Travel in London: Understanding our diverse communities

September 2015

MAYOR OF LONDON

TRANSPORT FOR LONDON
EVERY JOURNEY MATTERS

Travel in London: understanding our diverse communities 2015

A summary of existing research

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Cycling

Fifteen per cent of disabled Londoners sometimes use a bike to get around London, which is a smaller proportion than among non-disabled Londoners (where 18 per cent sometimes use a bike in the Capital) [17].

Proportion of Londoners who cycle (November 2014) [17]

%	Disabled	Non-disabled
Base	**(507)**	**(1,646)**
Cyclist (sometimes uses a bike to get around London)	15	18
Non-cyclist (never uses a bike to get around London)	85	82

Disabled Londoners are more likely to say that they cannot ride a bicycle (22 per cent of disabled Londoners cannot ride a bicycle) than non-disabled Londoners (15 per cent of non-disabled Londoners cannot ride a bicycle) [17].

Proportion of Londoners able to ride a bicycle (November 2014) [17]

%	Disabled	Non-disabled
Base	**(507)**	**(1,646)**
Can ride a bike	78	85
Cannot ride a bike	22	15

Disabled Londoners are slightly more likely to say that they never cycle around London than non-disabled Londoners (85 per cent compared with 82 per cent) [17].

%	Disabled	Non-disabled
Base	**(507)**	**(1,646)**
5 or more days a week	4	3
3 or 4 days a week	3	5
2 days a week	2	3
1 day a week	1	2
At least once a fortnight	1	1
At least once a month	-	1
At least once a year	1	1
Not used in last 12 months	-	-
Never used	-	1
Net: Used in the last 12 months	85	82

We have developed a behavioural change model to look at Londoners' readiness to cycle or cycle more. According to this model, 73 per cent of disabled Londoners are in the 'pre-contemplation' phase, meaning that they have never thought about cycling (more) or have thought about it but decided not to (higher than non-disabled Londoners at 68 per cent) [17].

Behaviour change model of non-cyclists (November 2014) [17]

%	Disabled	Non-disabled
Base (all non-cyclists)	(507)	(1,646)
Pre-contemplation: 'You have never thought about it, but would be unlikely to start in the future' 'You have thought about it, but don't intend starting in the future' 'You have never thought about it, but could be open to it in the future'	73	68
Contemplation: 'You are thinking about starting soon'	7	11
Preparation: 'You have decided to start soon'	2	3
Change: 'You have tried to start recently, but are finding it difficult' 'You have started recently and are finding it quite easy so far'	2	2
Sustained change: 'You started a while ago and are still doing it occasionally' 'You started a while ago and are still doing it regularly'	8	11
Lapsed: 'You had started doing this but couldn't stick to it'	8	6

Cycling schemes

Awareness of Cycle Hire is very high, with 93 per cent of disabled Londoners and 92 per cent of non-disabled Londoners saying that they know about the scheme [17].

Expected future use of Cycle Hire (people who say that they will probably or definitely use the scheme) is lower among disabled Londoners (20 per cent) than for non-disabled Londoners (29 per cent) [17].

Expected use of Cycle Hire (November 2014) [17]

%	Disabled	Non-disabled
Base	**(281)**	**(875)**
Yes, definitely/ probably	20	29
Yes, definitely	9	9
Yes, probably	11	20
No, probably not	27	31
No, definitely not	44	30
Not sure	9	10

Awareness of Cycle Superhighways is lower than awareness of Cycle Hire amongst both disabled and non-disabled Londoners. Sixty-four per cent of disabled Londoners and 61 per cent of non-disabled Londoners are aware of Cycle Superhighways [17].

Disabled Londoners are almost as likely as non-disabled Londoners to say that they probably or definitely expect to use Cycle Superhighways in the future (20 per cent compared with 23 per cent) [17].

Expected use of Cycle Superhighways (November 2014) [17]

%	All	Disabled	Non-disabled
Base	**(1,180)**	**(69)**	**(362)**
Yes, definitely/ probably	23	20	23
Yes, definitely	6	5	6
Yes, probably	17	15	17
No, probably not	28	23	30
No, definitely not	31	39	29
Not sure	17	17	17

Public Health England

Protecting and improving the nation's health

Everybody active, every day

An evidence-based approach to physical activity

October 2014

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Developed with over 1,000 health professionals, local authorities, research specialists, educationalists, charities and fitness experts at national and local levels through a process of discussion and engagement.

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Inequalities

How to close the gap

Being active every day needs to be embedded across every community in every aspect of life. The association between physical activity and leading a healthy, happy life means that issues of cost, access or cultural barriers need to be tackled. Under the Equality Act 2010 there is a responsibility to consider vulnerable groups – for example, by ensuring access, monitoring, and staff training.

Common inequalities

Economic

- people living in the least prosperous areas are twice as likely to be physically inactive as those living in more prosperous areas[37]

Geographic

- south east England has the highest proportion of men and women meeting recommended levels of physical activity; north west England has the lowest[1]

Age

- physical activity declines with age to the extent that by the age of 75 years only one in ten men and one in 20 women are active enough for good health[38]
- between 2008 and 2012, the proportion of children aged two to 15 years meeting recommended physical activity levels fell from 28% to 21% for boys and 19% to 16% for girls[39]

Disability

- disabled people are half as likely as non-disabled people to be active[40]
- only one in four people with learning difficulties take part in physical activity each month compared to over half of those without a disability[41]

Race

- only 11% of Bangladeshi women and 26% of men are sufficiently active for good health compared with 25/37% of the general population[42]

Gender

- men are more active than women in virtually every age group[18]
- girls are less likely to take part in physical activity than boys, and participation begins to drop even more from the age of ten to 11[19]

Sexual orientation and gender identity

- half of all lesbian, gay, bisexual and transgender people say they would not join a sports club, twice the number of their heterosexual counterparts[43]

Key fact

People in the least prosperous areas are twice as likely to be inactive than those in the most prosperous areas

Key fact

Disabled people are half as likely to be active than non-disabled people

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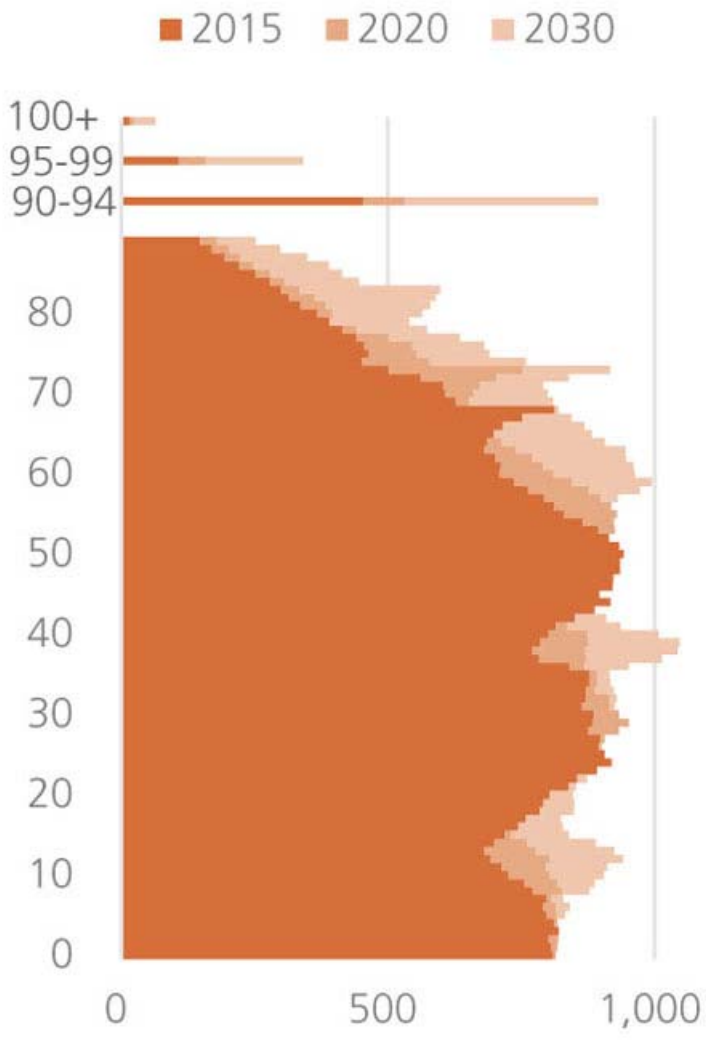
Political challenges relating to an aging population: Key issues for the 2015 Parliament

Vastly improved life expectancy, one of the great triumphs of the last century, looks set to be one of great challenges of this one.

Between 2015 and 2020, over a period when the general population is expected to rise 3%, the numbers aged over 65 are expected to increase by 12% (1.1 million); the numbers aged over 85 by 18% (300,000); and the number of centenarians by 40% (7,000).

Chart 1: the changing shape of the UK population

Age structure of the UK population in 2015, 2020 and 2030, by single year of age to 89 and bands thereafter, ONS 2012-based principal projections, thousands



A rise in the elderly population, particularly if not matched by health improvements, will place ever-greater pressure on the public finances, as a relatively smaller working-age population supports growing spending on health, social care and pensions.

More spending

Around 55% of welfare spending (£114bn in 2014/15) is currently paid to pensioners, with the state pension by far the largest element of this. This expenditure is forecast to increase by an average of £2.8 billion a year over the next five years, resulting in spending of £128 billion by 2019/20.

Growing numbers of elderly people will also have an impact on the NHS and social care expenditure. The prevalence of long-term health conditions increases with age; and according to a 2010 estimate made by the Department of Health, such conditions account for 70% of total health and social care spending in England.

The Department of Health also estimates that the average cost of providing hospital and community health services for a person aged 85 years or more is around three times greater than for a person aged 65 to 74 years.

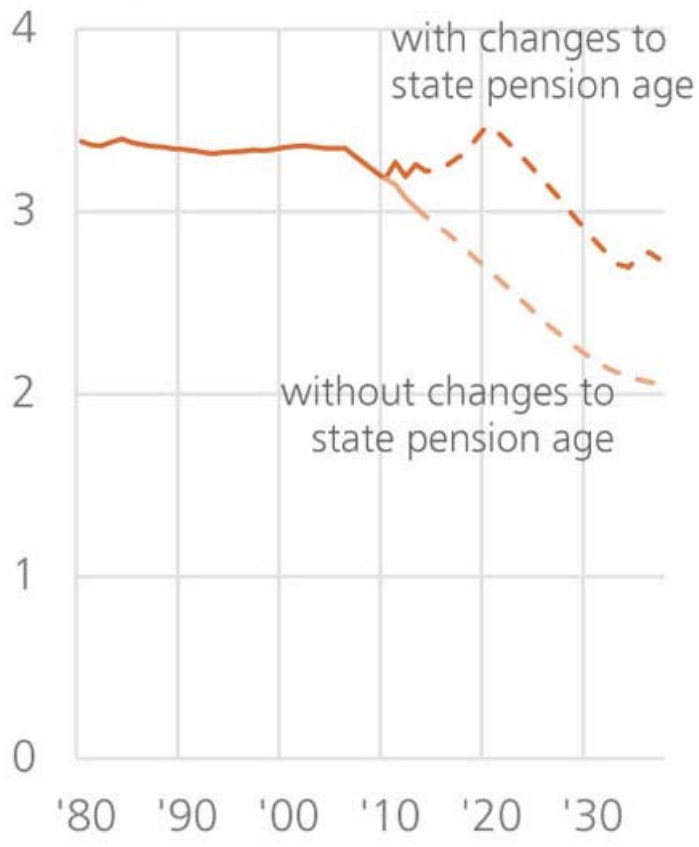
Less revenue

Further fiscal pressure is also likely to result from a decline in the working population relative to the number of pensioners (the 'dependency ratio'). A lower proportion of people in work means lower tax revenues and, in all likelihood, higher public expenditure.

Despite the recent increases in state pension age, it is expected that the pensioner population will continue to rise. In 2014 there were 3.2 people of working age for every person of pensionable age. This ratio is projected to fall to 2.7 by 2037.

Chart 2: Working-age people per pensioner

Even after planned increases to the state pension age, the number of working age people per pensioner is expected to fall. Number of working-age people per pensioner, 1980-2012 and projections to 2037



Challenges for future Governments

The Office for Budget Responsibility points out that without offsetting tax rises or spending cuts, the ageing population will cause a widening of budget deficits over time, eventually putting public sector debt on an unsustainable upward trajectory.

Dealing with the twofold pressures of increased demand and requirements for enhanced services is therefore likely to require both improvements in public sector productivity and increased taxation on the working population. The burden could also be mitigated through a number of other measures:

Reducing welfare payments

Public spending on the elderly could potentially be reduced, without impact on service quality, by a radical change to the means-testing approach to certain benefits and social care services.

If one were to take a view that age, on its own, is not a good indicator of need or ability to pay, it would seem sensible to review whether that should be the sole determinant of access to services and benefits.

However, the 'political economy' of an ageing population could hinder moves in this direction. In particular, older people are more likely to vote; and if they are growing in number, this could make changes that reduce welfare and care entitlements politically difficult.

Improving health

Much of the costs of old age have arisen because growth in total life expectancy has outpaced growth in healthy life expectancy (i.e. the number of years we can expect to live in good health). Policies that improve preventative healthcare, and help people to remain active and healthy in later life, could help increase the proportion of life spent in good health and reduce costs.

There are also large inequalities in healthy life expectancy, which for women ranges from 71 in Wokingham to 56 in Manchester, and for men ranges from 70 in Richmond upon Thames to 53 in Tower Hamlets.

Increasing employment.

A healthier old-age population would also allow greater numbers to remain in the labour market for longer, thereby mitigating the impact of an ageing population on the dependency ratio. This in turn could increase tax receipts and limit public expenditure growth.

The dependency ratio could also be reduced by encouraging immigration of working-age individuals, although this is unlikely to be seen as a politically attractive option.

Increased numbers of older people in work need not disadvantage the young. Indeed, previous attempts, both in the UK and abroad, to create jobs for young people by encouraging older people to withdraw from the labour market have failed.

The assumption that there is a "fixed supply" of jobs is not borne out by theory or experience: a larger workforce, with more people in work and earning, is likely to create its own demand.

Public Health England

Protecting and improving the nation's health

Disability and domestic abuse

Risk, impacts and response

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or be employed and more likely to live in poverty than non-disabled people.'[37] Disabled women experience dual discrimination, with less participation in the labour market than disabled men.[14] A study of disabled women highlights how labour market exclusion increases the risk of domestic abuse, with disabled women experiencing domestic abuse having lower incomes than disabled women not experiencing domestic abuse.[31]

Generally, a history of witnessing or experiencing violence in childhood significantly increases the risk of experiencing or perpetrating domestic abuse as an adult.[41,42] A study shows a significantly higher rate of psychological and sexual abuse in childhood and youth for disabled people, further increasing their risk of experiencing domestic abuse as an adult.[16]

Social and cultural views of gender and disability

The social and cultural views of disabled people may increase the risk for domestic abuse. Ableism presumes that able-bodied individuals are idealised and the norm.[43] Disabled people may be viewed by some as asexual, passive, undesirable, dependent, invisible and unvalued; many disabled people have less education about sexuality, sexual and reproductive health, are overprotected from exposure to issues around sexuality by family, schools or services and are denied the opportunity to experience their own sexuality.[31,44,45,46] Because of this, when domestic abuse does happen disabled people may be less likely to understand boundaries, recognise abuse, know their rights and how to report it.[13,23,31]

Isolation and dependence

An impairment raises the risk of domestic abuse for disabled people because it creates social isolation and the need for assistance with health and care needs, and potential increases situational vulnerabilities.

An impairment can create social isolation in two ways: via exclusion due to physical and environmental inaccessibility and via stigma and discriminiation in social situations. Disabled people are much more likely to be socially isolated and have smaller support networks.[46,47] Social isolation can be a risk factor for experiencing domestic abuse and a barrier to reporting. It has been suggested that perpetrators of abuse also target people who are socially isolated because they feel they can get away wih it.[48] Disabled people may not have anybody who might recognise the abuse, who they could confide in or who they could go to for support.[46,47,49]

Frequent interactions with institutional and medical settings and personal care assistants coming into their homes may increase disabled people's risk of experiencing domestic abuse.[8] While disabled women are most likely to be abused by an intimate partner,[39] they are also significantly more likely to experience abuse by personal care assistants, strangers, health care providers and family members than non-disabled women.[29,38,50] Reliance on care increases the situational vulnerability to other people's

controlling behaviour and can exacerbate difficulties in leaving an abusive situation. This reliance and dependence can create or exacerbate unequal power within a relationship. It has been suggested that perpetrators of abuse are more likely to target the most vulnerable to whom they have access.[48] However, it is important to acknowledge that it is the vulnerable situation, and not the impairment itself, that makes a person vulnerable.

Possibly due to this need for personal assistance, disabled people tend to experience domestic abuse differently. Disabled people may experience more extreme exercise of power, coercion and control, and more pervasive and wide-ranging abuse, than non-disabled people.[7] Disabled people report abuse through the form of intrusion and a lack of privacy.[7] Abuse can also happen when someone withholds, destroys or manipulates medical equipment, access to communication, medication, personal care, meals and transportation[50,51,52] Disabled people also report humiliation, belittling or ridicule related to a specific impairment.[7] Reliance for care from an abuser can be manipulated, with an abuser deliberately emphasising the woman's dependence as a way of asserting and maintaining control.

Particular vulnerable circumstances may decrease the ability of disabled people to defend themselves, or to recognise, report and escape abuse. Certain impairments, particularly physical ones, may increase the risk of abuse by a controlling partner or carer, or impact on a person's ability to physically defend themselves or escape an abuser. Other impairments, such as tramautic brain injuries, intellectual, learning or cognitive impairments, may limit a disabled person's ability to understand and recognize potential signs of danger and abuse. Also, people with sensory impairments may miss visual or auditory warning signs of abuse.[6,31,45]

"And for some disabled women there's a feeling that to put up with you, your partner must be a saint for putting up with them you know, so you kind of deserve it."

"People pity him because he is taking care of you and so noble. So people are reluctant to criticise this saint or to think he could be doing these terrible things."

"And it's not obvious abuse, it's not violence particularly, it's kind of sometimes quite manipulative and that...because you have to receive care you're quite passive and people can abuse that very easily. It's a very easy thing to abuse."

Source: Hague, G., Thiara, R. and McGowan, P. Making the Links: Disabled Women and Domestic Violence. London. Women's Aid, 2007.[7]