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Further examinations of mobility in later life and improving health and wellbeing

Editorial: Special section: Transport in Later Life part 2, Journal of Transport and Health

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Across many high income countries, older people are generally in better health than previous generations. However, those aged over 70 years are the group still most likely to have accessibility and mobility difficulties (Musselwhite, 2011 for overview). They are also more likely than other age groups to be reducing the amount they drive and ultimately give-up driving altogether (Box et al, 2011). Being mobile is related to psychological well-being in older age and fulfils many utilitarian and psychosocial needs (Musselwhite and Haddad, 2010; Mackett, 2015). A reduction in mobility can lead to an increase in isolation, loneliness and depression (Fonda et al 2001; Ling & Mannion 1995), and overall a poorer quality of life (Gabriel and Bowling 2004; Schlag et al 1996). There needs to be more research examining how to improve mobility in later life in order to improve health and wellbeing.

NICE guidance (2012) recommends that pedestrians and cyclists are given the highest priority when developing or maintaining streets or roads. Walking and cycling are important in later life, both for helping people reach their destinations without the need for expensive technologies (Stjernborg et al., 2014; Chudyk et al., 2015; Tsunoda et al., 2015), and also in keeping people healthy. For older people, carrying out daily physical activity, such as walking, throughout the lifecourse is related to reducing the likelihood of developing or dying from over 20 conditions and diseases including coronary heart disease, diabetes, some cancers, and obesity, as well as improving mental health and wellbeing (NICE 2012; PHE 2014). It is therefore important to examine what factors enable older people to walk. Previous research suggests good quality pavements, bus stop density, having safe places to cross busy roads, and the provision of toilets and seating are all important (Curl et al in press; Newton et al 2010; Newton and Ormerod, 2007; Ormerod et al 2014). Moniruzzaman et al (in this issue) have found that pet ownership, proximity to amenities and culture also emerge as walking enablers.

Two emerging mobility technologies that can enable older people to stay mobile longer in later life include mobility scooters (Thoreau, in this issue) and e-bikes (Johnson and Rose, in this issue). Both technologies are extremely popular with users but may require changes in legislation to enhance safe use, including use of them on pavements and considering training issues. In addition, as authors note themselves, both technologies require further research.

Driving is often viewed as a key mobility enabler for older people and continues to be a dominant mode of transport (e.g. Musselwhite, 2011; O'Hearn and Oxley, 2015); it requires minimal physical activity and gets people door-to-door with relative ease. However, changes in cognition can mean older people face challenges with their driving which may cause them to have to give up driving (Box et al., 2011). Older drivers on the whole would welcome more involvement of healthcare professionals, especially primary care doctors (General Practitioners, GPs) and opticians in deciding whether they are safe enough to continue driving (Berry 2011; Coughlan et al. 2004; Musselwhite

and Shergold 2013). However, healthcare professionals, are, on the whole, reluctant to be involved and very few give advice on driving cessation (Berry 2011; Hawley 2010; Musselwhite and Shergold 2013). In Ireland, GPs assess medical fitness to drive. However, Kahvedžić et al. (in this issue) found GPs themselves hold mixed feelings over such responsibility. In the UK, decisions on driving are based on self-declared fitness, keeping the locus of control with the individual. Hence, it is important to get individuals to assess their own driving ability and skills and recognise when limitations on these might be causing danger on themselves and other road users. Needless to say, pre-planning and self-reflection are therefore important to help the individual gradually regulate their driving (Musselwhite and Shergold, 2013). Holland and Gwyther (in this issue) suggest self-regulation planning and implementation intentions may help drivers achieve their mobility goals and promote safer driving across the lifecourse.

In conclusion, there is a need to look at the wider relationship between mobility and ageing in relation to health. As we concluded in the last issue (Musselwhite et al., 2015), there is a need to include other constructions of mobility – virtual, potential, imaginative, aspirational, emotive, for example. Murray (in this issue) discusses and notes the importance of using 'mobilities' in order to embrace a transdisciplinary and intergenerational approach to mobility in order to reveal aspects of mobility experiences that are otherwise hidden. This will help to achieve the desire of better understanding the relationship between health and mobility for older people in an ageing society.

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