describe their overall transport status. Generally speaking, women take a more positive view than men – 60 percent think their situation is good, very good or excellent, compared with 36 percent of the men, even though more women describe their transport situation as poor (Figure 4).

Figure 4: Transport status by gender

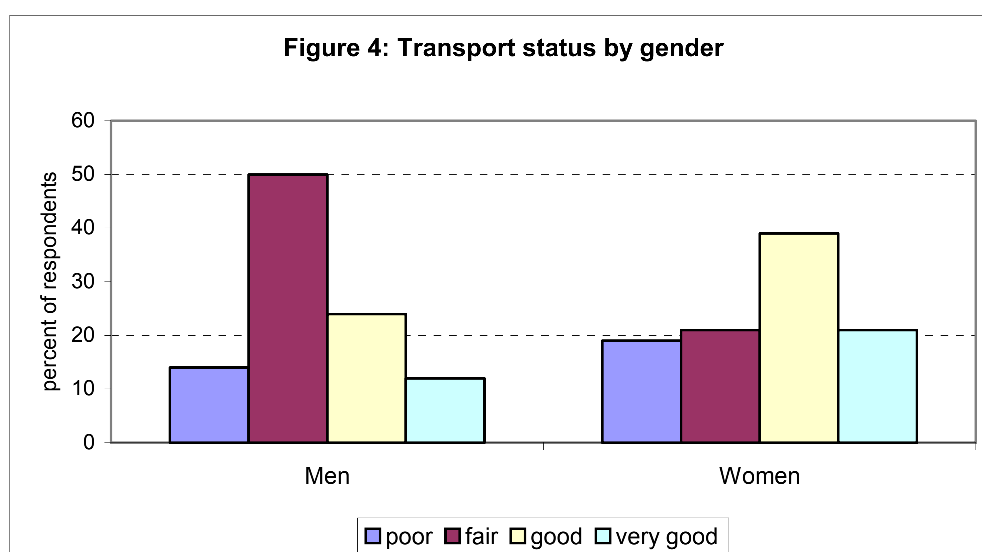


Table 10 summarises transport strategies by identifying the predominant mode or modes for the respondents in order of rank importance. Lifts in other people's cars are by far the most common transport mode. A third use lifts for all their transport needs and another third use lifts in combination with other modes (walking, taxis and scooters, in that order). For one-third, walking is a significant means of moving around, but only five of the respondents use this as their main means. Others combine walking with lifts and sometimes buses. Twenty percent use taxis, but only four suggest that taxis are their main means of getting about. Community transport does not figure as a major means of transport.

Table 10: Predominant mode/s of transport

	Frequency	Percent
Lifts in cars	21	30
Lifts and walk	15	21
Lifts and taxis	9	13
Walk and bus	6	8
Walk	5	7
Taxi	4	6
Mobility scooter	4	6
Scooter and walk	2	3
Scooter and lifts	2	3
Lifts and bus	2	3
Community transport	1	1
Total	71	100

4 Solutions – what would help?

Key points

- Families could assist older people more readily with their transport, and other, needs if it was recognised that "family-friendly" workplaces also accommodated eldercare.
- Organisations could help by arranging lifts, to help older people meet their transport needs and be involved in their activities, including voluntary work.
- Measures to ease feelings of obligation, which older people experience when they are given lifts, could be explored.
- It cannot be assumed that public transport will easily substitute for private transport once access to a car is lost.
- Public transport could become a more attractive and viable transport option for older people if:
  - access and safety are improved
  - drivers are more aware of the needs of older people
  - routes and timetables fit the needs of older people
  - there are more flexible and door-to-door services
  - services are better coordinated with community transport.
- Community transport could be a useful means of transport for older people if it was more widely available, better known and flexible enough to serve a range of transport needs.
- Total Mobility is a useful scheme, but some difficulties need to be addressed.
- Taxis offer many of the advantages of private cars, but their cost is a barrier and they are not available everywhere.
- Wherever possible, older people should be encouraged to go out and do their own shopping.
- Shopping centres could explore opportunities to improve their services for older people, while also gaining commercial advantages.
- Transport services to take older people to medical appointments could be extended, incorporating features for those with special needs.
- Location is an important influence on how well transport needs are met, with different problems in large and small centres.
- There are clear gender differences related to transport and adjustment to life without a car.
- Travel for pleasure is important to wellbeing as well as travel for "serious" matters.
- Changes in health status often result in decreased personal mobility and confidence, which increases dependence on others for transport.
- Attitudes, perceptions and personality factors are influential in the area of transport as in many other areas of life.

This chapter looks at what can be done to assist older people without access to private transport to meet their transport needs. It goes beyond what the older people

are able to do themselves, but builds on their experiences, described in previous chapters. These are suggestions that could become solutions if they are taken up.

Mobilising family resources

Chapter 2 clearly demonstrates how older people rely on lifts from family, but also from friends. However, having family close by does not necessarily fulfil the needs of older people for transport or for social contact. And high levels of contact with family and friends do not necessarily protect people from difficulty with shopping and medical visits – the most common reasons for needing transport. Lower levels of contact with family and friends are not necessarily associated with low health status but are associated with low numbers of outings per week. The reasons why having family close by does not necessarily solve transport problems are varied, but high levels of workforce participation by younger men and women are frequently mentioned. Older people recognise how busy their relatives are – with work, families and their own activities – and do not want to ask for lifts, especially for what might be seen as trivial or discretionary travel. They may ask for help to go to an appointment at the hospital, but not to see the spring flowers or to visit old friends. And, while family frequently visit older people in their own homes, this does not provide the variety and stimulation of an outing – seeing new or familiar people and places.

Instances were cited where older people had moved to be close to sons or daughters, only to find that their children were too busy to give them much support. This is not necessarily an indictment of the younger generation. The attitudes of some older people may not be conducive to close and supportive relationships, or help may be shunned by older people who will not concede any level of dependence.

Looking at the situation from the standpoint of the younger generation raises the issue of working carers. Recognition of the situation of people in paid work who also have eldercare responsibilities is only just beginning to surface in this country. "Family-friendly" workplace policies are oriented mainly to parents and young children. The first piece of New Zealand research on the topic shows some of the stresses involved and how working carers need recognition, support and information from employers, public agencies, voluntary organisations, and the public in general (Davey and Keeling 2004). It is unlikely, given the dynamics of an ageing workforce, that fewer people (especially women) in their 40s and 50s will participate in paid work in the future (Davey and Cornwall 2003). However, better support for working carers and more flexible employment conditions for people in mid-life might well contribute to assisting older people with their transport and other support needs.

Managing lifts

There are many advantages of lifts for older people who do not have their own transport: they provide door-to-door transport; there is someone to help with bags and to talk to; and the costs are usually low. Chapter 3 shows that lifts in other people's private cars are by far the most common mode of transport for the older people in the survey. However, there are attitudinal and practical barriers to making the most of lifts – waiting for other people, and worrying about inconvenience and how to repay – and these may result in the least mobile of older people becoming housebound.

In thinking about how to promote lifts for older people, it is useful to ask what, according to the research respondents, makes it easier to accept lifts.

- If the lift is with a family member, it may not even be seen as a lift at all and there is usually not the same sense of obligation and need for reciprocity. But it may still be seen as an imposition because family are busy, underlining the points made above.

- If the lift is offered – most respondents hate asking and find it embarrassing.

- If a driver is going to the same function and/or does not have to go out of their way.

- If you do not ask too often.

- If you can repay – this may be by offering money or gifts, or reciprocating in some way. Capacity to pay your way is a forceful symbol of independence for older people.

These principles could be used to explore ways of managing lifts for older people, on the basis of neighbourhoods, churches, recreation and sports clubs, and ethnic and other communities. If groups or organisations make themselves more aware of older people who could be interested in their activities but who lack transport, they could "broker" lifts. Knowing that Mrs A was coming to a club meeting and passing close to Mrs B's house, the organiser might invite Mrs B and ask Mrs A to pick her up. This would reduce the embarrassment of having to ask, and improve levels of community involvement. The same principle operates within retirement villages, supported housing and multi-unit developments, where neighbours are often also friends. The research shows that many older people miss out on seeing their friends because of lack of transport and because such trips are not seen as "serious" travel. Groups who organise reunions – for schools, workplaces, armed service groups and so on – could make sure they involve people who do not have transport. Facilitation of lifts, however, may be more difficult in large cities where fewer people know one another, and in rural areas, where distances are greater.

Measures to ease feelings of obligation could be explored. These might include "green dollar" schemes, guidelines on how much to give, or making petrol vouchers available in more outlets. Groups representing older people, such as Age Concern and Grey Power, may have a role to play. "Offer-a-lift" campaigns among their members would benefit those who offer and those who receive, so long as they are carefully handled.

Improving public transport

The use of public transport by older people is governed by its availability, but also, crucially, by their health status and ability to walk and stand. One respondent, when asked where her nearest bus route was, said "It might just as well be in Hong Kong!", indicating her inability to reach it. It cannot be assumed that public transport will easily substitute for private transport once access to a car is lost.

Respondents who did use public transport were generally satisfied with the timing and frequency of services. They were mostly not constrained by time. Most did not wish to go out at night and families are more easily able to help at weekends. People

know the schedules and are able to work around them. One couple rearranged an outing to avoid Waitangi Day, as they knew there would be no bus service then. There are clear gender differences in public transport use, with women usually being more familiar with it and willing to use it, from past experience.

However, the research illustrates many ways in which public transport could become a more attractive and viable transport option for older people with adequate stamina and mobility. The main complaint is about access – ease of mounting and alighting from the bus. This clearly relates to the design of buses. Information from Davey and Nimmo (2003) showed that many urban and metropolitan services now use "kneeling" buses, with low-level access, but these are not available everywhere. Some older people have been, or are afraid of being, injured by doors on buses, and this needs attention. The actions of drivers can also make it either easier or harder for older people to use buses. More than one respondent complained that the drivers did not come close enough to the kerb, to avoid a difficult step down and step up to and from the bus. Making sure that all passengers are safely seated before driving off is a simple safety procedure, and bus schedules should allow for this. Other issues, raised in the interviews and related to planning and organisation, could be developed into ways of improving public transport.

- Planning routes and timetables in relation to the needs of older people, especially shoppers' buses (the "orbiter" service in Christchurch was cited as a good example).

- Using smaller buses, for more flexibility and door-to-door transport.

- Linking commercial bus routes with community transport.

- Using signage and timetables that recognise the eyesight problems of older people – some people do not use buses because they cannot read the numbers or names of services.

- Long-distance bus routes are sometimes not easily accessible when they have out-of-town depots. It would be helpful if they could pick people up at central points, to intersect with other services.

Developing community transport

Compared to the situation in some other countries, described in Davey and Fraser (2003), community transport is not well developed in New Zealand, and many respondents do not know of or use such services. Many of the services that are available are for defined purposes, with a considerable emphasis on medical and hospital appointments. Others require affiliation to an organisation or membership of a specific ethnic or other community. There are advantages in this, as older people enjoy the company of others like themselves and feel more comfortable with an organisation that they know ("I only go on the [Pacific Island community] bus"). However, this can also make the services inflexible and exclusive.

Examples of community transport for older people in other countries, identified in Davey and Fraser (2003) and mentioned by some respondents (such as "dial-a-ride"), could be examined in more detail for their applicability to New Zealand. Pilot schemes could test their feasibility. More information is needed on why existing services are not used more; to pinpoint needs and level of demand; and on what

could be done to mobilise community resources. Coordination of such services appears crucial – with public transport, with car-pooling and with free services, such as shoppers' buses. Examples of community transport services currently operating in New Zealand, and the issues facing them, especially finding drivers, funding and regulatory issues, are cited in Davey and Nimmo (2003).

Low use of community transport by the respondents is matched by low levels of knowledge about these services, suggesting information should be more widely available. Ideally such services should be free or very low cost; be easily accessible by people with disabilities; accommodate multi-purpose and multi-destination trips; and be flexible enough to serve "discretionary" transport needs – seeing friends and enjoying the scenery – as well as "serious" trips.

Improving taxi services

Taxis are used extensively by the respondents and many are eligible for Total Mobility subsidies, which reduce the cost of this type of transport. Difficulties with Total Mobility, noted in Chapter 3, need to be looked at more closely, especially the use of smart cards, mentioned by Auckland respondents.

Taxis offer door-to-door transport and many of the advantages of private cars, but the main barrier to increased use is cost, mentioned by many respondents, even those who receive subsidies. In many cases, this barrier is based on attitudes, eg that taxis should only be used for important matters. A few people, however, recognise that saving on the cost of keeping up a car can free up funds to use on taxi rides. Information on these relative costs could open other eyes and mitigate some of the impact of losing a car. Concessions for older people could be a selling point for taxi companies, especially outside peak demand periods, perhaps involving "ten-trip" tickets. Shared taxis to places frequented by older people may be a way of keeping costs down.

However, there are other barriers apart from the cost of taxi fares. In some areas, services are non-existent or unreliable and, in others, waiting times for taxis can be unreasonable. Taxis are not well-suited for short trips or for trips with multiple destinations. One couple said that they went past their local cinema to one further away because they were embarrassed to ask for a taxi to go to the nearest one (even though the walk there would have been too much for them). Others did not find it acceptable to keep a taxi waiting while they popped into several shops or dealt with business in several locations.

Reasonable or not, some older people, especially older women, are apprehensive about getting into cars with strangers and this can be another barrier. One bad experience can easily put older people off using taxis. This suggests better training of drivers or finding ways to make drivers better known to their clients. People feel more confident with a familiar face, especially if the driver offers special services, such as carrying bags to the door.

Regulation of driving

The licensing and testing of older drivers is not part of the scope of this study. However, issues related to it were raised frequently in the interviews and examples of the impact that losing the ability to drive may have on the lives and wellbeing of older

people are clearly set out in Chapter 2. The government, through the LTSA, has been involved in several initiatives to help older people on the road; these include the *Positive Guide for Mature Road Users* and *Safe with Age* courses, described in Davey and Nimmo (2003). In the case of the older driver test, less than five percent of drivers aged 80 and over are unable to pass the test after one or more attempts. Clearly, many self-regulate and give up driving voluntarily. Eyesight problems are a major factor in giving up driving. Some of these may be preventable or remediable with early action. There are also a variety of measures in the areas of road design, traffic control and signage, which recognise increasing numbers of older drivers on the roads and might help to avoid or delay the impacts of losing private transport. The commitment of government agencies to ensure access and mobility for older road users is demonstrated through the application of the Positive Ageing Strategy and action plans associated with it.

Help with shopping

The survey showed that shopping is an activity in which almost all older people are involved on a regular basis. It generates transport needs, but also produces difficulties and dependence. It may be seen as a chore, but also offers the opportunity for social contact and diverse experiences. Selecting your own food and other purchases, and having time to do this in a measured way, is important in exercising choice and autonomy. Sometimes relatives or caregivers accompanying older people to shop tend to hurry them up. This suggests that, wherever possible, older people should be encouraged to go out and do their own shopping. An exception may be the use of mail order firms for clothing purchase. Some older people may find it difficult or embarrassing to try on clothes in a shop, if they need help to do this.

The interviews produced examples where shopping centres provide pick-up services for shopping. There are now local examples of malls providing mobility scooters for hire, along the lines of the British “Shopmobility” schemes (Davey and Fraser 2003). Perhaps “senior citizen-friendly” shopping could be extended as a selling point – with special times, prices and conditions for older people (free delivery of purchases, displays of interest, special rates for haircuts and personal services, financial and health advisors in attendance and so on). Cinemas are often located in malls and they could promote sessions with “classic” films. Special “senior citizen” days could make it easier for older people to combine shopping with entertainment, social contact and professional appointments. In the USA, “mall walkers” groups add a dimension of exercise in a safe and weather-proof environment, where people with crutches, sticks and walkers feel comfortable.

A further regular requirement, mentioned by several respondents, is “paying bills”. Increasingly, this is done by direct credit – probably an easier and safer way – but the current cohort of older people often like to do this in person (and can often do this through a post shop). This could also take place while shopping, providing that facilities are conveniently placed.

Supermarkets are already attractive to older people, for their prices amongst other things, as the respondents attest. This could be built on, with specially designed, stable trolleys for those who need them, wider aisles for walkers and scooters, and easily reached shelves (or people to help). With an ageing population, commercial considerations could well stimulate more imaginative thinking along these lines.

Involving organisations

Many organisations already assist with the transport needs of older people and this is acknowledged in the interviews and in this report. They include commercial businesses offering services, and ideas for them are mentioned in the previous section on shopping. Churches, charitable organisations and voluntary groups already assist in helping members reach their meetings, as already mentioned. Perhaps this role could be widened to include the brokering of lifts for other activities, especially non-essential travel, which older people may hesitate to ask about. Networks based on such organisations may be able to seek out and assist older people made housebound by lack of transport and hence missing out on social contact. Many of the respondents have given up voluntary work, which may have helped them to feel they are making a contribution. Where lack of transport has contributed to this, initiatives from voluntary organisations may help people to re-connect, to the benefit of both.

There is considerable emphasis already on transport services to take older people to medical appointments. Examples cited by respondents, where transport is offered at the time of making an appointment, usually on the basis of no charge or a low one, seem well worth promoting more widely. Other issues in this area include the need for someone to accompany frail older people and assist them in the hospital environment, which can be difficult to negotiate. Spouses of people with dementia being cared for at home face serious problems if the sufferer will not go alone to day care or appointments. In these cases, providing transport is only part of the solution.

Some cross-cutting issues

- Location is an important influence on how well transport needs can be met in the absence of private means. People who live in large cities have a different set of issues compared to those in smaller centres. Small towns often provide fewer options for transport – but congestion and traffic volume in large cities present different challenges. In addition, the transport options that are available for older people will depend on individual factors, including their specific location (with respect to bus routes, people who might give lifts, and also terrain, which might affect walking and the use of mobility scooters) and their personal circumstances, capabilities and preferences.

- There are clear gender issues related to transport and wellbeing in later life, and previous chapters throw up many of these, related to driving and its cessation, the use of public transport, and openness to new modes, such as mobility scooters. These gender differences need to be taken into account in public education and information. From the survey findings, it appears that older men find it harder than older women to adjust to life without a car and being car-less is more of a threat to their independence and self-image. Older men living alone differ from older women in their circumstances and attitudes, and so do couples compared to single people.

- The report has highlighted a distinction between "serious" and "discretionary" travel. The former includes trips to medical appointments, shopping and special occasions. Such trips are often supported by community transport. Older people feel less reticent about asking family and friends for lifts if the purpose is necessary and serious. And they are less hesitant about using taxis for such purposes. Travel to admire the scenery, visit old friends or to go out on a whim

(as was possible when they had use of a car) may be seen as discretionary and trivial. These trips may not happen if bus services are not available at the times and to the place, if it is embarrassing to ask sons and daughters to take them, or if the taxi money cannot be spared. The activities of the older people are curtailed, their choices are diminished and their enjoyment of life is impaired, with possible negative effects on health and wellbeing. The stories of the respondents suggest that this type of travel is not really so unimportant.

- In later life, circumstances change and this will also impact on transport needs and their fulfilment. The report has highlighted changes resulting from loss of access to private transport. Changes in health status are also important, especially when they result in decreased personal mobility and confidence. Respondents who perceive their health status as poor or fair are generally more dependent on others for transport. Loss of a spouse can remove the person who provided transport, especially in the case of older women. Moving house may or may not improve the transport situation, as examples quoted in this report show, and moving to be closer to families does not necessarily translate into improved support levels.

- Attitudes and perceptions are influential in the area of transport as in many other areas of life. They influence whether or how people ask for lifts, who they ask and for what types of trip. They influence what types of travel are considered serious and which trivial. Personality factors, based on a lifetime of experience, hold sway in decision making about lifestyle and activities. They influence the extent and strength of social networks and the risk of social isolation. Diversity increases with age, relating to transport as well as other areas of life.

Appendix 1: References

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Gilhooly, Mary et al. (2003) *Transport and Ageing: Extending Quality of Life through Public and Private Transport.* ESRC Growing Older Programme, Research Findings 16, Sheffield.

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Appendix 2: Methodology

Definitions

Private transport is defined as a motor vehicle or vehicles owned by an individual or couple, kept at their residence and available at all times for personal transport. Three-quarters of New Zealanders aged 60–74 either live alone or with a spouse only. This is true of 85 percent of people 75 and over who are living in the community. The minority of older people who live with other related or unrelated people where the other household members own vehicles and use them for their own purposes would not be deemed to have access to private transport. The situation of these people is similar to those who may be able to use private transport owned by relatives and friends living in other households.

The definition does not preclude people still owning a car, and in fact several respondents to the survey do so, However, if no one in the household has a valid driver licence, then they are not deemed to have access to the car at all times. "Driving", in the context of this study, means being able to do so legally. People who use bicycles and mobility scooters are not considered to have access to private transport for the purposes of this definition. People who, separately or with a partner, have never owned a car and never driven were also excluded from the study, because these people will never have had access to private transport, as defined here.

Thus there are several situations that could be included in the research:
- single person or couple had a car but no longer do so because of cost
- had a car but single person or both members of the couple have either lost or relinquished their licences, or one partner never drove, and the car has been sold or given away
- single person never drove and partner who drove is now deceased
- single person or couple own a car, which they cannot legally drive or choose not to drive, but which is kept insured and registered for others to drive.

As well as having no access to private transport, as defined above, the research is aimed at individuals and couples living in private dwellings in the community (this includes living in retirement villages, pensioner flats and supported housing). Those eligible for inclusion were intended to be aged 75 or older. This requirement was relaxed in the case of Māori and Pacific respondents, with the age reduced to 70 or older, as there were difficulties of recruitment, probably related to lower average life expectancy in these two ethnic groups.

Research design

Information to address the research questions was collected through semi-structured personal interviews with eligible individuals and couples (aiming for a balance between these two categories). The face-to-face interviews were conducted by three trained and experienced interviewers, usually in the respondents' homes but sometimes in another location of their choice. The sessions lasted, on average, about an hour.

Respondents were identified through the Volunteer Community Coordinators (VCCs) appointed by the Office for Senior Citizens. The VCCs were briefed by their national coordinator and by the principal researcher at their national conference in October 2003. Each VCC then approached individuals and couples who fitted the requirements for the study to recruit two single persons and two couples in each area or community. This allowed for two "back-ups" in case the nominated respondent(s) was/were not available on the day of the interview. This arrangement was clearly explained to the first and back-up respondents. The VCCs also were responsible for explaining the survey to the respondents, gaining their informed consent to be interviewed (which was checked again before the interview started) and setting up a meeting with the interviewer at a mutually convenient time and place. This

required a considerable amount of detailed liaison between the VCCs, their coordinator in Wellington and the research team.

At the time that the research took place, there were 39 VCCs throughout New Zealand in metropolitan, urban, small town and rural areas. Most of them represent a geographical area, but others relate to an ethnic community. The method of recruitment ensured representation of people from a variety of locations and communities, but cannot be described as a random sample. Māori, Pacific and Asian VCCs recruited people from their own communities and assisted with the interviews to ensure cultural sensitivy and provide translation services, where required. However, ethnicity was not treated as a major basis for disaggregation in the survey analysis.

In addition to the full survey, a pilot study of two single people and two couples was carried out in the Wellington and Kapiti areas, to test the survey questionnaire and provide a basis for its revision.

The Victoria University Ethics Committee approved the project in late September 2003, with final sign-off of the questionnaire in mid-January 2004.

The questionnaire used in the personal interviews is attached as Appendix 3. It includes a mixture of semi-structured and open-ended questions. The form was developed with reference to instruments used in similar surveys, to generic questions found to be appropriate for use with older people (eg on self-perceived health status), and in consultation with the Office for Senior Citizens, the Land Transport Safety Authority and the Ministry of Transport.

Progress of the research

Interviewing began in February 2004 and was completed by early March. Out of a potential total of 78 interviews (assuming each of 39 VCCs produced two appropriate candidates), information from 71 couples and single people was included in the analysis. The shortfall had several causes. There were recruitment difficulties in some areas, and there were no suitable back-up candidates in adjoining areas. Three interviewees were found to be still driving their own cars. And in a few instances, unexpected illness or deaths of people close to the intended respondents meant that the interviews could not go ahead. Funding constraints and the logistics of the interview programme, which covered the whole country and involved a great deal of travel, ,meant that call-backs were not possible, except in the larger centres.

Analysis of findings

The analysis of survey results was based on three sources of information:

- an SPSS database of interview data, which was used for frequencies and cross-tabulations
- a database of qualitative comments from the interviews, and vignettes that summarised the situation of each respondent
- notes from a two-day meeting of the three interviewers (one of whom is the principal researcher), at which the above sources were considered in the light of understandings gained during the fieldwork stage. This group analysis process was valuable in the identification of themes and key variables.

Characteristics of the respondents

Location

The respondents are located according to the distribution of the VCCs, but represent people from a wide geographic range:

- 26 live in metropolitan centres – Auckland, Hamilton, Wellington, Christchurch and Dunedin

- 24 live in main urban centres, including Whangarei, Tauranga, Rotorua, Gisborne, Hastings, New Plymouth, Wanganui, Palmerston North, Nelson and Invercargill
- 21 live in small urban centres and rural areas, including Taupo, Marton, Masterton, Timaru, Taihape, Blenheim and Ashburton.

This probably underrepresents people in smaller centres, where transport difficulties might be expected to be greater, but this was a result of the method of recruitment.

Note: In the report, the locations of the respondents quoted are not given, for reasons of confidentiality, unless this can be safeguarded (eg in references to Auckland). The names given are pseudonyms.

Housing

The majority of the respondents live in detached houses or semi-detached units in suburban streets. Twelve are in villas or apartments in retirement villages and five in local authority pensioner flats (one in a kaumātua flat). No details of housing condition were recorded, but interviewers noted that very few were below average in quality.

Household circumstances

The 71 interviews were with 43 single people – 14 men and 29 women – and 28 couples. The intended balance between couples and single people and between single men and women was not fully realised. Many of the questions asked for one response from a married couple (and in some cases, one partner dominated the responses – sometimes the wife and sometimes the husband), but others recorded separately the remarks of the man and the woman. This allows for some gender comparisons in the analysis. Counting both partners in a couple gives a total of 99 respondents – 42 men and 57 women.

Age

As already mentioned, the requirement that interviewees should be aged 75 or over was lowered for Māori, Pacific and other ethnic communities. Ultimately all except one man and two women fell into the 75 plus age group and only one woman was under 70. The average age of the men was 84.5 years and of the women 81.4 years. The men are fairly evenly divided between the 70–84 and 85 plus age groups and the oldest was 94. Rather more of the women are under 85 and the oldest was 91.

Ethnicity

Ethnicity was not expected to be a major variable in the analysis, although the sample includes Māori, Pacific and Indian respondents. These are five Māori women, three men and three women from the Pacific community, and two women and two men from the Indian community. The vast majority of respondents, however, describe themselves as New Zealanders of European descent or Pākehā.

Income

Respondents were asked about the source or sources of their income but not about its amount. Sixty percent say they rely on New Zealand Superannuation alone. The rest have some supplementary sources including, in order of importance, income from investments and savings, war pensions, occupational pensions and other welfare benefits.

Health status

Among the 71 respondents, about half say their health is good, very good or excellent, slightly more men than women. All the people who say their health is excellent are women (Table 11).

Table 11: Health status by gender

	Male %	Female %
Poor	14	5
Fair	29	44
Good	45	37
Very good	12	10
Excellent	0	4
	100	100

People who say their health is poor or fair often listed several complaints. But several people, apparently with equally serious health issues, answered “good” or “very good”, sometimes qualifying this with “for my age” or “all things considered”. This appears to show a positive view of life, despite restrictions.

Coping without a Car

Questionnaire for Personal Interviews

Conducted for the Office for Senior Citizens

by

The New Zealand Institute for Research on Ageing

Te Putahi Rangahau i te Pakeke Haere

Victoria University of Wellington

Coping without a Car

Questionnaire for Personal Interviews

Name of Interviewee(s) ……………………………………………………….

Full address ………………………………………………………………….

Date of interview ……………………………..

Location (if not at address above) …………………………………………….

Type of house/size/general age and condition general description of location and neighbourhood (interviewer to note)

…………………………………………………………………………………

…………………………………………………………………………………

…………………………………………………………………………………

Introductory comments (see Information sheet and Consent form, brief outline of topics to be covered)

LOCATION

1. How long have you been living here? ……………years ……….. months

(If less than 10 years) Where did you live before? ……………………………….

2. Why did you move? …………………………………………………………

3. What do you like best about living in this location?

……………………………………………………………………………..

4. What do you like least?

……………………………………………………………………………..

5. Are you thinking of moving house in the near future? If so, why?

………………………………………………………………………………

SOCIAL CONTACTS

6. Please tell me about your close family

Who do you consider your close family? Where do they live? How often do they come to see you? How often do you go to see them?

…………………………………………………………………………………….

…………………………………………………………………………………….

…………………………………………………………………………………….

…………………………………………………………………………………….

…………………………………………………………………………………….

7. What about your closest friends?

Where do they live? How often do they come to see you? How often do you go to see them?

…………………………………………………………………………………….

…………………………………………………………………………………….

…………………………………………………………………………………….

…………………………………………………………………………………….

…………………………………………………………………………………….

8. What about your neighbours?

How often do they come to see you? How often do you go to see them?

…………………………………………………………………………………….

…………………………………………………………………………………….

…………………………………………………………………………………….

…………………………………………………………………………………….

…………………………………………………………………………………….

TRANSPORT PATTERNS

9. Can you tell me about where you go in a typical week, say last week?
(*note M and F for husband's and wife's trips*)

Week beginning	To	Mode (car, walk)	Comments, including time and cost, if possible
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

(Use table flexibly to collect information on typical travel patterns)

10. Please tell me about other, less frequent, outings that you make (e.g. meetings, visiting etc)?

………………………………………………………………………………………..

…………………………………………………………………………………………

11. I am going to talk about some of your activities.

Can you tell me whether the lack of private transport ever interferes with your ability to do, saying often, sometimes or never?

(circle as appropriate and record comment, probe if necessary)

Food shopping	Often	Sometimes	Never

Comment ……………………………………………………………………………..

………………………………………………………………………………………..

………………………………………………………………………………………..

Other shopping	Often	Sometimes	Never

Comment ………………………………………………………………………………

………………………………………………………………………………………..

………………………………………………………………………………………..

Church attendance/religious ceremony	Often	Sometimes	Never

Comment ……………………………………………………………………………..

………………………………………………………………………………………..

………………………………………………………………………………………..

Doctor's appointments and other health services	Often	Sometimes	Never

Comment ………………………………………………………………………………

………………………………………………………………………………………..

………………………………………………………………………………………..

Seeing friends	Often	Sometimes	Never

Comment ……………………………………………………………………………..

………………………………………………………………………………………..

………………………………………………………………………………………..

Seeing family	Often	Sometimes	Never

Comment ……………………………………………………………………………..

………………………………………………………………………………………..

………………………………………………………………………………………..

Entertainment and recreation (including physical activities) Often Sometimes Never

Comment ……………………………………………………………………………..

……………………………………………………………………………………..

……………………………………………………………………………………..

Volunteer work Often Sometimes Never

Comment ………………………………………………………………………………

……………………………………………………………………………………..

……………………………………………………………………………………..

Other activities (specify) Often Sometimes Never

Comment ………………………………………………………………………………………

……………………………………………………………………………………..

……………………………………………………………………………………..

13. Can you tell me about a recent instance when lack of transport was a problem and what happened?

………………………………………………………………………………………

……….. ……………………………………………………………………………

14. And what do you think would improve your transport situation?

…………………………………………………………………………………….

……………………………………………………………………………………..

DRIVING

Ask questions to each of partners in a couple.

	FEMALE	MALE
15. Have you ever been a driver?		
If no, would you like to tell me why not? (*Go to Q.19)*		
If yes, when did you stop driving?		
16. Why did you stop driving?		
17. What effect did giving up driving have • On your daily routine		
• On other household members		
• Is there anything else about stopping driving that you would like to tell me about?		

Comment …………………………………………………………………………

……………………………………………………………………………………….

……………………………………………………………………………………..

……………………………………………………………………………………..

(In following sections note F or M for comments of partners in a couple)

GETTING A LIFT/BEING DRIVEN

18. How often do you get a lift with someone else in their private car?

Every day or almost every day
About once a week
About once or twice a month
Never or hardly ever (*if Never, go to Q.24)*

…………………………………………………………………………………………..

19. Who drives you to places you need to go?

…………………………………………………………………………………………

20. What type of journeys do you get lifts for?

…………………………………………………………………………………………

21. When you get a lift, do you have to ask for the lift or is it offered to you?

…………………………………………………………………………………………

22. Since you stopped driving/gave up having a car, do you find you have been getting lifts –

MORE LESS ABOUT THE SAME

Probe for comment …………………………………………………………………..

……………………………………………………………………………………….

23. What are the advantages and disadvantages of getting lifts with other people?

………………………………………………………………………………

……………………………………………………………………………….

………………………………………………………………………………

……………………………………………………………………………….

USE OF PUBLIC TRANSPORT (BUSES AND TRAINS)

24. Do you use public transport?

YES How often?

Every day or almost every day
About once a week
About once or twice a month
Never or hardly ever

NO Why is that? (probe for reasons) (*Go to Q.28*)

…………………………………………………………………………………….

25. What type of journeys do you use public transport for? (*purpose, destination*)

…………………………………………………………………………………….

26. Since you stopped driving/gave up having a car, do you find you have been using public transport –

MORE LESS ABOUT THE SAME

Probe for comment ……………………………………………………………

……………………………………………………………………………………

27. Where is your closest point of access to public transport?

……………………………………………………………………………………

Type of service (bus or train) …………………………………………………..

Frequency (during day, at night and weekends)
(*probe if knowledge of night and weekend means that they do not know or do not use)*

……………………………………………………………………………………..

28. How easy is it for you to use public transport (*physical access*)?

……………………………………………………………………………………

29 . Where would you like to be able to travel by bus/public transport that you currently cannot?

………………………………………………………………………………………

30. What would encourage you to use public transport more? (*If not raised, prompt for cost, reliability, safety, shelter*)

……………………………………………………………………………………

USE OF COMMUNITY TRANSPORT
(defined as door-to-door transport by reservation, run by community and voluntary groups – give examples if possible)

31. What community transport services do you know of in your area?

…………………………………………………………………………………………

…………………………………………………………………………………………

32. Do you use community transport?

YES How often?

Every day or almost every day
About once a week
About once or twice a month
Never or hardly ever

NO Why not? ……………………………………………………………………………….
(*Go to Q.36)*

33. Please describe the services – provider, frequency, booking system, frequency/reliability

…………………………………………………………………………………………

…………………………………………………………………………………………

Does the service pick you up from your door? (*circle)* Y/N

Does it take you directly to your destination? Y/N

Does the service return you directly to your door? Y/N

How much do you pay?

…………………………………………………………………………………………

34. Is the service only for certain types of trip? What types of trip?

…………………………………………………………………………………………

35. Since you stopped driving/gave up having a car, do you find you have been using community transport –

MORE LESS ABOUT THE SAME

Probe for comment ……………………………………………………………………….

………………………………………………………………………………………….

USE OF TAXIS

36. Do you use taxis?
YES How often?

Every day or almost every day
About once a week
About once or twice a month
Never or hardly ever

NO Why not? ……………………………………………………………………..
(*Go to Q.39)*
……………………………………………………………………………………………….

37. What kind of journey do you use taxis for?

………………………………………………………………………………………………..

38. Since you stopped driving/gave up having a car, do you find you have been using taxis –

MORE LESS ABOUT THE SAME

Probe for comment ………………………………………………………………………………..

………………………………………………………………………………………………

39. What would encourage you to use taxis more?

………………………………………………………………………………………………

………………………………………………………………………………………………

40. Do you know about the Total Mobility scheme?
(subsidies on taxi fares for people with disabilities) Y/N

41. Do you use the Total Mobility scheme? Y/N

(Information on the scheme can be obtained from Regional Councils, Age Concern branches or CABs)

MOBILITY SCOOTERS

42. Do you own a mobility scooter? YES (go to Q.44) NO (continue)

43. Would you ever consider using a mobility scooter? YES NO
(*Probe for attitudes*) Under what circumstances?

…………………………………………………………………………(*Go to Q.48)*

44. Did you start to use your scooter before or after you stopped driving a car?

…………………………………………………………………………………….

45. When you use your scooter how far do you generally travel with it (one way)?

– less than a kilometre per trip (under 15 minutes)
– 1–3 km per trip (15 to 45 minutes)
– more than 3 km per trip (more than 45 minutes)

46. How does your mobility scooter help you in meeting your transport needs?

………………………………………………………………………………….

47. Do you have any problems when using your mobility scooter?

…………………………………………………………………………………

48. What are your views on using a mobility scooter?

……………………………………………………………………………………..

WALKING

49. Since you stopped driving/gave up having a car have you been walking –

MORE LESS ABOUT THE SAME

If more or less, Why is that? *(Probe for health, fitness, enjoyment, physical environment)*
……………………………………………………………………………………..

……………………………………………………………………………………..

50. What distance do you consider is a long walk? (either in distance or in time)

…………………………………………………………………………………….

51. Do you have any difficulty with footpaths, pedestrian crossings? If so, what is it that causes you difficulty? (*Probe for external factors*)

………………………………………………………………………………………

PERSONAL CHARACTERISTICS

	FEMALE	MALE
52. Which age group do you come into – 70–84 85 or over		
53. What ethnic group do you identify with? *(If prompt needed ask what ethnic group they noted in the census)*		
54. What is your main source of income?		
55. How would you say your health is generally? 1. poor 2. fair 3. good 4. very good 5. excellent		
56. Which of these answers best describes how you feel about your transport situation? 1. poor 2. fair 3. good 4. very good 5. excellent		

Comment on health…………………………………………………………………………..

…………………………………………………………………………………………

Comment on transport situation …………………………………………………………..

…………………………………………………………………………………………

57. Is there anything on the topic of transport that we have not talked about that you would like to discuss?

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That is the end of my questions. Thank you very much for answering them. Is there anything you would like to add or to ask me about the survey?

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