An Analysis of Travel and Transportation I:

Results from the Pilot Sample

Vera Institute of Justice

Easyride Research

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I. INTRODUCTION

Transportation: A Problem of the Urban Elderly

EASYRIDE was designed to test the hypothesis that a transportation system suited to the needs of elderly and disabled people would contribute to the maintenance or enhancement of their independence. Old people are increasingly unable to use public transportation because of their fear of crime and because they cannot overcome physical barriers such as high steps, stairways, great distances to bus or subway stops, nor can they cope with crowds, jolting vehicles, and the fear of falling on the street. Thus, the difficulties elderly people encounter in travel lead them to become increasingly housebound, and unable to get to those places which make life interesting and worthwhile and to other places where vital services are available--shops, doctors' offices and nutrition center, as well as government offices or banks. Contact with relatives, friends, social agencies, and religious organizations are vital resources in providing material and emotional support. Yet, if elderly people cannot visit friends and relatives, it is left up to the friends and relatives to keep in touch. Transportation then is the link between home and the world beyond.

Independence for most people necessarily implies the ability to participate in some activities outside of the home. The housebound must depend on others for many crucial activities; at minimum, for bringing to them such vital necessities as food and helping them get to their doctor. Most people need some social interaction; few can live with any degree of contentment and sanity if they have no contact with others. Such contact is much more likely to occur and to be maintained if some kind of transportation is available which is compatible with the disabilities and needs of its passengers.

Many social programs operate to make life for elderly people less difficult, to compensate as far as possible for their disabilities, and to give help where it is most needed. These kinds of services may conveniently be divided into three types. The most encompassing and the most costly are those that provide housing and domiciliary care, with or without medical care and supervision. While necessary for those older people who cannot take care of themselves or do not have a home environment in which they can get the help they need, this kind of care is clearly least desirable from the point of view of its social and psychological cost. Even in this situation, some elderly people feel better and maintain a better contact with the world

if they are given opportunities to leave the institution to visit family and friends and participate in religious and cultural events. Transportation may be necessary for them, but whether they will be given such a service depends in large part on the economic resources available to pay for transportation.

Social programs to maintain elderly people in their own homes--to improve their lives and to help them to avoid or postpone institutionalization--may provide them with services in or outside of their homes. Providing people in their home with visiting nurse services, homemaker services, or meals on wheels may be much less costly than institutionalization. In addition, [illegible] old people who are able to stay in their family surroundings generally have much more autonomy over their lives, however much they may be limited by illness, by immobility, and dependence on others. For people in this situation, transportation may be a great problem on those few occasions when they have to go somewhere. Thus, transportation which they can use, performs a vital service for people in this situation.

The majority of older persons want to get out of their homes for such reasons as visiting doctors and social agencies and going to senior centers where they meet other people and eat a lowcost meal. Like most other people, no matter what age,

elderly people need to do things which most of us do routinely. To the considerable degree that old people cannot take advantage of public services, they need special transportation. Our research will provide some specification for these claims, which motivated the creation of Easyride.

The Lower East Side has so often appeared in the literature of people seeking their American roots that it has an almost mythical aura. But it is a real place, a two square mile area of lower Manhattan Island where in the 19th and 20th centuries waves of immigrants settled. This was the womb of the Jewish colonies which later, pushed by intense overcrowding, spilled over into the Bronx and Brooklyn. Both social science and literature preserve vivid descriptions of the sweatshops, the streets alive with the cries of pushcart owners touting their wares, the kosher chicken stores, the Sunday afternoon bargain hunters crowding the streets, and the tiny neighborhood synagogues filled with the devout. But times have changed. The Lower East Side is now a deteriorated poverty area which has more than its share of elderly people who are poor and isolated. Many of these elderly, especially those of Jewish origins, are the remnants of immigrants from the period before 1950 when the

area was almost totally white. During the last decade, the Puerto Rican, Black and Chinese communities have grown enormously and now make up most of the younger generation and the "younger" elderly in the Lower East Side (Schwartz, p. 16).

Currently, the Lower East Side is served by a wide range of social programs which are provided by settlement houses founded at the turn of the century. At that time, they served primarily 1st and 2nd generation Jews; now they also serve other ethnic groups who have more recently moved into the community. These settlement houses must deal with a concentration of ills which distinguish the Lower East Side from other communities (Schwartz, p. 17). While in New York City, 30% of elderly over 65 live alone, in poverty areas this figure increases to 39%, and in the Lower East Side, according to the 1970 census, 45% live alone. The problems associated with living alone, especially during a time in life when physical and mental abilities are declining, are particularly widespread in the Lower East Side. These Lower East Side elderly people are not only living alone more than other population groups and more than the old people in other parts of the city, but they are also poorer. The percentage of old people on the Lower East Side whose incomes were below the poverty level was 7 times that for people over 65 in the rest of New York City at the time of the 1970 Census. The percent receiving supplementary security income (SSI) is 3 times greater

than the city-wide proportion. In addition, per-capita income was, according to the City Planning Committee, $2,849 in 1974 while elderly people in the rest of the city had an average per-capita income of $4,014.

In this situation, inexpensive transportation may be expected to play an important role in maintaining elderly people's contacts with family and friends, with cultural institutions and with health care facilities. The historical development of New York's transportation system and the Lower East Side's geographic location have left this area fairly isolated from the rest of Manhattan (Schwartz, p. 5). Connections to the dominant north-south subway lines are missing, thereby insuring that the buses are, besides walking, the dominant mode of transportation for most Lower East Side inhabitants. However, many elderly people's ability to walk is restricted and many, as will be discussed later, experience great difficulty with public transportation.

It is generally recognized that the lack of transportation is one vital link in a chain of events which leads to physical isolation from certain social contacts. In 1975, the Vera Institute picked the Lower East Side as an area in which to develop an innovative service for elderly and disabled individuals. Representatives of elderly and handicapped people repeatedly emphasized the need for door-to-door transportation. This need was substantiated by preliminary explorations which revealed

that a good deal of money was being spent on transportation, albeit in a fragmented way, and that an organization would be required to coordinate the service needs, arrange the financing, and develop an operation system which would meet the needs of elderly and handicapped people.

Vera Institute planners chose the Lower East Side for several reasons: the community had organized around the issue of transportation and recognized that the lack of transportation is often a barrier to services and a cause of social isolation; the Lower East Side has an ethnically mixed population, a fact which might permit assessment of how a demonstration service affects different racial and cultural groups; Lower East Side residents have low to middle range incomes, a fact which suggests that their use of taxis would not be high and that other forms of accessible transportation (e.g., private ambulettes and autos) would not be available; the elderly in this community make up about 16% of the population and, if generally recognized estimates that 5% of the total population is handicapped applied, the potential market for such a service in this community would be sizable.

Total population of Lower East Side	= 173,331
Elderly, 60+ (16%)	= 28,301
Handicapped (Estimated at 5%)	= 8,667

In April 1975, the Vera Institute and the Association of Lower East Side Settlements (ALESS) agreed to work together to

establish a door-to-door transportation service in the Lower East Side. The next year was devoted to developing applications for funds for vehicles and for operating costs, designing the operating system, arranging for insurance, locating garage and office space, obtaining necessary regulatory approvals, and selecting, hiring and training personnel. In June 1976, Easyride began pilot operations with three leased vehicles and a staff of six. In June 1977, Easyride expanded its staff and its operating hours, clarified its eligibility rules, and established a fare structure. Initially, a 15¢ fare was suggested, but not demanded. As of June 1, 1979, a 25¢ fare will be charged;* exceptions will be arranged for through social agencies.

Since May 1978, people 65 and over (previously, people 60 and over) and any person over 18 with a transportation handicap and eligible for Medicare can register with Easyride by telephone. After they have registered, clients are encouraged to call in at least 48 hours in advance to reserve a ride. Easyride schedulers negotiate trip times with passengers to maximize vehicle utilization and call up a day before their scheduled trips those passengers who are known to have difficulty remembering their appointment times. Passengers are encouraged to meet drivers at the entrance to their building to save time and to discourage overdependence. However, for those passengers who require such assistance, drivers will give door-to-door service. Easyride most fre-

*As of May 9, 1979, this fare policy is again suspended, pending various administrative decisions.

quently takes people to nutrition programs, to the hospital, to private doctors, to work, and to shopping. Two Easyride buses go to uptown doctors two afternoons a week. An Easyride shuttle service runs to the major hospital out-patient clinics in the area.

Easyride is being operated in order to test the interest of transportation handicapped persons in travelling, their ability to travel when most barriers are removed, and the adequacy of a system like Easyride to meet the transportation needs of these transportation handicapped people. The drivers and office staff have been specially trained to understand the problems which elderly and handicapped persons face, to handle safely people who use wheelchairs, crutches, canes, and walkers, to administer basic first aid, to drive defensively, to handle record-keeping and to follow operations procedures correctly, and to be alert to possible criminal activity on the street. Vehicles are specially designed with high headroom, low steps, grab rails, seat belts, air conditioning, and other passenger comfort and accesibility features. Vehicles are maintained by a staff of mechanics who work on a part-time basis under contract with Easyride. This arrangement was intended to minimize vehicle out-of-service time. Records are kept on trips and on registrants. These records also provide the basis for third-party and direct billing.

At present, the primary third-party payment source is Medicare which pays for health and nutrition trips taken by Medicare

beneficiaries. This reimbursement is made possible by a waiver, under Section 222 of the 1972 amendments to the Social Security Act, signed in June 1977 by HEW Secretary Joseph Califano. This waiver authorizes reimbursement in order that the impact of available accessible transportation on transportation handicapped persons and their service providers can be studied. This is the first report on these studies.

Easyride Research: Report on the Pilot Study

The major objective of Easyride Research is to analyze the effects of Easyride. To this end, this report will focus on the travel practices of a group of elderly people--many with some degree of disability--some of whom use Easyride and others who do not. Also discussed will be the obstacles to transportation which elderly and disabled people face, their interest in travelling by an alternative transportation system, and the effects of accessible transportation on health care utilization, on social interaction, and on morale. It must be noted, however, that this report is about a pilot study, data from which will help Easyride Research get acquainted with the matter under study and generate hypotheses for later confirmation by other studies.

The data which are discussed in this report are based on interviews which were conducted in the spring of 1977 with a sample of 188 people who were located through senior centers on the Lower East Side, and on interviews conducted with 140 of the

same people in the spring of 1978. In the selection of respondents for this pre-test, the choice of senior center clients in settlement houses was by no means arbitrary. The Easyride project grew out of a community concern, effectively expressed through local organizations in which the settlement houses played a central role. Thus, it was natural that the initial recruitment of clients of Easyride would take place through the agency of the settlement houses. And it was equally natural to seek respondents for an impact study in this group. At that time, the fact that clients of settlement houses might not be representative of the future clients of Easyride was recognized, but this group offered an opportunity to gather some baseline data before the service began operation. The sample of those 188 people for this pilot study was thus not randomly selected. They constitute a "convenience sample" obtained through the recommendations of several social workers who cited people who would be most in need of such a service as Easyride. This convenience sample is, of course, unreproducible: Even if social workers could pick people in a similar way elsewhere in the Lower East Side or in another part of town, it would be difficult to claim similarity since (1) the clientele is likely to be different, (2) the social workers are likely to be different, and (3) the criteria used by the social workers in the settlement houses were not spelled out.

Interviews of the first "wave"--in 1977--were made, by and large, in person at senior centers, or by telephone to the respon-

dent's home--social workers at the senior center having assisted in making contacts. Of 188 interviews completed, roughly three-fifths were personal interviews and two-fifths were by telephone.

The goal of this study was to interview people before they were regular Easyride users. And, indeed, only three of the respondents had used Easyride as individual riders, 60 had been on one or more group trips on Easyride organized by a senior center, and at least 122 had never taken any trip by Easyride. Yet, all but 45 had heard of the Easyride service. Thus, Easyride was at this time getting to be known. However, among those interviewed, no one had as yet become a regular customer of the service.

Our respondents, it must be remembered, do not constitute a representative sample of the elderly of the Lower East Side, nor even of the clients of the settlement house senior centers. These clients are old, but that is not only an artifact of the Easyride criteria for service. Whereas the 1970 Census reports 25% of Manhattan senior citizens were over 75 years of age, 44% of this first wave of the pilot study were over 75. In addition, 149 respondents were women and 47 were men, making a 3:1 ratio of women to men--whereas in Manhattan the ratio is 3:2 for people over 65. Roughly one-half of these respondents are Jewish, one-third Hispanic--two-thirds of whom do not speak English--and the remainder are in nearly equal numbers, Italian, Slavic, or Black. The disproportionate representation of Jews in the pilot sample

reflects both the disproportionate representation of Jews among the elderly on the Lower East Side and the long standing ties between the Jewish community and the settlement houses. There has been enough change on the Lower East Side since the 1970 Census that it is not quite clear what a representative sample of people, to say nothing of a representative sample of senior citizens, would be. Still, the relatively heavy representation of Hispanic respondents mirrors their presence in some neighborhoods.

Of the 188 respondents, 131 live alone, 41 live with a spouse and the remainder have some other arrangement with a relative, a friend, or a hired person. The number of people who live alone is surely one of the most important facts about this population. Transportation (or help in getting from one place to another) is probably even more important for these people.

These interviews have proved to be valuable as a pre-test for other studies which have been conducted of homebound and visually handicapped elderly people, of people who live in public housing for the elderly, and of Easyride Registrants. The original plan of the evaluation was a "before and after" design, and to this end 140 of those 188 respondents were re-interviewed in the spring of 1978. The design of subsequent samples reflected the conviction that interviewing respondents before they ever took a ride with Easyride was not so all-important, inasmuch as

the effects of Easyride will not appear overnight, but only after a considerable period of time.

In reading this report, it is important to bear in mind that it is a "Pilot Study" pursued more for generating hypotheses than for arriving at certain generalizable conclusions. Still, it is descriptive of this particular sample of people and their experiences with transportation in general and with Easyride in particular.

II. TRAVEL AND TRANSPORTATION

A. The Need for Transportation in the Context of Other Needs

The First Year Final Report on the project to Monitor Title XX Senior Services in New York State states that transportation is one of the services for which elderly people express the most need (State Communities Aid Association, 1976). The Technical Report of the National Survey of Transportation Handicapped People (UMTA: 1978, p. 26, 35) estimates that there are 7,440,000 transportation handicapped people in the urban population 5 years of age and older, of whom 3,479,100 or 47% are 65 years old or older. This report, while paying little special attention to this 47% minority, correctly states that it is not age alone, but a combination of age and physical problems that creates difficulty in the use of public transportation (Ibid. p. 35). This survey also affirms that elderly and handicapped people want to travel and do, even though they have difficulty using public transportation. The multiple barriers they face when attempting to use public transportation relate to the entire process of using the system and not only to the mechanical aspects of vehicles and access to them (Ibid., p. 139).

In the survey data collected in connection with Easyride, the desire to travel more, difficulties encountered with public transportation, and deprivations suffered because of the absence of appropriate transportation stand out very clearly. Even though

handicapped and elderly people take fewer trips in general, they do travel and they want to travel more. Where do they go? Various studies report that the elderly and handicapped travel for many reasons: They travel to their doctors or clinics, to do their shopping, to senior centers and lunch programs, to visit family and friends, to go to places of recreation, and to worship at their churches or synagogues (Ibid., pg. 82). As a step toward helping the elderly and handicapped overcome their transportation problems, various studies have been done (UMTA, 1978; Falcocchio, et al, 1976) and various demonstration projects have been initiated. These studies tend to focus on the types of transportation problems faced by the elderly and handicapped, on the physical transportation improvements that might meet their needs, and on cost-effectiveness.

Many of the demonstration programs are private systems (like Handi-Cab in Milwaukee and Handi-Car in Tucson) which are often expensive; taxi-systems with subsidized rates (Dial-A-Ride in the Northwest Bronx); or modifications of public transit. Some of these modifications involve reduced fares (N.Y. City --Nahemow, 1978), others involve modifying public transit by using special design features (Metro, Washington D.C./Bart, San Francisco--(Bell, 1975, p. 6)), while many other programs are based on special purpose transit services. The goal of most of these special purpose programs is to increase the mobil-

ity of the elderly and handicapped and to develop an efficient, cost-effective program to serve them (Fitzgerald, 1977, Cooper 1978.)

Unlike Easyride, most of these programs are not, except incidentally, oriented to the effects that accessible and readily available transportation may reasonably be thought to have on various aspects of the lives of elderly and handicapped people--their health and health care--their utilization of health care facilities, their morale, sense of independence, feelings of social isolation, and the need to protect and take care of them in institutions. In addition, transportation programs typically have not been systematically evaluated (Kahana and Coe, 1975). However, these programs do point out problems which alternate transportation services must deal with and, by their failures and successes, suggest directions other transportation services might take.

Studies of both the San Diego and Atlanta Wheelchair Accessible bus systems found that ridership was low due to the fact that elderly and handicapped people could not get to the buses because they could not overcome other barriers like curbs, bus intersections, and hilly terrains (Casey, 1977/Paul and Casey, 1978). The Call-A-Bus Demonstration Project in Syracuse, New York, an advance reservation and subscription service for elderly and handicapped which ran from October 1973 to October 1975 and

which has been continued by CNY Centro, found that its ridership dropped by more than 50% during the fall and winter because elderly and handicapped people were reluctant to go out in bad weather. The Handyride project in Denver began in April, 1977, and is, according to the available literature, still continuing as a door-to-door subsidized service along prescribed routes. This project's stated priorities are to serve handicapped over elderly, handicapped in wheelchairs over other handicapped, and to give priority to work and school trips before other trips. Taking people to work, it is claimed, helps them not to lead segregated lives as a direct result of their handicap. This project's lowest priority is to transport those whose disabilities do not significantly interfere with their use of public transportation. Included in this category are the mentally retarded and those with epilepsy (Handyride Evaluation 2/9076, preliminary study). Unlike these transportation services, Dial-A-Ride in the Bronx, N.Y. was a door-to-door demand activated low-cost service which ran from June 1972 to August 1973 (Cantor, 1975). The majority of elderly and handicapped riders used this service to reach vital medical services. It was expected that this inexpensive transportation service would allow older people to make better use of services available in the community and would help them increase their social contacts. It was hypothesized that, as a result, older people's independence,

morale, and sense of well-being would be strengthened. However, the report on this project claimed that Dial-A-Ride had little effect on clients' attitudes and had no effect on elderly people's mobility patterns because most had already established patterns of travel to satisfy their basic needs. The TOTE project in St. Petersburg, Florida was started in September, 1973 as a maxi-van service to transport elderly people to any destination of their choice (Florida Department of Transportation, 1974). This project found that a maxi-van provided sufficient flexibility and operating efficiency for door-to-door service requirements.

All of these projects assert that transportation is a necessary service. Many studies of the elderly have also supported this assertion directly and indirectly. In "Community Care for the Elderly: An Alternative to Institutionalization", William G. Bell claims that medical self-neglect is principally caused by the inability to get to medical resources and is not always due to lack of medical resources. He also estimates that 15 to 30% of the aged recently admitted to nursing homes could have avoided or postponed admission if community care had been available and adequate. Bell discusses a program which aims at helping prevent functionally impaired people from being institutionalized, in which transportation services for the elderly and handicapped are an important element (Bell, 1973). Laurence E. Blonsky, in "An Innovative Service for the Elderly", discusses OACAP (Older

Adult Community Action Program), a program in St. Louis which helped to meet the three priorities which emerged from interviews with the elderly: transportation, adequate housing, and medical services (Blonsky, 1973). Jane Barney in "The Perogative of Choice in Long Term Care" also concurs with these other studies' assessments of the importance of transportation. In her study of the Well-Being Clinic of Detroit (Barney, 1977), she discusses transportation as an important facilitating service which enables clients to obtain what they need. Eva Kahana (Kahana and Coe, 1975) suggests that transportation may help to compensate for the lack of a strong social support system. She reports that the lack of transportation is the lack of the one service responsible for the under-utilization of all other services, because most places to which the elderly need to go are beyond walking distance (Carp, 1971). It might be suggested that lack of transportation is similarly responsible for the over-utilization of long term care in institutions. Without the social supports which were in the past provided by the family, elderly people are more likely to be institutionalized than are those elderly people who are still living with their families in the communities (Maddox, 1975/Brody, et al, 1978/Treas, 1977). Indeed, Peter Townsend writes that fewer older people with relatives enter institutions while those who live with relatives are able, prior to admission, to remain in their community to a more advanced level of disability (Townsend, 1957). There is thus much support for

Barney's conclusion: "individuals lacking strong social or financial supports are likely to be prematurely admitted to a nursing home--thus, a socioeconomic need is met with a health care solution" (Barney, 1977).

Other studies suggest that the community must help the elderly to maintain independent living by giving them the appropriate services which, as has been noted, include as a key factor, adequate, accessible transportation. For example, in suitably organized hospitals, one might be able to remain for the day only and get all the care that one needs. In his "The Case for Geriatric Day Hospitals", Hattack maintains that day hospitals, which at present are more common in Great Britain than in the United States, allow for the earlier and more successful discharge of inpatients to the community and the maintenance of the frail and the elderly in their communities (Hattack, 1975). He also emphasizes the importance of transportation as contributing that facilitating factor which makes a day care program possible just as it would make possible a community based continuing care program (Robertson, et al, 1977). However, transportation not only enables elderly people to utilize the health care facilities they need, but also contributes to many aspects of the quality of life:

> Whether old age is a period of retirement leisure, fruitful in personal fulfillment and social contribution, or a sterile stretch of "free time" depends, in large part, upon the

> individual's access to services and goods he needs, and to activities and people he enjoys. In other words, the quality of later life depends upon the quality of housing and environment, made dynamic by transportation. (Cutler, 1975)

Cutler also suggests that declining life satisfaction will be more prevalent among persons without means of personal transportation because of impediments to social interaction. Isolation is an important factor in psychological depression which, as many studies have shown, results ultimately in a disproportionate claim on services and in institutionalization (Townsend 1957/Palmore, 1971/Maddox, 1975/Brody, et al, 1978, Treas, 1977/ Larson, 1978).

It is, then, against this background of information on the difficulties older and disabled people experience in getting to the places they want to go that data were analyzed from the first and second waves of the pilot study.

IIb. Frequencies, Destinations and Modes of Travel

How frequently and by what means do the elderly people in the pilot sample travel to and from various destinations? What obstacles prevent them from travelling? Are barriers to travelling inherent in the public transportation systems or in these old people's disabilities, their state of health, need for help, or fears for their safety? This chapter will describe the travel patterns and transportation habits of the 188 respondents in the first wave of the pilot study and the 140 respondents who were re-interviewed a year later.

Where we are attempting a comparison between 1977 and 1978 travel patterns, data from both waves are used. However, when the purpose is essentially descriptive and non-comparative, data from wave II interviews are generally used. The data from this wave are more extensive and the rate of response to particular questions is higher than in wave I. It will be explicitly stated when reference is being made to the 188 respondents of the first wave. Data will also be presented about respondents' interest in travelling and in alternative transportation which enables them to get to places to which they cannot easily go.

Respondents in the pilot study were asked how many trips they made out of the house during the week preceding the interview. From the number of trips, it can be inferred that 39% of the respondents stayed at home for at least one out of seven

days (i.e., made fewer than seven trips), and 29% stayed in the house at least two days (made fewer than six trips) during the week about which they were questioned. Thus, a large number of people stay in their apartments at least one day each week.

Where did respondents go? During the week before the interview, 90 of the 140 respondents made at least one trip to their social centers where lunch programs are available; 70 made at least one trip to shop for groceries; 49 made at least one trip to church or synagogue; 36 made trips to a hospital or a clinic; 6 went to their dentist; 58 made at least one trip to the park or to the benches outside their apartments; and 23 went to the bank. Because of the potential importance of transportation for the maintenance of social contacts, it is noteworthy that 28 managed to visit a family member and 25 a friend.

The data on modes of travel indicate that the population relies heavily on walking to their destinations. For example, 80% of those who went to the social center and answered questions about how they got there indicated that they had walked. The comparable statistic for those who went grocery shopping was 94%. Moreover, other statistics on distances travelled indicate that 75% of those travelling to social centers go a distance of six blocks or less, while the comparable statistic for grocery shopping was 92%. Thus, this population relies heavily on walking relatively short distances to these two key destinations. If these distances suggest limits which an elderly population

can manage by foot, one might infer that there are many elderly in the Lower East Side (and throughout the city, for that matter) who do not visit social centers and local shopping centers because these centers are not sufficiently near their homes.

Where respondents go, what percentage of respondents go to each destination, and the frequency of their visits were investigated through their answers to questions about not only what trips they made out of the house during the previous week but also how often they generally go to these various destinations. Table II-1 contains data which derive from these questions.

TABLE II-1: DESTINATIONS AND FREQUENCIES

Pilot Study: Respondents in Both Waves, N = 140

DESTINATION	(1) % who went there last week		(2) % Who Generally Go: 1/week or more often		1-3 times/ month		Less often*	
	1977 (N=140)	1978 (N=140)	1977	1978	1977	1978	1977	1978
Hospital/Clinic	26%	26%	4%	6%	44%	44%	51%	50%
Grocery Shopping	68	50	64	56	4	7	32	38
Religious Places	35	35	28	28	2	8	70	64
Social Center/ Lunch Program	77	50	72	69	4	7	24	24
Family	14	20	7	12	9	16	84	71
Friends	6	18	2	25	4	9	94	66
Recreation+	6	11	6	4	6	9	88	87
Park/Bench	18	41	21	44	6	2	73	54

* "Less often" includes respondents who go several times a year, once a year, rarely or never, and missing information.

+Movie, theater, museum, library, sports event, restaurant.

Some parts of this table provide evidence that supports data in other parts. The numbers (Column 2) who said that they go "in general" do parallel the numbers who claim that they went to the same destinations the preceding week. For example, the 1978 general travel frequency and the trips made "last week" to the hospital/clinic can be compared by adding to the 6% who generally go there at least once a week, to half of the 44% who go there 1-3 times a month. (It can be assumed that half of the respondents would be going to the hospital in any one week.) The sum of this procedure is 28% who might go to the hospital or clinic in any one week. This 28% can be compared to the 26% who reported going the week previous to the interview. In a similar manner, reported general frequency and reported number of trips last week can be shown to correspond with regard to a number of destinations.

Respondents in both waves travel most frequently to the grocery store and to a social center and next most frequently to a church/synagogue and a hospital/clinic. In part, the fact that more respondents reported going to the social center than to any other destination is a consequence of the sampling method since all respondents were recruited in 1977 at a social center or through a social worker at one of these centers. Despite this sampling bias, respondents' high frequency of travel to social centers does suggest the importance of these centers as places to get a hot meal and as a social and recreational

gathering place. Respondents' high frequency of travel to grocery stores results from their not being able to carry heavy loads any appreciable distance and thus, having to make additional trips. Respondents travel more frequently to religious places and to medical facilities than they do to visit their friends and family or to go to recreational facilities and to the park/bench. This finding reflects both position in a hierarchy in the need to travel as well as the accessibility of these various destinations. Indeed, at the time of the second interview, the higher number of reported trips in 1978 than in 1977 to these destinations may be explained by the warmer weather which makes them more easily accessible.

In response to questions about how respondents travelled to their destinations, it was found that walking or taking the bus are the most common modes of transportation (Table II-2). We have previously mentioned that the Lower East Side transportation system makes walking and riding the bus the usual modes of travel for most Lower East Side residents. How much trouble these modes of travel are for respondents in this study will be discussed later. Modes of transportation, other than walking or taking a bus, play a significant role only when respondents visit friends, family or a private doctor.

Table II-2 presents the percentages of respondents who use each mode among those who go to any particular destination. Another way of describing the same data, differently arranged, is to ask what percentage of respondents ever use each mode for any destination whatsoever.

TABLE II-2: Usual Mode Used to Destination, 1977

Pilot Study, Wave I, N = 188

MODE OF TRANS.	HOSP.-CLINIC	PRIV. DOCTOR	DENTIST	GOVERN. OFFICE	SOCIAL CEN. LUNCH PROG.	VISIT FAMILY	VISIT FRIENDS	RECREATION	PARK	RELIG. CNTRS.	SHOPPING
Foot	41%	36%	54%	13%	92%	12%	55%	36%	94%	77%	97%
Bus	44	29	27	77	6	22	9	33	4	6	2
Car	5	7	--	--	1	36	--	--	--	8	1
Taxi	3	11	--	10	--	4	--	3	--	1	--
Ambu.	8	--	4	--	--	--	4	9	--	--	--
Subway	--	18	15	--	1	26	32	18	--	7	--
TOTAL:	100% (150)	100% (45)	100% (26)	100% (30)	100% (142)	100% (73)	100% (22)	100% (33)	100% (49)	100% (85)	100% (122)

In 1977, before the actual operation of Easyride, 90% of the respondents walked to at least one destination, 23% went to at least one destination by bus, 11% by car, 8% by subway, 5% by ambulette or Easyride, and 3% by cab. The fact that 90% of respondents walk can mean either that they are healthy enough to do so, even though it may also imply that they must restrict themselves to relatively small areas, or that public transportation is so difficult, expensive or inconvenient for them that they do not use it very much.

How far did these people go during the week? 55% travelled 6 blocks or less. Yet distances greater than 6 blocks do not

seem to daunt almost half of our respondents, the majority of whom we know make many trips on foot. Are they therefore sufficiently healthy and able to walk unassisted that they can get about easily on foot as well as by public transportation? As indicated later in this section, their responses to questions about obstacles to travel suggest, rather, that they have great difficulties using public transportation. Respondents thus are forced to walk, thereby restricting their travels to the distances they can manage on foot.

II TRAVEL AND TRANSPORTATION

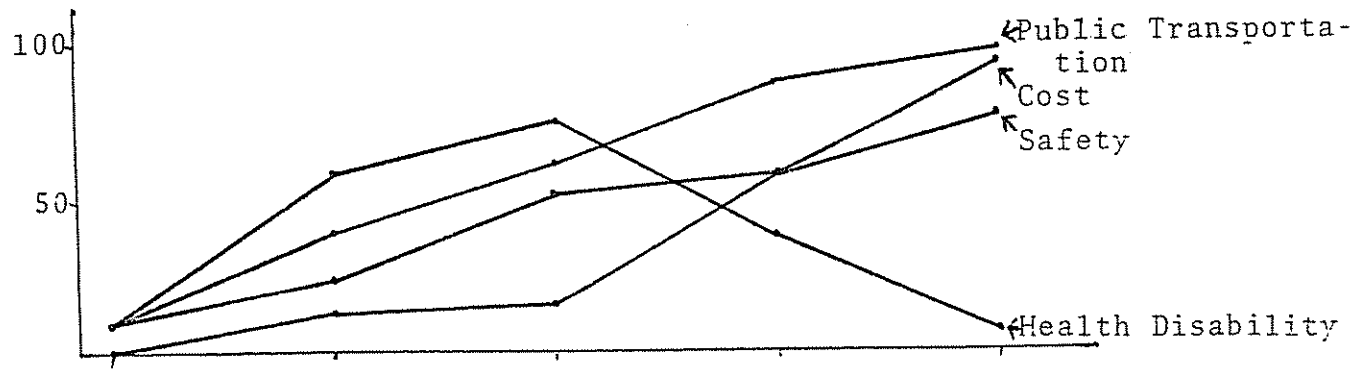
c. Obstacles to Traveling

Elderly people are prevented from travelling as much as they would like because of their difficulties with using and affording public transportation, their physical disabilities, their health, and their fear for their safety in public places. Data will be presented which indicates that respondents in the first wave of the pilot study experience these difficulties. First however, it is appropiate to cite some evidence that these people indeed want to travel more than they do. In response to the question: "Is there any place else where you'd like to be able to go that you don't go these days?" , most people mentioned one or two places (27% one, 29%two), others mentioned three or four (23%), and one out of seven (14%) mentioned more than 4 places. Only 6% (11 out of 188) could not mention one such place. Perhaps this question tapped or even stimulated respondents' fantasy. Various correlates to their claims to want to go to more places can be investigated on the assumption that fantasy makes only limited requirements of logical consistency. Thus, in order to investigate their responses, those respondents who mentioned some place where they would like to go but do not, were asked "Why is it you don't go there?" The most common response involved "difficulties with public transportation". The more destinations respondents mentioned being desirable but unreachable, the more likely they cited difficul-

ties with public transportation. A similar relation to the number of places mentioned is found when respondents cited fear for their safety as the reason for their not going somewhere. We may think of the number of additional places elderly people want to go but don't as a rough measure of their dissatisfaction with their mobility. Thus, for example, the higher their mobility dissatisfaction, the more likely they are to mention difficulties with public transportation as a cause of their inability to get to the places they want to go: At the low end of the scale (only one additional place mentioned) 39% mentioned public transportation; at the high end (5 places or more) 96% did so. Safety is mentioned by 24% at the low end of the scale, by 78% at the high end. The difference is yet greater when cost is cited as an obstacle: it is mentioned by 12% at the low end of the scale, and by 96% at the high end. However, as seen in Chart II-I, the health disability curve is considerably more complicated.

CHART II-1

Percent Citing Different Reasons For Not Going to Some Desired Place by the Number of Such Places They Mentioned



The highest percentage of respondents mentioning health or disability as an obstacle occurs among those who specified two destinations to which they want to go but don't (73%). 59% who mention health or disability as an obstacle want to go to one additional place, and the percent of respondents is very small for those wanting to go to more than two additional places. It also appears that if respondents mention 3 or more places to which they want to go, they are unlikely to cite health or disability as a reason for their not going. This response makes sense in that health and disability put limits on people's ambition to travel. This argument is supported by the observation that those respondents who mention only one or two other places to which they would like to go are more likely to mention health or disability as reasons for their not goin than they do other reasons.

The marginal totals indicate the percentages of respondents who cite particular obstacles to travelling to desired locations. The columns show the distribution of cited obstacles among those who have, at some time, desired to go to a particular location, but were unable to do so. So for example, 66% of those who were frustrated in their desire to go to a medical location cited problems with public transportation as a general obstacle to their travel desires.

TABLE II-2

Travel Obstacles Cited by Those Unable to Reach a Desired Destination, by Specific Destination-Pilot Study, Wave I, N = 188

Reasons for not going out / Destination Mentioned:	Medical	Social	Recre-ation	Ceme-tery	Reli-gious	Shop ping	Work	Total
Public Trans-portation:	66%	92%	60%	89%	95%	86%	77%	62%
Safety:	57	71	47	61	69	65	57	50
Cost:	49	67	24	59	77	56	60	33
Health/ Disa-bility:	46	21	66	24	23	35	30	48
TOTAL:	(97)	(48)	(90)	(54)	(39)	(80)	(47)	(188)

It seems reasonable from the preceding data to pursue the idea that respondents in this study were prevented from travelling as much as they would like to and where they would like to go because of their difficulties with using and affording public transportation, fear for their safety, physical disabilities, and their health. Table II-2 clarifies what prevents these elderly respondents from going where they want: 62% (118 out of 188 respondents) claim they have difficulties with public transportation, 48% mention disabilities or health problems, 50% cite fear for safety, and 33% mentioned cost. In addition, 11% mention that they need assistance in order to travel.

Elderly people have many reasons for avoiding public transportation or using it as little as possible: Both because of their difficulty with walking and their fear of being mugged,

they often consider bus and subway stops to be inaccessible territory. In addition, people who want to use the subway must be physically able to get to their trains, and, even if they succeed in doing so, believe that risk being assaulted, robbed, or in other ways molested in the station. If they surmount these obstacles or decide to ignore them, they must be able to deal with still other difficulties public transportation presents to them. For example, many must have a seat because standing in a crowded subway is too great a physcal exertion for them. Even more than younger transportation users, elderly people may have difficulties understanding announcements and seeing signs telling them, for example, where they are. These problems are further aggravated by declining hearing and eyesight and, in addition, by the impatience often encountered when one asks others for directions.

It must also be taken into account that these people live in deteriorated neighborhoods and are isolated geographically, prone to attacks by muggers, criminals, youth gangs, and others. 84% of the respondents reported being worried about getting mugged and 66% about falling down in the street. Yet, even if their housing is relatively protected, as may be the case with public housing for the elderly, the area immediately surrounding these buildings presents almost insuperable barriers because they are located in deteriorating neighborhoods,

surrounded by abandoned buildings and far from public transportation and from desired destinations. All of these aspects of home and environment keep the elderly isolated from the world beyond their homes. Because of this situation, accessible transportation is a crucial factor in their lives. In fact, only 15 of the 183 respondents (8%) who answered this question say that they definitely get to enough places to give their lives some variety or change; 79 (43%) say they do so "to some extent"; and 90 (49%) say that they do not. In addition, almost half (45%) of the respondents reported having a friend or relative living somewhere in the city whom they would have liked to visit in the past year but did not because it was too hard to get there. More than half (57%) also said that there are times when they do not get to their doctor or to their clinic because it is hard for them to get there. 86% of the respondents say that they look forward to going out of the house in nice weather, that it would be a pleasure for them. Thus again, motivation to go out and to go out more is not lacking in most of the respondents in the pilot study.

As has been indicated, public transportation is one of the major barriers cited by elderly and disabled people which prevents them from going out as frequently as they would like to and where they would like to go. It must be emphasized that complaints about public transportation are not restricted to the

Lower East Side of Manhattan or to older people. Louis Harris and Associates (Harris, 1978) report that all age groups complain about public transportation. Only 32% of the respondents in his study were satisfied with the bus and subway systems while 64% indicated dissatisfaction. In addition, 42% cited fear of subway crime, 50% complained about the dirty conditions of equipment and terrible smells, and 28% did not like the overcrowding. Harris also found that 27% of respondents over 50 years of age use local buses compared to 13% who are between the ages of 18 and 29. According to this survey, the use of subways decreases with age: 86% of young people, compared with 53% of people 50 years and over, use subways. Data from the pilot study give a stark picture of these elderly respondents' problems with public transportation. (Table II-5)

TABLE II-3

Some Obstacles to the Use of Transportation: What Old People Find Difficult or Impossible
Pilot Study, Wave I, 1977, N=188

	Percent of People Who Say It Is Impossible or Difficult
Travelling during rush hour:	96%
Taking trips with trains:	94%
Using a subway station with no escalator:	94%
Using a subway station with elevator:	94%
Using a subway station with escalator:	91%
Getting in and out of bus seat:	93%
Standing in moving vehicle:	90%

(Table II-3 continued)

	Percent Of People Who Say It Is Impossible or Difficult
Climbing on bus:	86%
Standing and waiting for bus:	78%
Walking to nearest bus stop:	70%
Reading signs on trains and buses:	64%
Hearing announcements on trains:	57%

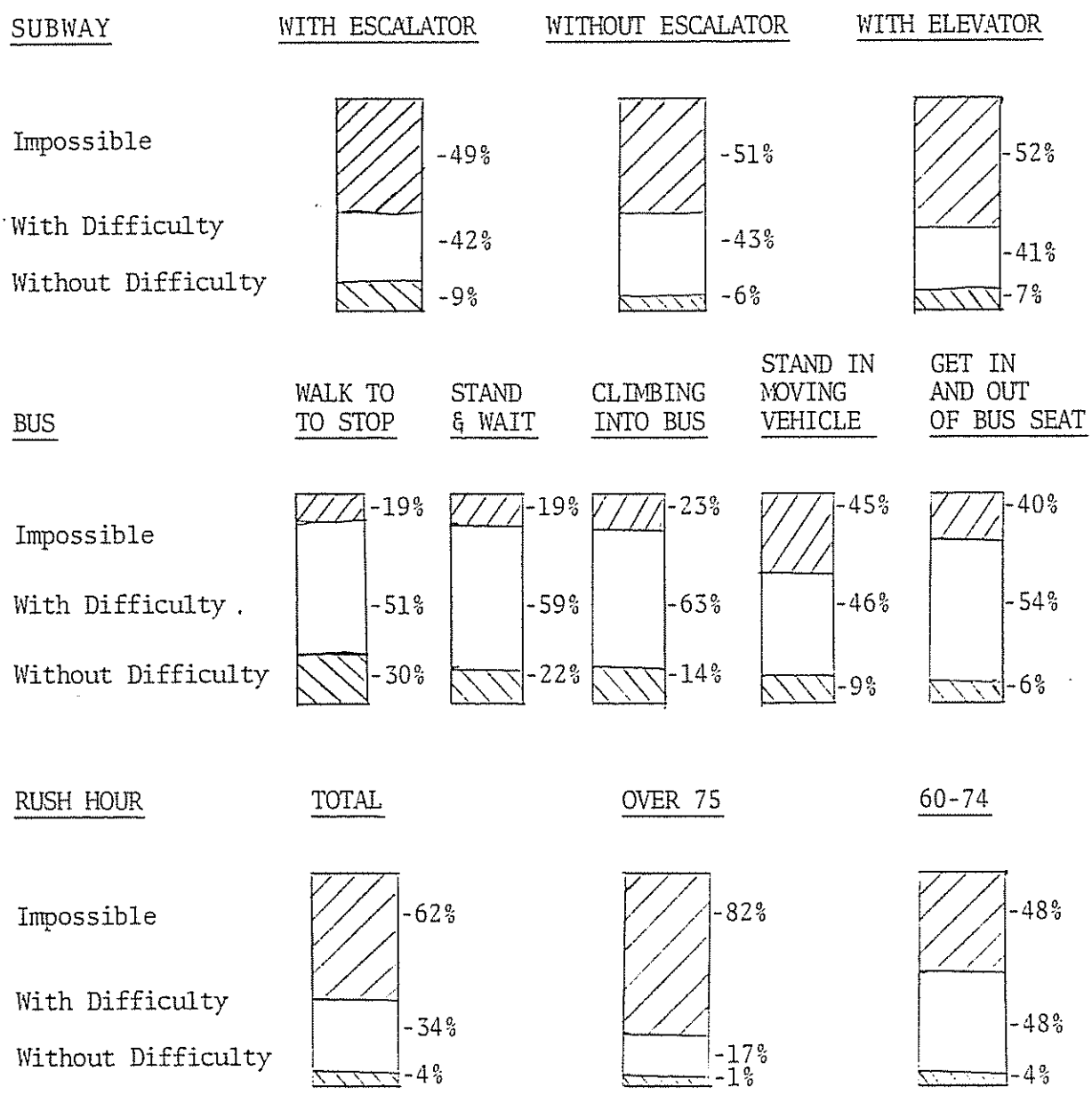
It is clear from their comments that the respondents cannot cope with the public transportation system said to be "available" to them. This perhaps explains why so many of them walk so much of the time and restrict their travel to the distances they can manage on foot. For the vast majority, it is either physically impossible or at least difficult for them to take the subway using stations with and without escalators or with elevators. In each case, more than half said it was impossible and less than 10% said they could do it without difficulty. The respondents were asked about their ability to use the bus to get where they wanted to go. It was especially of interest whether they could walk to the nearest bus stop. Can it be assumed that because three out of ten say they do it without difficulty, the claim is exaggerated that this activity is so difficult for them? Indeed, only two out of ten say it is impossible, but the remaining 50% say that it is difficult for them. When they were then asked how difficult it would be for them to stand and wait for the bus, similar figures materialized: 19% say it is

impossible, 22% say they can do it without difficulty, and 59% say it is difficult for them to stand and wait for the bus. Do these people have difficulty climbing on the bus? Only 14%, approximately 1 out of 7, say they can do it without difficulty, while 23% say it is impossible for them, and the majority (63%) say that it would be difficult for them. People of all ages face the problem on public busses of maneuvering into or out of a seat after the bus has started. Only 6% of the elderly respondents say they can do it without difficulty, and 40% say it is impossible. Of course, the alternative to getting a seat is to stand--and getting a seat is not a realistic expectation in our culture since there seems very little expectation of anyone to surrender their seats to anyone else. Less than 10% of the respondents say that they can stand on a moving bus without difficulty, while less than half say that they would find it impossible to stand, and the rest say it would be difficult for them.

The numbers and percents so far presented are proportions of all of the respondents who comment on their difficulty with these activities. When respondents are subdivided by age, no great change appears except that, without exception, everything is much more difficult for people over 75. This is especially true in regard to their ability to travel during rush hour: 62% of all the respondents say that it is impossible, 82% over 75 years old find it impossible, and just under 48% of the respon-

dents between 60 and 74 years old say that it is impossible. Even in this group, only four out of ninety say that they can travel during rush hour without difficulty; in the older group, not one respondent said he can travel without difficulty during rush hour. All of the preceding data is presented in Chart II-2.

CHART II-2



It is evident from the preceding discussion that the difficulties elderly people have with public transportation are consequences of their age only to the degree that their physical disabilities put them at a disadvantage. After all, age has no logical relationship to difficulty with public transportation: It is physical disability that should make the difference. To find out about physical disability, a mobility scale which makes no reference to transportation was used. Respondents were asked whether they could go outdoors without difficulty by themselves, whether they have some difficulty, whether they can do it only with help, or whether they can not do it at all. Similarly, they were asked whether they could walk up and down stairs and get about their house or room. These are the three mobility items in the Shanas-Wilker Scale. The relationship between their responses to these questions and their responses to the questions about difficulties with public transportation are very clearcut. Those respondents who experience greater disability, as measured by this scale, have greater difficulty with each of the different aspects of public transportation that were inquired about. Indeed, these relationships are so structured that in many of the cross-tabulations all cells on one side of the diagonal are completely empty. The degree of disability puts an absolute limit on what aspects of public transportation can be coped with. In the light of the logical structure of

their responses, it does not seem likely that these respondents are merely chronic complainers.

Table II-5 illustrates the relationship between disability variables and transportation variables. It relates "difficulty walking up and down stairs" and a transportation variable taken almost at random, "Are you able to walk to the nearest bus stop?"

TABLE II-5

Difficulty Walking Up and Down Stairs
By Ability to Walk to Bus Stop
Wave 1, N = 188 - 12 = 176

	ABILITY TO WALK TO BUS STOP			
DIFFICULTY WITH STAIRS	Impossible	Difficulty	Without Difficulty	Row Total
Can't do it at all	8 66.7	3 25.0	1 8.3	(12) 100
Needs Help	13 56.5	9 39.1	1 4.3	(23) 100
Some Difficulty	13 11.5	70 61.9	30 26.5	(113) 100
Without Difficulty	0 0.0	7 25.0	21 75.0	(28) 100
COLUMN TOTAL:	(34) 19.3	(89) 50.6	(53) 30.1	(176) 100

Two-thirds of the respondents who claim that they cannot walk up and down stairs at all cannot walk to the nearest bus stop. Only one respondent of the twelve says that he can do this without difficulty. Looking down the first column, one sees the percentage of respondents who say that it is impossible

for them to walk to the nearest bus stop decreasing as the ability to walk up and down stairs increases. Indeed, of the small number who say that they can walk up and down stairs without difficulty, none says that it is impossible for him to walk to the nearest bus stop and 75% say that they can do it without difficulty. Since these two variables ask quite different questions, this strong correlation pattern suggests that respondents were not merely expressing general dissatisfaction with transportation but were reporting their physical difficulties. An even more convincing correlation pattern is evident in Table II-6 in which respondents' ability to go out of doors is related to another transportation varible (also chosen arbitrarily): difficulty in getting in and out of a bus seat.

TABLE II-6

Ability To Go Out By Difficulty
Getting In And Out Of Bus Seat
Wave 1, N = 188 - 14 = 174
Raw Figures

	DIFFICULTY GETTING IN AND OUT OF BUS SEAT			
ABILITY TO GO OUT	Impossible	Difficulty	Without Difficulty	Row Total
Can't do it at all	2	0	0	2
Needs help	18	1	0	19
Some difficulty	39	28	0	67
Without difficulty	9	65	12	86
COLUMN TOTAL:	68	94	12	174

In this table, the only two people who say they cannot go out at all also claim that it is impossible for them to get in and out of a bus seat. Among those respondents who say that they need help going out, only one respondent says he can get in and out of a bus seat with difficulty while the other respondents say that it is impossible for them to do so. Indeed, those respondents who have some difficulty going out still reject unanimously the idea that they could get in and out of a bus seat without difficulty, although a much larger fraction say that they can do it with difficulty. Finally, among those respondents who say that they can go out without difficulty, some do say that they can get in and out of a bus seat without difficulty. The pattern of numbers in the table clearly indicates that physical disability, not age alone or a tendency to complain, limits a person's reported ability to use the bus.

III. EASYRIDE USE

Before data are presented on how Easyride has been used by the respondents in the pilot study, it will be useful to recall the nature of our respondent group which has, of course, been discussed in some detail in an earlier section. The initial sample was recruited through senior centers and consisted of 188 respondents. Whether or not they used Easyride is here reported for only the 140 who were re-interviewed. (It is possible to find out about the use of Easyride by people who were not re-interviewed by studying operations data. However, their use of Easyride will not be reported on here.) As is inevitable in a panel study (in which the same respondents are interviewd and then re-interviewed), the numbers and types of respondents who refuse to participate at some point or fail to answer particular questions are larger than in other kinds of studies. Thus, besides the "panel loss", the loss of those respondents who for whatever reason drop out between the first and second interviews, a respondent's refusal to answer a particular question may occur in the first interview, or in the second interview, or both. Thus, as will be seen in the next section, besides losing 48 cases to "panel mortality", only 119 respondents gave useable responses both to the first interview question on whether they were likely to use Easyride and to the second interview question on how much they actually used the service.

A. Expressed Interest and Actual Use

We have seen that the elderly people in our sample express a great deal of dissatisfaction with public transportation, that they claim to travel less than they want to, and that they say they would use a door-to-door minibus service if it were available. "Latent demand" is usually studied by asking people whether they would be interested in the goods or service for which a prognosis of actual demand is to be made. We can test whether respondents' expressed intentions to use an alternative transportation system had any relationship to their actions the following year.

Table III-1 shows the relationship between respondents' saying that they would use a "free or inexpensive door-to-door transport in a small bus" if it were available, and their having actually used Easyride a year later. Of those who said they would use it once a month or more, 82% did use the service, more than half of whom used it more than once a month, and only 18% never used it. Similarly, of those who thought that they would not use the service as often as once a month, and perhaps not at all, 15% used the service once a month or more. Of the remainder more than half never used it. 61% of 119 respondents who answered both questions said at the first interview that they would use alternative transportation once a

TABLE III-1: Easyride Use in 1978 by Reported Intention in 1977

Frequency of Use Reported in 1978:		Will Use Door-To-Door Minibus: At least once a month	Occasionally, Maybe, Unlikely	
Never		18%	50%	
Occasionally		36	35	
At least once/month		46	15	
	(N)	(73)	(46)	(119)
		61%	39%	100%

month or more, while of the 184 who initially answered this question, 63% had also said they would use this service once a month or more. Thus, it is likely that those respondents who either were not interviewed a second time or chose not to answer these questions cannot have been too different in regard to their intentions.

To forestall an easy misunderstanding, it seems worth mentioning that such a correspondence between the sample of 188 and the subsample of 140 gives some evidence of the similarity of the subsample to the sample, but has no bearing on the representativeness of the sample. Obtaining similar evidence from different, independently selected samples is reassuring even if samples are not perfectly random; but a subsample, selected as this one is by refusals, difficulty finding respondents a second time, and death, does not give any independent information that would increase validity.

This finding can be put to more use than just to document the relationship between what our respondents say and what they do. Even though we know that our sample of elderly people is of unknown representativeness, we have no reason to think that these people differ enormously from other people in similar situations. It is thus safe to assume that other people with similar characteristics would have similar intentions. On the other hand, we must be aware that these particular data present problems that should rouse special suspicion in evaluation studies. The interviewers knew that they were participating in an evaluation study of a program that, we may assume, they thought was a good program. They therefore may have encouraged favorable responses to the question of whether people thought they would use the service when it became available. In addition, they were interviewing people who had been selected by social workers as likely to use the service. It is thus certainly possible that those elderly respondents who were perceived by their social workers as likely Easyride users might have been influenced by both their social workers and their interviewer's enthusiasm, and thus also might have used Easyride more. That is, it might be that the correlation found between intention and use does not reflect the distinct causal relationship between professed intentions and Easyride use, but rather that both have a common cause in the respondents' suggestibility or in the interviewer's or social worker's influence on respondents.

B. Who Used Easyride

Note: In the following section, reference will be made to Easyride Registration data and Census data as well as data from the surveys of the pilot study. The reader should look carefully at the legend for each table to see what data are under discussion. Easyride Registration data is used here for the period June 1977 to September 1978. Census data from the 1970 Census is, of course, out of date, but it gives a rough indication of how registration and survey data deviate from corresponding data for the population of the Lower East Side.

The following pages detail Easyride use by respondent's age, sex, ethnicity, and disability, and, where possible, compares this information to what is known about Easyride registrants as a group.

1) Age The age distribution of the people who registered for Easyride during its first year was fixed to a large degree by the requirement that people be either sixty years or more, or at least 18 years old and having a handicap which makes public transportation facilities inadequate for their needs. As Table III-2 documents, almost half of the registrants are 75 years old or older and the disabled under 60 constitute only 7% of the total registrants.

TABLE III-2: Age Distributions

(1), (2), & (3) Easyride Registrations, June 1977 through Sept. 1978.
(4) Population, Lower East Side, 1970 Census.
(5) Respondents, Pilot Study, Wave 2 (N=140).

AGE	Easyride Registrants			Lower East Side 1970 Census	Pilot Study Wave 2
	(1) #	(2) %	(3) %	(4) %	(5) %
80 Years and over	427	31	34	26	50
75-79	259	19	20		
70-74	253	19	20	21	48
65-69	228	17	18	25	
61-64	102	7	8	28	
Under 60	98	7	*	--	2
Total	1367	100%	100%	100%	100%
(N)		(1367)	(1269)	(28,301)	(124)
Age Unknown	129				
Total	1496				

*Percents in column 3 are given only for registrants 60 years old or older.

When the age distribution of the Easyride registrants 60 and over is compared with the 1970 Census figures, it becomes even clearer how skewed towards old age the Easyride population is relative to the total Lower East Side population. It should be said that the eligibility restriction limiting Easyride use to people 65 and over, with the exception of disabled people,

was not instituted until months after the time that most of these Easyride passengers were registered. By comparing the age distributions of those 60 and over who registered for Easyride with the comparable 1970 Census distribution for the Lower East Side, we note that the percentage under 70 (26%) is just about half the census figure (53%), and the identical disproportion, reversed, holds for those 75 and over. Of Easyride registrants, 54% are in that age group while only 26% of the general population are. (The 1970 Census figures were obtained from Community Planning District Profiles of Older New Yorkers, N.Y.C. Office for the Aging, Sept. 1974, Vol. 6, #3.)

While it is not clear to what degree Easyride serves the younger disabled, since denominators are difficult to find, it does appear that Easyride serves the elderly, and, in particular, the very old. Here we wish to ask whether respondents in the pilot study are similarly distributed with regard to age, and who among them uses Easyride. With 50% of the respondents among the "old" old, 75 years and over, and almost 50% among the "young" old, between 60 and 74, it is clear that this sample is, in regard to age, very similar to people who were registered for Easyride during the first year of the service.

Table III-3 shows that the "old" old group reports less use of Easyride than does the young group.

TABLE III-3: Easyride Use by Age

Pilot Sample, 1978. N = 140 - 16 = 124*

	AGE GROUP		
EASYRIDE USE	Under 75	75 and Over	
Never	26%	36%	
Sometimes (less than 1x/month)	32	37	
1x/month or more	42	27	
	100%	100%	
	(62)	(62)	(124)

*Of the 140 respondents in Wave 2, sixteen did not give adequate information about their age or their use of Easyride. Hence N = 140 - 16 = 124.

This is, of course, what we would expect in spite of Easyride's intention to compensate for the difficulties of travel. Even with the availability of ideal alternative transportation, we expect that with increasing age, there will be decreasing mobility, because of the greater likelihood of getting sick, of suffering from chronic diseases, of experiencing greater disability, and declining energy.

If we say that we expect certain changes to occur with aging because of one factor or another, we should be able to either prove this causal connection, or give some evidence supporting it. We considered in the previous chapter whether disability and health have a bearing on travel behavior. Here we want to ask the

corresponding questions about a particular type of travel behavior, Easyride use. But first we want to describe further the respondents in our sample who do or do not use Easyride by looking at other factors such as sex, ethnicity, and economic status.

2. Sex. (For reasons that are not entirely clear, men are greatly under-represented in our sample as they are in the Easyride registration list.) Table III-4 gives the sex distributions for people 65 years and older in New York City, in the Easyride Registration list, and in samples from the pilot study.

TABLE III-4: Sex Distributions

% Male: Age 60 years or more

NY SMSA 1970 Census	Easyride Registrants September 1978	Pilot Study 1977 Sample	1978 Sample
41.2%	36.5%	23.4%	18.6%

One probable reason for the under-representation of men is the great under-representation of married people. A far greater fraction of older men than older women are married. Few married people are in this sample because respondents were recruited through senior centers which cater much more to the isolated than to the married, and the Easyride user population includes few married people.

However, we are less interested in the sex distribution

TABLE III-6: Easyride Use by Ethnicity in the Pilot Study

	% Ever Use Easyride	(N)	% of Easyride Users Who Use Easyride More Than 1x/month	(N)
White	67%	(82)	35%	(55)
Hispanic	87%	(23)	85%	(20)
Black and other	56%	(18)	#60%	(10)

N<15.

While their numbers are small, Hispanics seem to be the most enthusiastic users of Easyride while whites are less likely to use Easyride once a month or more.

4. Economic Status. Two rough indicators are available for assessing respondents' economic position. Income source and health insurance provide two indicators of economic position. Almost all persons over 65 are eligible for Social Security benefits and Medicare. Low income persons may be identical by their receipt of Medicaid and Supplemental Security Income (SSI). In Table III-7, it may be seen that roughly two-thirds of the respondents have used Easyride, no matter what their income source or health insurance. On the other hand, receipt of SSI and Medicaid, the two indicators of low economic status, in very similar fashion increase the fraction of Easyride users who use Easyride more than once a month.

TABLE III-7: Easyride Use in the Pilot Study by Income and Health Insurance Sources in the Pilot Study, Wave II

	% Ever Use Easyride	(N)	% of Easyride Users Who Use Easyride More Than 1x/month	(N)
Income Source				
Receive SSI	67%	(46)	55%	(31)
Receive soc. sec. only	68%	(73)	48%	(50)
Health Insurance				
Medicare, no Medicaid	66%	(62)	49%	(41)
Medicaid, or Medicaid & Medicare	70%	(57)	55%	(40)

5. Disability. One of the central questions in the evaluation of Easyride is whether it serves the transportation handicapped. Accordingly, it is important to document that the elderly people most in need of alternative transportation are, in fact, the ones who use Easyride. The following tables show how different categories of Easyride users and non-users are distributed with respect to three different mobility tasks which suggest three different levels of disability: ability to go up and down the stairs, to go out, and to get around the house. These three tasks are discussed in order of their difficulty, the first being the most difficult for elderly people. Tables III-8, 9,

TABLE III-8: Ability to Go Up and Down Stairs

Easyride Registrants up to Sept. 1978; Pilot Study, Wave II

	Can't do it at all or only with help	With some Difficulty	With no Difficulty	(N)
Easyride Registrants (September 1978)	43%	34%	24%	100% (1390)
Pilot Study (1978)	23	60	17	100% (124)
Easyride Use:				
Never	29	42	29	100% (38)
Less than once a month	9	67	23	100% (43)
Once a month or more	30	70	0	100% (43)
% Ever Using Easyride (N)	61 (28)	79 (75)	48 (21)	
% Using Easyride more than once a month of those who ever use Easyride (N)	76 (17)	51 (59)	0 (10)	

and 10 show a number of interesting relationships between disability indicators and Easyride use.

The first row of each table gives the distribution of the degree of difficulty of the task for all Easyride registrants (registered by September 1978) from whom adequate information was obtained. By comparing this first row in Tables III-8, 9, and 10, it can easily be seen that going up and down stairs is

TABLE III-9: Ability to Go Out

Easyride Registrants up to Sept. 1978; Pilot Study, Wave II

	Can't do it at all or only with help	With some Difficulty	With no Difficulty	(N)
Easyride Registrants (September 1978)	31%	34%	35%	100% (1475)
Pilot Study (1978)	16	31	53	100% (124)
Easyride Use:				
Never	21	24	55	100% (38)
Less than once a month	9	23	67	100% (43)
Once a month or more	19	44	37	100% (43)
% Ever Using Easyride (N)	60 (20)	76 (38)	68 (66)	
% Using Easyride more than once a month of those who ever use Easyride (N)	67 (12)	66 (29)	36 (45)	

the most difficult task, impossible without help for 43% of the registrants (done without difficulty by only 24%), while getting about the house is the easiest of the three tasks, impossible for only 17% (and done without difficulty by 46%).

The second row of each table gives the corresponding percentages for the respondents in the Pilot Study. On the basis of these percentages, one can infer that the total Easyride registration list is more heterogeneous than the pilot sample: an

inference supported by the fact that the majority of respondents in the pilot study were interviewed first at a social center and therefore had a degree of mobility, which many Easyride registrants may not have: almost a third of them (31%) say that they cannot go out without help. The pilot sample is most probably deficient in the number of the most disabled.

TABLE III-10: Ability To Get About The House

Easyride Registrants up to Sept. 1978; Pilot Study, Wave II

	Can't do it at all or only with help	With some Difficulty	With no Difficulty	(N)
Easyride Registrants (September 1978)	17%	38%	46%	100% (1404)
Pilot Study (1978)	6	36	58	100% (124)
Easyride Use:				
Never	3	42	55	100% (38)
Less than once a month	2	28	70	100% (43)
Once a month or more	14	40	46	100% (43)
% Ever Using Easyride (N)	88 (8)	64 (45)	70 (71)	
% Using Easyride more than once a month of those who ever use Easyride (N)	86 (7)	59 (29)	40 (50)	

The next three rows of Tables III-8, 9, and 10 give the disability distributions for each of the three tasks, the rows of each table giving the distributions of Easyride non-users, occasional users, and frequent users. In each table, it can be clearly seen that the frequent Easyride users are the most disabled; but the occasional Easyride users are the least disabled, less disabled than those who never use Easyride.

The last two rows of each table give further support to the finding of the last paragraph correlating disability with Easyride use. While the percentage ever using Easyride in each category of each task does not show any discernible regularity, the percentage using Easyride once a month or more among those who ever use it increases steadily with increasing disability for each of the tasks.

The three disability variables may be combined into an index to simplify the description of the relationship between disability and travel. For present purposes, it is useful simply to distinguish between those who can do all of the three mobility tasks (though, perhaps, with some difficulty) from those who cannot do at least one of the mobility tasks without help. In terms of this categorization of respondents as "disabled" (if they fail to accomplish at least one of the mobility tasks) or "non-disabled" (if they accomplish all three), it may be seen in Table III-11 that the "disabled" are only slightly more likely than the non-disabled to ever use Easyride. However, disabled users have a considerably greater likelihood of using Easyride

TABLE III-11: Disability Indices and Easyride Use

Pilot Study, Wave II

	% Ever Use Easyride	(N)	% of Easyride 1x/month of all who use Easyride	(N)
Mobility Index				
Non-Disabled	67%	(67)	38%	(45)
Disabled	72%	(54)	62%	(39)
Personal Care Index				
Non-Disabled	62%	(80)	42%	(50)
Disabled	80%	(41)	60%	(33)

once a month or more than do non-disabled users. Another disability index based on the "personal care" items (washing and dressing yourself and cutting your own toenails) has a very similar relationship to Easyride use. (See also Table III-11.)

IIIC. Travel Patterns

General Travel of Easyride Users

Do users of Easyride differ noticeably in their travel behavior from respondents who never used Easyride? Does the travel of frequent and less frequent Easyride users differ? These questions will be considered in this section in terms of the general frequency of travel, the number of different destinations to which respondents travel, and the distance most frequently travelled by respondents. Differences in travel behavior are first studied in the data of the first wave (1977). Then travel behavior will be considered as it changed between 1977 and 1978, with a view to differences that might have come about through the availability or use of Easyride.

Since a great deal of information was gathered about the respondents' travel behavior--where, how often, by what means--it is necessary to use some indices which condense varied information. To describe how much travelling a respondent is doing, an index will be used called General Frequency of Travel (usually referred to as General Frequency). Detailed information was obtained about how often, in general, respondents travelled to 18 different destinations; General Frequency is the sum of the frequencies of travel to each of these destinations. Since these frequencies were recorded in the interviews in code categories, they had to be converted into monthly rates before

they could reasonably be added. "Daily" was given the weight of 20, several times a week was considered 8 times per month, once a week was weighted 5, several times a month 3, and once a month 1. Any respondent who claimed to go less often than once a month or for whom information was not obtained, was weighted 0 for the particular destination.

Thus this measure is conservative in the sense that it is more likely to underestimate the frequency of travelling done by all respondents. This may actually be a problem in the 1977 data, where the frequency of missing data is quite high, which results probably in overestimation of the increases in travel frequencies between 1977 and 1978. Since the first wave of data were collected by a different research group, operating on a shoestring, it is no great criticism to say that the travel information obtained in the first wave suffers from incompleteness. It does present us with problems of interpreting findings; but it is necessary to bear in mind that this is an effort to use the best data available, and to use it in what we consider a pilot study.

The General Frequency Index was computed for both waves of interviews of the pilot study. Since here the object is to describe the relationship between travel and Easyride use (in 1978), interest is restricted to the 140 respondents availablein both waves. When they are divided into three roughly equal groups on the

General Frequency Index, the lower third has a range up to 20 trips per month, the middle third makes 21 to 33 trips per month, and the frequent travellers make 34 or more trips per month.

Respondents in the pilot study who reported taking frequent trips outside of their home in 1977--that is, 34 or more trips per month--were somewhat more likely to become Easyride users than those who reported less travel. As Table III-12 shows, the frequent travellers are a little more likely to become Easyride users--78% of them, as contrasted with two-thirds of those who travelled less. Among those who became

TABLE III-12: Easyride Use, 1978, by General Frequency of Trips Per Month, 1977

Pilot Study, N = 140 - 18 = 122

TAKING:	% Ever Used Easyride	(N)	% Used Easyride 1x/month or more	(N)
0-20 trips/month	67%	(39)	35%	(26)
21-33 trips/month	65%	(43)	61%	(28)
34 or more trips/month	78%	(40)	52%	(31)

Easyride users, those who were in the "low travel" category in 1977 are least likely to become "heavy" (i.e. once a month or more) Easyride users. The Easyride users among the most frequent travel group (34 or more trips per month) are, however, not the most likely to use Easyride frequently (i.e. once a month

or more). An obvious hypothesis is that they are less disabled, and therefore find other means of transportation more convenient.

The number of different destinations to which people travel once a month or more is an indicator for another dimension of their general travel, its diversity. While high frequency of travel results, in the pilot sample, in a slightly higher propensity ever to use Easyride, the number of destinations has more equivocal relationship to Easyride use. The only figure worth noting in Table III-13 is the small percentage of frequent Easyride users among those who went to six or more destinations. Only 35% of this group used Easyride once a month

TABLE III-13: Easyride Use, 1978, by the Number of Different Destinations to Which Respondents Travelled Once a Month or More, (1977)

Pilot Study, N = 140 - 16 = 124

GOING TO:	% Ever Used Easyride	(N)	% Used Easyride 1x/month or more	(N)
0-3 Destinations	71%	(45)	50%	(32)
4-5 Destinations	66%	(56)	57%	(37)
6 or More Destinations	74%	(23)	35%	(17)

or more often, while in the other two groups, who generally travelled less, 50% or more use Easyride so frequently.

Various other dimensions of travel have been studied in terms of their relevance to Easyride use, but little has appeared

that adds clarity. For example, a variable descriptive of the distance most often travelled did not reveal any interpretable relationship to Easyride use. It may be that this variable puts too heterogeneous subgroups into the same category. For example, people whose most frequent trip is over twenty blocks, may well consist of very active people, who make many trips far away, and of very sick people who rarely go out, but when they do, make a relatively long trip to a hospital or doctor.

Various experiments attempting to distinguish patterns of travel have not resulted in any good predictors of Easyride use. There are, however, a number of promising paths open. While it is perfectly reasonable to think that more than previous transportation patterns may be necessary to predict Easyride use--perhaps dissatisfaction with transportation, or specific unsatisfied needs--the combination of the various travel variables may, in conjunction with other variables, still provide some clearer picture of who uses Easyride.

Travel Change and Easyride Use

Since the General Frequency Index gives a convenient measure of how much travelling any person does, and it was computed both for 1977 and 1978, it is convenient to use as a change index for the difference between 1978 and 1977. Since the number of cases is small, it was appropriate merely to distinguish those

who increased their monthly number of trips from those whose number of trips decreased, or stayed constant. In order not to overemphasize small differences, the index of travel change took into account only the three categories of the general frequency index and the changes in terms of changes between categories.

Table III-14 shows a number of surprises. The generally high level of increase in travel may be due to some artifact of the changing interview form and different interviewers. If, as seems likely, the number of trips in 1977 was underestimated, the number of trips in 1978 would be expected to be larger than the underestimate of 1977. The fact that Easyride users' trips did not increase more than non-users' trips seems contrary to expectations; and this is hardly balanced by the fact that

TABLE III-14: Change in Amount of Travel and Easyride Use

Pilot Study
N = 140 - 18 = 122

	EASYRIDE USE			
TRAVEL CHANGE	Never	Occasional	More Often	Total
Less trips 1978	8%	12%	26%	16%
Stable	43	52	31	42
More trips 1978	49	36	43	42
TOTAL:	100%	100%	100%	100%
	(37)	(42)	(42)	(121)

TABLE III-15: Ratio of Disabled to Non-Disabled
Pilot Study

	EASYRIDE USE		
TRAVEL CHANGE	Never	Occasional	More Often
Less trips 1978	2/1	3/3	8/3
Stable	7/8	11/11	7/7
More trips 1978	5/13	1/14	10/6
Total	14/22	15/28	25/16

those who use Easyride more often increased their travel frequency somewhat more than those who used Easyride occasionally. Most surprising is the fact that frequent Easyride users have the largest fraction of respondents whose number of trips has decreased. But this becomes less surprising if it is recalled that the more frequent Easyride passengers are disproportionately disabled. It has been argued that services for the elderly may not be able to improve their conditions, but help to slow down deterioration. If, indeed, Easyride passengers are relatively badly off, and at least some of them on a downhill trajectory, the data become understandable. Table III-15 shows the ratios of disabled to non-disabled (in terms of the mobility criterion) in each cell of the table relating Easyride use to change in travel frequency; it makes perfectly plain that those who use Easyride more often are the most disabled (25/16), and that the largest ratios of disabled to non-disabled are to be found in the cells of the table that represent those who have increased

(10/16) and those who have decreased (8/3) their general frequency of travel among those who use Easyride more often. It seems likely that those who increased their travel did so thanks to Easyride, while those who decreased their travel did so because of failing health or increasing disability. But it must be clearly borne in mind that these are conjectures. Nonetheless conjectures of this sort can be useful in the generation of specific hypotheses for analyzing data with better statistical control when they become available.

Inevitably, a new mode of transportation introduced into an area will, if it captures any part of the "market", result in some change in the distribution of mode use. It is not easy to describe individual behavior with regard to mode, since most people use more than one mode for getting to a variety of destinations. In this study, it is necessary to single out one mode, Easyride, for attention. Yet it would be of interest to specify what modes of transportation people used before Easyride became available. While some description of this is possible based on the pilot study, more information will be available in later studies. Here we present only two distributions which indicate how with the appearance of Easyride the distribution of mode of travel to two medical destinations has changed.

Chart I indicates that the most used transportation modes to the hospital or clinic are the bus and walking, and between 1977 and 1978 these two modes, while maintaining their preeminence, both declined. While car and taxi also declined, their share of the trips is very small. Relatively large increases can be seen for ambulettes, and Easyride. Easyride, of course, started from zero, since none of the respondents of Wave I of the pilot study were going to the hospital by Easyride by the time of the first interview. The fact that ambulette showed a considerable increase is a puzzle. Whether some respondents consider Easyride an ambulette, or whether some change in procedure made

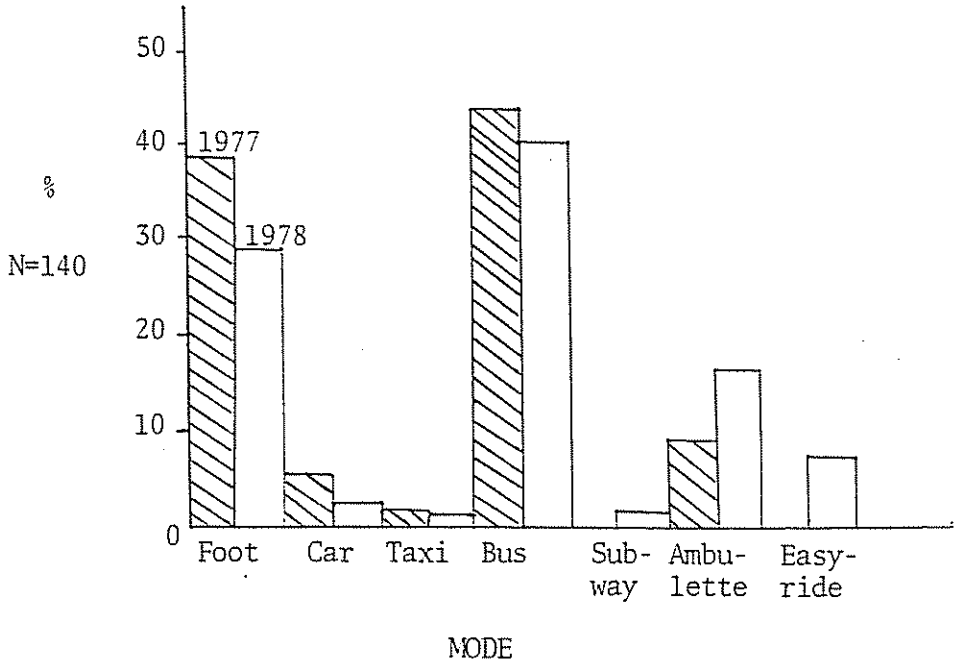
ambulettes more available, or whether a number of respondents discovered the availability of ambulettes, we do not know.

Chart II shows many similarities with Chart I. For trips to a private doctor, going on foot is the most common mode, and its decrease was somewhat less than its decrease as a mode to the hospital or clinic. While the bus is only in second place, it gained in popularity between 1977 and 1978. Ambulette and Easyride both start from nothing and reach slightly over 10%. We note that the big declines are in the numbers who use subways and taxis. Further analysis will give a less speculative view of where the Easyride and ambulette riders come.

Percentage Distribution, 1977 & 1978

Transportation Used to Hospital or Clinic

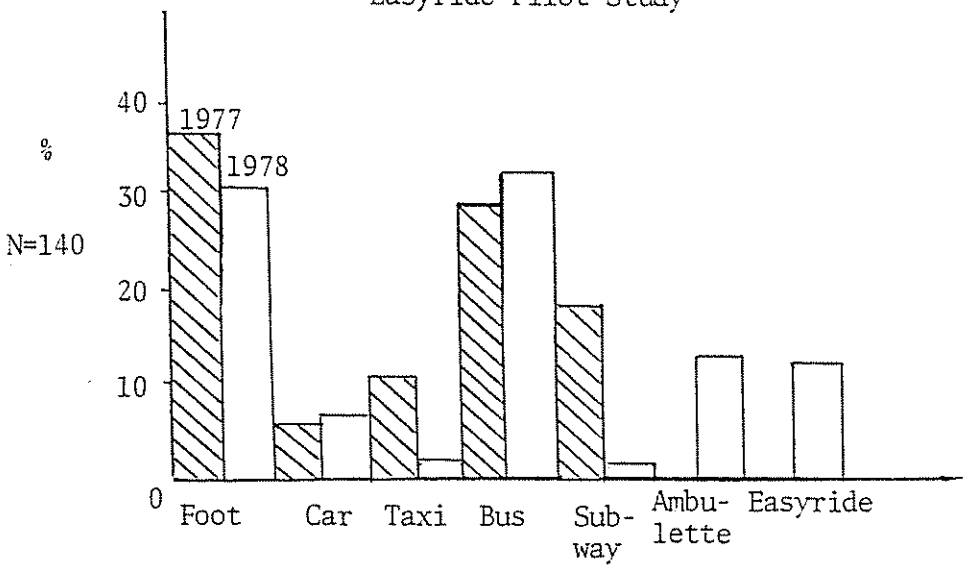
Easyride Pilot Study



Percentage Distribution, 1977 & 1978--

Transportation Used to Private Doctor

Easyride Pilot Study



IV. HEALTH CARE UTILIZATION

A. Introduction

That transportation is an essential pre-requisite for adequate health care for an older and disabled population is a matter no one is likely to dispute. Nonetheless, it is a matter about which it is difficult to make cogent policy without further knowledge about the population, its variability, its needs and disabilities, as well as knowledge about present health care utilization might be influenced by available alternative transportation.

Here the health and health care utilization of the pilot sample will be examined. It was anticipated that health would largely determine level of utilization; but it was of equal interest to discover what other social characteristics or resources influenced utilization. Disabilities--not necessarily illnesses, but impairments of movement and activities of daily living, frailty, mental function impairments--may bear a relationship to health care utilization, in part because they may make it more difficult for a person to get to where help is available. An important question in this context is whether easier access to outpatient services may reduce the need for short or long term hospitalization; a transportation system like Easyride may make access to outpatient services a great deal easier. Access surely depends, in part, on people's ability to get from one place to another; accordingly, it is of

interest to ask about the relationship between health care utilization and various aspects of people's travel--how much, the variety of destinations they go to, their geographic range.

Section B describes the 3 types of health care here taken into account--outpatient visits, hospital emergency room visits, and short term hospitalization. The utilization rates for the pilot sample both for 1977 and 1978 are considerably higher than rates of other urban samples and national rates for urban and low income groups. In Section C, utilization is studied in relation to a variety of the respondents' characteristics. In this old group of people, distinctions between age do not seem to make a difference to utilization. Most other demographic variables make some difference. Although all of our sample can be said to be poor, the less poor, those who do not receive Supplementary Security Income (SSI), show a pattern of utilization that may be an indicator of an inadequacy of access, namely, low outpatient visits but a high level of hospitalization.

Various indicators of health and disability are then investigated for their relationship to utilization. High scorers on disability scales show the pattern of low outpatient utilization and high hospitalization. In Section D, the relationships between travel and health care utilization are examined. It is found, for example, that those who report only "some difficulty" in getting to the doctor make more medical visits than those who say that they need assistance to get to the doctor or clinic,

despite the fact that the latter group has poorer health and a higher hospitalization rate. Finally some attention is paid to the relationship between how much people travel and their health care utilization, and the health care utilization of Easyride users.

B. Health Care Utilization Indicators and Indexes

1. Description of Pilot Study Utilization Variables

Three types of health care utilization are examined in our analysis: medical visits, which may consist of visits to a private doctor or to an outpatient clinic; hospital emergency room use; and short-term hospitalization. To measure outpatient utilization rates we asked respondents how often they usually go to the hospital or clinic and how often they go to a private doctor's office. The frequency of reported trips to a hospital or clinic and the trips to private doctors are added together for each respondent and reported as medical visits based on "usual frequency". (See Table IV.1) In a later part of the 1978 questionnaire, we asked respondents how many times they went to the doctor during the past year. On the basis of "last year" responses, about 15 trips a year were made on the average, less than the average of 20 trips based on "how often do you usually go". This difference in trips is consistent with the idea that some

TABLE IV-1: Physician Visits, 1977 and 1978, Pilot Study

	Hospital or Clinic		Private Doctor*		Total Medical Visits "Usual Frequency"		Total Physician Visits "Last Year"	
	1977	1978	1977	1978	1977	1978	#/	1978
Never	20%	30%	75%	26%	**	**		
Less than 1/month	31	20	10	20	36	24	0-9	33%
1/month	23	30	9	40	29	42	10-24	51
More than 1/month	26	20	7	14	35	34	25+	15
	(188)	(126)	(188)	(118)	(140)	(129)		(123)

See footnotes next page

people make clinic visits which do not involve contact with a physician and the idea that when asked "how often did you go to your doctor last year", respondents may have reported only their private doctor visits. Patterns of outpatient utilization in Table IV.2 support these possibilities. In 1978, 35% reported use of both a clinic and a private doctor, 19% of a clinic only, and 15% of private doctor only; 31% of neither. In any case,

TABLE IV.2: Percentage Distribution, Outpatient Utilization Pilot Study

	1977	1978
Less than 1/month clinic or private doctor	42%	31%
Hospital or clinic only	43	19
Private Doctor's Office only	10	15
Both hospital/clinic and doctor	5	35
	(185)	(140)

an average of 15 to 20 trips a year is much higher than the 6.6 visits for persons 65+ reported by the National Health Survey

*The large difference in doctor visits may be due to the fact that the 1977 form explicitly asks about visits to the doctor in his private office and that the 1978 form simply asks about doctor. In 1978, respondents may have answered about doctor as a repetition of their hospital/clinic answer. Total medical visits, 1978, is adjusted for this possibility.

**NA responses for both clinic and private doctor is considered missing information. Rarely or never on both is grouped as less than 1/month.

(HEW, Wilder, 1977) from data collected in interviews during 1972. In the Boston Elders Survey (Branch, 1978), based on interview data from an urban sample, only 14% of the elderly 65+ went to the doctor once a month or more often, compared to our 1978 figures of 76% for usual frequency. These differences may be related to the fact that our respondents were recruited at senior centers, to their poverty, and perhaps their relatively poorer health. The difference may also be related to high reported hospital emergency room use and hospitalization rates. (See Table IV-3)

TABLE IV-3: Use of Emergency Room and Short-Term Hospitalization

Pilot Study, N = 140

Hospital Emergency Room Use

	1977	1978
None	75%	65%
One	12	22
2-7	13	13
	(188)	(137)
Average # Trips	.7	.8

Short-term Hospitalization

	1977	1978
None	69%	76%
One or more	31	24
	(188)	(132)
Average # Stays	.31*	.33

*How many hospitalizations was not asked in 1977. .31 hospitalizations/respondent may be somewhat lower than actual hospitalization that year. In 1978, 30 respondents were hospitalized once, 5 twice, and one three times.

The hospitalization rate during 1978 was 24%, higher than the 17.3% National Health Survey rate for elderly in the lowest income category (annual income under $5,000) and higher than the 20% for elderly reported by the N.Y. City Department of Aging (Cantor, 1974). The average length of stay for those in our sample hospitalized during 1978 was 19.6 days, higher than the National Health Survey's finding of 16.6 days for persons 65+ in the lowest income category (here, under $3,000), not very different from the 18.9 days for inner city poor elderly found by the N.Y.C. Dept. of Aging.

Hospital emergency rooms may be used for minor but immediate treatment, for serious treatment which is often a prelude to hospitalization, or for "off the street" treatment which substitutes for clinic appointments. The National Health Survey's finding of emergency room use for persons 65+ and under $5,000 income, an average of .2 trips a year is lower than the .8 trips found in our 1978 sample.

2. Typology of Health Care Utilization

The Health Care Utilization Typology is a categorization of people according to their contact with health care providers. Three variables are taken into account. Each is dichotomized to provide one category, its "positive value", indicative of significant utilization; and a residual category. The three variables are:

Medical Visits--Positive Value: Once a month or more.

Hospital Emergency Room Visits--Positive Value: One or more during the past year.

Short-Term Hospitalization--Positive Value: One or more during the past year.

TABLE IV-4: Typology of Health Care Utilization

Distributions of Pilot Samples, 1977 and 1978, N = 140

	No or Low Utilization	M only	E only	ME	H only	MH	EH	MEH
1977 (185)	24.9%	34.1%	4.9%	6.5%	3.8%	13.5%	3.8%	8.5%
1978 (118)	17.8	38.1	2.5	16.1	.8	11.0	.8	12.7

M = Medical Visits (1+/month)
E = Hospital Emergency Room Use (1+/year)
H = Short-term Hospitalization (1+/year)

Table IV-4 gives the distributions of the two waves of the pilot study for the set of possible combinations of these three utilization variables which constitute the typology. Much can be seen from distributions of this sort. For example, it is noteworthy that in 1978, only 4.1% of the respondents (N = 118, since 22 did not supply adequate information on all three variables) made an emergency room visit, or were hospitalized, or both, without reporting medical visits at a rate of once a month or more often. When frequencies are given for all possible patterns, as is the case in this health care utilization typology, rates in sub-groups can be computed. For example, emergency room use was

much more common among those who had been hospitalized in the course of the year than among those who had not: 52% of those who had been hospitalized had used the emergency room, while only 32% of those who had not been hospitalized in the course of the year had used the emergency service of a hospital.

Table IV-4a examines 1978 health care utilization in light of the respondents' utilization experience in 1977. The table collapses the typology into three categories: low utilization (those going to the doctor less often than once a month and no emergency room use or hospitalization during the year), medical visits only (at a rate of one or more a month), and hospitalization (one or more during the year and visits to the doctor at a rate of 1+/month). The overall pattern is drift--the low

TABLE IV-4A: % Distribution, Health Care Utilization, 1978 by 1977

Pilot Study, N = 140

	1978 HEALTH CARE UTILIZATION			
1977	Low Utilization	Medical Visits	Hospitalization	Total
Low Utilization	45%	39%	16%	100% (31)
Medical Visits (1+/Month)	5%	63%	32%	100% (56)
Hospitalization	13%	65%	23%	100% (31)

TOTAL: (118)

utilizers in 1977 tended to move upwards in intensity of care and the high utilizers tended to move down. The middle group, those who made frequent medical visits in 1977, were the most likely to remain in the same category a year later, but were also likely to be hospitalized in 1978. Although those who were hospitalized in 1977 were more likely to become low utilizers than those who made medical visits, most (65%) were making frequent medical visits in 1978.

C. Background and Conditions of Elderly and Health Care Utilization: "Who Utilizes?"

1. Age, Sex, Ethnicity and Income

Since each category of the health care utilization index represents a more intense level of utilization, a group which tends not to utilize, say those who report good health, should also tend to be not hospitalized, the most serious health care utilization category. A subgroup with a large percentage in the "low utilization" category, and a similarly large group in the "high hospitalization" category may indicate insufficient regular physician contact, perhaps because of difficulties in access. For example, in our sample, men show high hospitalization compared to women; 41% of the men and 22% of the women were hospitalized, yet women were more likely to make frequent visits to the doctor. The difference in utilization between men and women

TABLE IV-5: % Distribution, Health Care Utilization By Age, Sex, Ethnicity 1978, N = 140

	Low Utilization*	Medical Visits	Hospitalization	
Age				
60-74	17%	58%	25%	(59)
75+	19	56	25	(57)
Sex				
Male	23	36	41	(22)
Female	17	61	22	(96)
Ethnicity				
Black and Hispanic	4	85	11	(28)
Jewish	25	50	25	(69)
Other, white	11	52	37	(19)

*Infrequent (less than 1/month or none) medical visits, no emergency room use or hospitalization.

is not explained by age; 48% of the men and 51% of the women are over 75 and whatever their age, men and women showed the same utilization pattern. The apparent difficulty in access to outpatient care for men may be psychological, but this is to be discussed a bit later.

Surprisingly, age made no difference in utilization in this sample.

Strong differences in utilization are related to ethnicity (Table IV-5). Blacks and Hispanics show high medical visits and

TABLE IV-6: % Distribution, SSI by Age, Sex, Ethnicity, 1978
Pilot Study, N = 140

	Receive SSI (based on low income and assets)	Social Security Only	
Age			
60-74	40	60	(63)
75+	40	60	(69)
Sex			
Male	36	64	(25)
Female	42	58	(109)
Ethnicity			
Black and Hispanic	67	33	(28)
Jewish	28	72	(69)
White	40	60	(19)

low hospitalization; Jews and other whites show high hospitalization and low doctor visits. Table IV-6 shows a strong relationship between ethnicity and poverty with blacks and Hispanics showing a greater dependence on SSI than do whites or Jews as a subgroup. It is not surprising, therefore, that Table IV-7 shows a pattern of high medical visits and low hospitalization to be characteristic of the poorer sample members, SSI recipients. In order to be eligible for SSI, a person's assets must be under $1,500 and income less than $200 a month. The less poor, those not receiving SSI, show high hospitalization and low physician visits. Many of our respondents who do not receive SSI are still likely to be very

TABLE IV-7: % Distribution, Health Care Utilization By Income, 1978 Pilot Study, N = 140

	Low Utilization	Medical Visits	Hospitalization	
	%	%	%	
Government Benefits				
SSI	13	65	22	(46)
Social Security Only	22	50	28	(68)
Health Insurance				
Medicaid (low income and assets)	16	54	30	(57)
Medicare	20	57	22	(60)
Ability to Get Along on Income				
"Cannot make ends meet"	12	44	44	(16)
"Just enough"	17	60	23	(72)
"Enough and some extra"	24	59	17	(29)
Way living compares to friends				
"worse"	21	50	29	(24)
"same"	15	65	20	(65)
"better"	25	46	29	(24)

poor--close to eligibility or in their desire to be independent refusing "welfare". If high hospitalization and low physician visits is a combination indicative of inadequate medical care, this group may in fact be at greater risk of institutionalization and loss of "independence".

Medicaid eligibility is also income based, but persons with high medical costs may also be eligible, which may explain the high hospitalization associated with Medicaid coverage. The high hospitalization rate among those who evaluated their ability to get along on their income as "cannot make ends meet" again raises the question of how poverty impairs health. Those who answered "enough and some extra" utilize the least.

2. Household Composition and Marital Status

Household composition and marital status give us some idea of the support provided by spouse or others (presumably close relatives). Persons who live alone (75% of our sample in 1978) go to the doctor more than those living with a spouse (Table IV-9). Perhaps those who live alone rely on the doctor for the reassurance and support he can offer in responding to their health problems, whereas those who live with a spouse may rely on the spouse for such support. It is true that 69% of private doctor visits in the National Health Survey (HEW: 1977) were characterized as slightly serious or not serious; but doctors made this characterization, and it may look different to patients. The small group who live with others go to the doctor often.

TABLE IV-9: % Distribution, Health Care Utilization By Household Composition, Marital Status, 1978

	Low Utilization	Medical Visits	Hospitalization	
Household Composition	%	%	%	
Alone	18	61	26	(88)
With Spouse	24	48	28	(21)
With Others	--	78	22	(9)
Marital Status				
Never Married	50	30	20	(10)
Married	21	46	33	(24)
Widowed	16	64	20	(69)
Divorced, Separated	--	60	40	(15)

We can also compare those who are married and living with their spouse to those who were never married, or were widowed, or were divorced or separated (the three respondents who are married but not living with their spouse may have a spouse who is institutionalized). The never married for some reason show low utilization; those who no longer have a spouse, either widowed or divorced, visit the doctor more often. The divorced or separated utilize the most, showing high hospitalization and high doctor visits. Those married are hospitalized more often and go to the doctor less often than the widowed.

3. Health

Health may be expected to be an important determinant of health care utilization. Our study attempted to measure health status in a variety of ways--respondents were asked to evaluate their health and to compare their health to other old persons, to report which of 12 health problems were enough of a bother to keep them from going places, to report chronic illnesses such as heart condition or arthritis, to report whether they were sick during the previous week, and to report their capacity to perform tasks of everyday living. From the health problem list, two indexes were created: frailty, based on weakness or lack of strength, tiring easily or feeling that you have no energy, and having no pep most of the time; and mental function difficulties, based on memory problems, nervousness or tensions or depression, and becoming easily upset most of the time. An index was also made up from chronic health conditions* based on those who have none, one to three, and 4 to 7. The latter index and self-reported evaluation of health measures are reported in Table IV-10 by various subgroups.

*Tally of high blood pressure, heart conditions, arthritis, other leg problems, kidney or prostate problem, stroke, and "other".

TABLE IV-10: % Distribution Self-Reported Health and Health Conditions by Background, 1978

Pilot Study, N = 140

	Self-reported Health			# of Reported Health Conditions			
	"Poor"	"Fair"	"Good-Excellent"	None	1-3	4-7	
	%	%	%	%	%	%	
Age							
60-74	39	42	19	10	56	34	(68)
75+	41	44	14	7	53	40	(70)
Sex							
Male	28	52	20	12	57	31	(26)
Female	44	40	16	9	53	39	(114)
Ethnicity							
Black & Hispanic	51	43	5	11	46	43	(37)
Jewish	38	39	23	9	58	33	(78)
Other	36	50	14	9	55	36	(22)
Income							
SSI	49	38	13	9	47	44	(55)
Social Security Only	37	42	21	8	61	32	(79)
Medical Coverage							
Medicaid	50	39	11	9	53	39	(70)
Medicare	33	45	22	9	57	34	(65)
Household Composition							
Alone	36	45	19	10	54	35	(105)
With Spouse	57	29	14	9	50	41	(22)
With Others	54	46	--	8	54	38	(13)
Marital Status							
Never Married	33	50	17	--	83	17	(12)
Married	60	28	12	15	46	39	(26)
Widowed	36	47	17	10	53	37	(83)
Divorced & Separated	42	37	21	5	47	47	(19)
"How Health Compares to Other Older Persons"							
"Worse"	78	22	--				
"Same"	36	52	12				
"Better"	6	47	47				

The last item in the table, "how health compares to other old persons", relates to self-reported health. Those who say their health is better are likely to report good or excellent health (47%) and unlikely to report poor health (6%) and none who claim worse health than others also report good health. The 41% in our sample who assess their health as poor is high compared to the 12.2% in the National Health Survey (HEW 1977) reporting poor health (65+, incomes under $5,000), and compared to the 31% in the Cantor study (N.Y.C. Office for the Aging--1974) who report poor health status (60+, substandard income).

Self-reported health and number of health conditions tend to show the same trends among the subgroups. For example, those 60-74 and those 75+, show similar differences for self-reported health and for number of health conditions. Age, as reported earlier, also made little difference to health care utilization. Interestingly, men, who tended to be hospitalized but not to go to the doctor, also seem reluctant to admit to poor health compared to the women, yet when asked specifically about illnesses, men do not deny having them. The difference in number of health conditions are small--31% of men, 39% of women report 4-7 health conditions. Men are more likely to report their health as fair, less likely to go to the doctor for help, yet more likely to be hospitalized.

When we examine the health measures against ethnicity and income, a different pattern emerges. Those who report poorer health and more health conditions--Black and Hispanics, persons

receiving SSI--were the same who tended to go to the doctor often and not be hospitalized during the year, whereas those reporting better health, Jews and those who receive social security, were more likely to be hospitalized and less likely to go to the doctor.

Household composition and marital status show a fairly consistent relationship between health status and utilization; only the married show inconsistency, reporting poor health and comparatively low health care utilization.

Altogether the health status measures are strongly related to health care utilization. In general, the sicker a person is, the higher his utilization. However, it is important to note that a small percentage reports poor health and low health care utilization, and that high frequency of hospitalization is reported by those who report no health conditions.

TABLE IV-11: % Distribution, Health Care Utilization By Health, 1978

Pilot Study, N = 140

	Low Utilization	Medical Visits 1+/month	Hospitalization	
	%	%	%	
Self-reported health				
"Poor"	6	60	34	(52)
"Fair"	21	62	17	(47)
"Good-excellent"	39	39	22	(18)
# Health Conditions				
None	57	14	29	(7)
1-3	20	61	19	(64)
4-7	9	57	24	(47)
How Health Compares to Others				
"worse"	5	51	44	(37)
"same"	24	57	19	(54)
"better"	22	67	15	(27)
Sick Last Week				
Yes	4	58	38	(24)
No	21	56	22	(94)

The relationship between income and health care utilization (See Table IV-7)--those who receive SSI show low hospitalization and high doctor visits compared to those who do not--is not explained by self-reported health. (See Table IV-11a)

TABLE IV-11a: % Distribution, Health Care Utilization by Income and Self-Reported Health

Pilot Study, 1978, N = 140

	Low Utilization %	Medical Visits % (1x/month)	Hospitalization %	
"Poor" Health				
SSI	8	64	28	(25)
Social Security	4	54	42	(26)
"Fair" Health				
SSI	19	69	13	(16)
Social Security	25	57	18	(28)
"Good-Excellent Health				
SSI	#20	#60	#20	(5)
Social Security	#46	#31	#23	(13)

N < 15

TABLE IV-12: % Distribution, Health Care Utilization By Disability

1978, Pilot Study, N = 140

	Low Utilization	Medical Visits 1+/month	Hospitalization	
	%	%	%	
Functional Incapacity Scale				
No disability	26	59	15	(51)
1	10	61	29	(31)
2	19	56	25	(16)
3-6	6	41	53	(17)
Scale for Mobility				
No disability	22	60	17	(63)
1	9	56	35	(32)
2-3	15	45	40	(20)
Scale for Personal Care				
No disability	22	59	18	(76)
1	7	63	30	(27)
2-3	8	31	62	(13)

4. Disability

Each of the functional incapacity scales (Table IV-12) indicate that the more disabled are more likely to be hospitalized but are no more likely to go to the doctor than those who are less disabled.

5. Frailty, Mental Function Difficulties, Nutrition Problems and Use of Social Center/Nutrition Program

Frailty is a health measure which focuses on problems of weakness or lack of strength, tiring easily or having no energy, and having no pep. The problems were only scored if they sometimes or often prevented the respondent from going out or in the case of having no pep, the condition is true most of the time. In our sample, age and sex make little difference to frailty (Table 13); Jews are somewhat less frail than other Whites and Blacks and Hispanics. Those who receive SSI or Medicaid are somewhat more likely to be frail than those who receive Social Security or Medicare. Frailty strongly correlated with self-assessed low income. Frailty also strongly correlated with poor health and disability, and the frail were likely to feel that their life is worse than other old persons'. The frail show a regular pattern of health care utilization; the more frail a person is the more utilization is likely (Table 15).

The measure of mental function difficulty is based on memory problems, nervousness, tensions, or depression (when the problems are severe enough to inhibit travel), and the problem of being easily upset most of the time. Again, age and sex make little difference and Jews were less likely to have difficulty than other Whites, Blacks and Hispanics (Table 14). Those who have mental function difficulty were more likely to assess their income as low ("unable to make ends meet"), and somewhat more likely to receive Medicaid. Income as measured by SSI or Social Security

TABLE IV-13: % Distribution, Frailty By Background, Health, Disability, 1978

Pilot Study, N = 140

	Frailty Problems				
	None	One	Two	Three	
	%	%	%	%	
Age					
60-74	22	37	23	18	(65)
75+	21	22	45	12	(67)
Sex					
Male	25	42	21	13	(24)
Female	20	26	38	16	(110)
Ethnicity					
Black & Hispanic	19	22	46	13	(37)
Jewish	25	30	30	15	(73)
Other, white	10	38	38	14	(21)
Income					
Receive SSI	14	27	48	12	(52)
Receive Soc.Sec.	26	27	29	17	(76)
* * *					
Receive Medicaid	18	26	39	17	(66)
Other health insurance	24	29	33	14	(63)
* * *					
"Unable to make ends meet"	--	23	41	35	(17)
"Just enough money"	19	30	41	11	(84)
"Enough, some extra"	38	31	19	12	(32)
How Living Compared to Friends					
"worse"	7	43	32	18	(28)
"some"	23	27	40	11	(75)
"better"	35	27	19	19	(26)
Health Self-accessed					
"Poor"	5	20	44	31	(55)
"Fair"	28	33	35	5	(58)
"Good-excellent"	40	45	15	--	(20)

TABLE 13 (cont.)

	Frailty Problems				
	None	One	Two	Three	
	%	%	%	%	
# Health Conditions					
None	50	8	33	8	(12)
1-3	28	28	32	12	(72)
4-7	4	26	40	20	(50)
Disability Wilker Functional Incapacity Scale					
None	38	27	27	8	(60)
1 problem	6	26	51	17	(35)
2	11	23	39	17	(18)
3-6	--	44	22	39	(18)
TOTAL:	21%	29%	35%	15%	(134)

TABLE IV-14 : % Distribution, Mental Function Difficulties By Background, Health, Disability, 1978
Pilot Study, N = 140

	Mental Function Difficulty				
	None %	One %	Two %	Three %	
Age					
60-74	25	29	29	17	(65)
75+	32	25	27	16	(68)
Sex					
Male	36	20	32	12	(25)
Female	26	28	28	17	(110)
Ethnicity					
Black & Hispanic	17	25	39	19	(36)
Jewish	39	30	19	12	(74)
Other white	9	18	50	23	(22)
Income					
Receive SSI	27	25	29	19	(52)
Receive Social Security * * *	30	27	27	16	(77)
Receive Medicaid	25	22	30	22	(67)
Other health insurance * * *	30	29	26	11	(66)
"Unable to make ends meet"	6	12	59	24	(17)
"Just enough money"	27	29	24	20	(85)
"Enough, some extra"	44	28	25	3	(32)
How living compared to others					
"worse"	10	31	48	10	(29)
"same"	32	29	17	21	(75)
"better"	42	12	39	8	(26)
Health Self-accessed					
"Poor"	18	20	36	28	(56)
"Fair"	33	31	26	10	(58)
"Good-excellent"	40	35	25	5	(20)

TABLE 14 (cont.)

	Mental Function Difficulty				
	None	One	Two	Three	
	%	%	%	%	
# Health Conditions					
None	50	--	33	17	(12)
1-3	31	32	19	18	(72)
4-7	20	26	41	14	(51)
Disability Wilker Functional Incapacity Scale					
No problems	35	27	27	12	(60)
1	25	33	22	19	(36)
2	11	28	50	11	(18)
3-6	28	11	28	33	(18)
TOTAL:	28%	27%	29%	16%	(135)

made little difference. Poor health, more health conditions, and feeling that how you live is worse than how others live were also associated with mental function difficulty. Those who have mental function difficulty are more likely to utilize health care facilities than those who have none, but among those who do have difficulty the less the difficulty the more they utilize (Table 15). This pattern is contrary to the relationship between poor health and mental function difficulty.

Respondents who claim they do not get enough to eat show high health care utilization (Table 15). Those that state money problems as the reason tend to go to the doctor often while those that have difficulty getting to the store tend to be hospitalized. If poor nutrition contributes to the need to utilize, participation in a nutrition program may help. The numbers are too small to test this hypothesis but it does appear that social center attendance encourages doctor visits and helps make hospitalization less likely. Table 16 examines health care utilization and social center/nutrition program attendance controlling for health.

TABLE IV-15: % Distribution, Health Care Utilization By Frailty, Mental Function Difficulties, Nutrition Problems, and Social Center Use

1978, Pilot Study, N = 140

	Low Utilization	Medical Visits	Hospitalization	
	%	%	%	
Frailty				
No problems	44	48	8	(23)
1	19	59	22	(32)
2	10	63	26	(39)
3	5	45	50	(20)
Mental Function Difficulties				
No problems	34	56	10	(32)
1	3	69	28	(29)
2	14	49	37	(35)
3	18	53	30	(17)
Do Not Eat Enough Because Money Problems				
Yes	--	75	25	(12)
No	20	55	25	(100)
Do Not Eat Enough Because Can't go to Store				
Yes	11	56	33	(18)
No	19	57	24	(100)
Use of Social Center/ Nutrition Program				
None	20	50	30	(30)
1-8 Trps/month	3	76	21	(38)
Daily	28	46	26	(50)

TABLE IV-16: Health Care Utilization By Nutrition Program and Health, 1978

Pilot Study, N = 140

	Low Utilization	Medical Visits	Hospitalization	
"Poor" Health	%	%	%	
No attendance	10	55	35	(20)
1-8 Trips/month	--	75	25	(16)
Daily Attendance	6	50	44	(16)
"Fair" Health				
No attendance	#25	#50	#25	(8)
1-8 Trips/month	6	72	22	(18)
Daily Attendance	33	57	10	(21)
"Good-excellent" Health				
No attendance	#100	--	--	(2)
1-8 Trips/month	---	#100	--	(4)
Daily Attendance	#42	#25	#33	(12)

N<15

Being unable to eat enough is strongly correlated with frailty and mental function difficulty. Both frailty and mental function difficulty are highly related to non-attendance at social center nutrition programs (Table IV-17).

TABLE IV-17: Frailty and Mental Function Difficulty By Nutrition and Nutrition Program, 1978

Pilot Study, N = 140

	FRAILTY # Problems					MENTAL FUNCTION DIFFICULTY # Problems				
	None	1	2	3		None	1	2	3	
	%	%	%	%		%	%	%	%	
Not enough to eat, money										
Yes	6	17	50	28	(18)	6	22	39	33	(18)
No	23	31	33	13	(116)	32	27	27	14	(117)
Not enough to eat, get to store										
Yes	14	23	32	32	(22)	18	18	46	18	(22)
No	22	30	36	12	(112)	30	28	26	16	(113)
Social Center, Nutrition Program Attendance										
None	--	33	46	21	(33)	18	6	42	33	(33)
1-8 Trips/mo.	16	33	38	13	(45)	26	43	21	11	(47)
Daily attendance	38	23	27	13	(56)	36	26	27	11	(55)

D. Travel and Health Care Utilization

1. Reported Difficulty Getting to Doctor

We asked respondents if there are times when they don't go to the doctor or clinic because it is hard to get there. The respondents who report that this happens (34% of our sample) also report high health care utilization, in particular medical visits (Table 18). Apparently the more often one needs to go to the doctor the more likely there will be times when it is too hard to go. We also asked respondents whether they could get to the doctor on their own, with some or no difficulty, or whether they need assistance. The lowest utilization is shown by those who claim to have no difficulty getting to the doctor. Those who have some difficulty go to the doctor often and tend not to be hospitalized, while those who need assistance in order to go to the doctor don't go to the doctor as often. This pattern of utilization is contrary to the relationship between poor health, disability, frailty, mental function difficulties, and difficulty getting to the doctor (Table 19).

TABLE IV-18 : % Distribution, Health Care Utilization By Reported Difficulties in Access

1978, Pilot Study, N = 140

	Low Utilization	Medical Visits Only (1+/month)	Hospitalization	
	%	%	%	
Times don't go to Doctor or Clinic Because it is Hard to go				
Yes	13	64	23	(39)
No	21	52	27	(75)
Difficulty Getting to Doctor or Clinic				
None	23	55	23	(66)
Some	—	86	14	(14)
Need Assistance	16	50	34	(38)

TABLE IV-19 : % Distribution, Reported Difficulty in Doctor Access by Health Measures, 1978

Pilot Study, N = 140

	Times Don't Go, Too Hard			Difficulty Getting to Doctor, Clinic			
	Yes %	No %		Need Assistance %	Some %	None %	
Self-accessed Health							
"Poor"	40	60	(53)	44	21	35	(57)
"Fair"	38	62	(56)	20	12	68	(59)
"Good"	9	91	(22)	23	--	78	(23)
Disability--Wilker Functional Incapacity Scale*							
3-6 items need assistance	42	58	(19)	95	5	--	(19)
2	53	47	(18)	56	6	39	(18)
1	23	77	(37)	24	14	62	(37)
No items need assistance	30	70	(63)	8	16	76	(63)
Frailty							
None	16	24		10	5	31	
One	20	33		34	11	31	
Two	43	31		27	68	31	
Three	20	12		29	16	7	
Mental Function Difficulty							
None	11	36		27	11	33	
One	23	30		20	16	33	
Two	39	23		37	42	21	
Three	27	11		17	32	12	
	(44)	(82)		(41)	(19)	(74)	

*Number of items need assistance: going outdoors, walking stairs, getting about house, washing yourself, dressing, and cutting toenails.

2. Travel Behavior

Table IV-20 presents four measures of mobility--amount of travel based on usual frequency to 15 destinations, variety of destinations travelled to once a month or more often, and two measures of geographic range, distance to destination most frequented and farthest distance traveled by foot during past week of travel. Two of the measures--amount of travel and farthest distance by foot--clearly show that health care utilization is lower where there is less mobility. One would expect the least mobile, who are the sickest, most disabled and frail, to show the highest utilization. Instead, those who are in the middle range of mobility, 21-44 average trips per month and those who are able to walk the farthest distances show the most utilization. The relationship between utilization and mobility controlling, in turn, for health, disability, and frailty is presented in Table IV-21. The numbers are very small, but certain trends appear with consistency. With better health, low utilization is more common no matter how much travelling is reported. With better health, high utilization is more infrequent, no matter how much travelling is reported. But travel does seem to play a role in that the medium number of trips category shows an especially high utilization rate.

According to the measure of distance to the most frequented destination, there is a slightly greater tendency to be hospitalized the further a person travels. This is probably because

some respondents travel a long distance (e.g. a hospital or relatives) even though they do this comparatively less often, while others most often travel shorter distances (e.g. shopping, social center).

TABLE IV-20: % Distribution Health Care Utilization by Travel, 1978

Pilot Study, N = 140

	Low Utilization %	Medical Visits (1+/mo) %	Hospitalization %	
Amount* of travel				
0-20 trips per month	15	56	28	(39)
21-44	--	67	33	(33)
45+	31	51	18	(45)
Variety of destinations+				
0-3	23	50	27	(26)
4-8	15	55	30	(60)
9-14	19	66	16	(32)
Distance to most frequented Destination				
Under 3 blocks	17	59	24	(54)
3-6 blocks	20	60	20	(25)
7+ blocks	18	51	31	(39)
Farthest Distance by foot last week of travel				
Under 3 blocks	26	37	37	(19)
3-6	24	59	18	(17)
7-20	14	61	25	(56)

*Based on how often the respondents usually goes to a list of 15 destinations (excluding doctor).

+Destinations frequented at a usual rate of one or more trips a month.

TABLE IV-21: % Distribution Health Care Utilization By Usual Travel and Health, Disability, & Frailty 1978

Pilot Study, N = 140

	Low Utilization %	Medical Visits (1+/mo.) %	Hospitalization %	
SELF-ASSESSED				
"Poor" Health				
0-20 trips/mo.	5	62	33	(21)
21-44	--	58	42	(19)
45+	9	64	27	(11)
"Fair" Health				
0-20 trips/mo.	21	57	21	(14)
21-44	--	75	25	(12)
45+	33	57	10	(21)
"Good-excellent" Health				
0-20 trips/mo.	50	25	25	(4)
21-44	--	100	--	(2)
45+	42	33	25	(12)
WILKER FUNCTIONAL INCAPACITY SCALE FOR MOBILITY:				
3 Items Need Assistance*				
0-20 trips/mo.	15	48	37	(17)
21-44	0	57	43	(14)
45+	10	60	30	(10)

*Need assistance: going outdoors, walking stairs, getting about house.

Table 21 (cont.)

	Low Utilization %	Medical Visits (1+/Mo.) %	Hospitalization %	
No Items Need Assistance				
0-20 trips/mo.	18	73	9	(11)
21-44	--	72	28	(18)
45	35	50	15	(34)
FRAILTY				
Two-Three Problems				
0-20 trips/mo.	4	64	32	(25)
21-44	--	58	42	(19)
45+	21	50	29	(14)
One				
0-20 trips/mo.	39	39	23	(13)
21-44	--	71	29	(7)
45+	8	75	17	(12)
None				
0-20 trips/mo.	--	100	--	(1)
21-44	--	80	20	(5)
45+	59	35	6	(17)

3. Easyride Use

Between 1977 and 1978, Easyride came into full operation, giving respondents in our pilot study the opportunity to register and to travel by this new mode of transportation. As reported elsewhere in this report, and in the marginals in Table IV-23, Easyride tended to attract respondents who report poor health, disability, frailty, and mental function difficulty. Respondents who said that they use Easyride once a month or more often show high health care utilization, not only high physician visits but also high hospitalization (Table IV-22). The hospitalization rate is particularly high for the Easyride users in poor health, for those who are more disabled, and for the frail (Table IV-23), but the pattern of high hospitalization and low doctor visits from which difficulties in access might be inferred does not occur. The higher hospitalization among Easyride users also implies that however their health or disabilities are reported, for Easyride users the need for care is more serious. For example, 60% Easyride users reporting poor health were hospitalized compared to 18% non-Easyride users reporting poor health.

TABLE IV-22: % Distribution Health Care Utilization by Easyride Use, 1978

Pilot Study, N = 140

	Low Utilization %	Medical Visits %	Hospitalization %	
Easyride Use				
Never	23	64	13	(31)
Occasionally	23	57	20	(40)
1+/month	11	47	42	(36)

TABLE IV-23: Health Care Utilization by Easyride Use and Health, Disability, and Frailty, 1978

Pilot Study, N = 140

	Low Utilization %	Medical Visits %	Hospitalization %	
SELF-ASSESSED				
"Poor" Health				
Never Use Easyride	9	73	18	(11)
Occasionally	7	71	21	(14)
1+/month	5	35	60	(20)
"Fair" Health				
Never Use Easyride	14	71	14	(14)
Occasionally	29	59	12	(17)
1+/month	17	67	17	(12)
"Good-excellent Health"				
Never Use Easyride	67	33	--	(6)
Occasionally	25	38	37	(8)
1+/month	25	50	25	(4)
FUNCTIONAL INCAPACITY FOR MOBILITY SCALE				
2-3 Items Need Assistance				
Never Use Easyride	25	75	--	(4)
Occasionally	20	40	40	(5)
1+/month	13	25	63	(8)
One				
Never Use Easyride	13	63	25	(8)
Occasionally	11	67	22	(9)
1+/month	7	47	47	(15)

TABLE 23 cont.

	Low Utilization %	Medical Visits %	Hospitalization %	
None				
Never Use Easyride	28	61	11	(18)
Occasionally	27	58	15	(26)
1+/month	9	64	27	(11)
FRAILTY				
Two-Three Problems				
Never Use Easyride	8	69	23	(13)
Occasionally	21	57	21	(14)
1+/month	4	46	50	(26)
One				
Never Use Easyride	27	64	9	(11)
Occasionally	9	73	18	(11)
1+/month	33	33	33	(6)
None				
Never Use Easyride	50	50	--	(6)
Occasionally	42	42	17	(12)
1+/month	25	75	--	(4)
MENTAL FUNCTION DIFFICULTY				
One-Three Problems				
Never Use Easyride	11	68	21	(19)
Occasionally	22	57	22	(23)
1+/month	6	52	42	(31)
None				
Never Use Easyride	36	64	--	(11)
Occasionally	29	57	14	(14)
1+/month	50	25	25	(4)

TABLE IV-24: % Distribution, Easyride Use and Difficulty in Access to Doctor/Clinic, 1978

Pilot Study, N = 140

	Times Don't Go, Too Hard to Get There		Difficulty Getting to Doctor			
	Yes %	No %	Need Assistance %	Some %	None %	
Never Use Easyride	22	78	24	13	63	(37)
Occasionally	36	64	23	16	61	(42)
1+/Month	39	61	42	12	47	(41)

TABLE IV-24a: % Distribution, Times Don't Go To The Doctor By Ability To Get To Doctor

1978, Pilot Study, N = 140

	Times Don't Go, Too Hard to Get There		
	Yes (%)	No (%)	
Need Assistance to Get to Doctor	39	61	(39)
Some Difficulty	59	41	(17)
No Difficulty	25	75	(76)

Easyride users go to the doctor more often than non-Easyride users, given a high level of disability, frailty, or mental function difficulty. The only indication that Easyride users have difficulty in access is in reported difficulty in getting to the doctor (Table IV-24). 39% of the Easyride users report times when they do not go to the doctor because it is too hard, compared to only 22% of those who never have used Easyride. Easyride users

also need assistance when they go to the doctor. 42%, compared to the 24% of non-Easyride users, and this has a (non-monotonic) relationship to difficulty in access (Table IV-24a). It will be of interest to see whether over a longer time interval the difficulty of getting to the doctor for Easyride users will decrease.

CHAPTER FIVE: SOCIAL SUPPORT

As an individual gets older, the social ties he has developed throughout his lifetime tend to weaken. Hess (1971) points out that as people, especially those with low incomes, get old, they participate less in clubs and organizations and their informal relationships diminish as neighborhoods change, as families separate when children marry and pursue jobs, and as relatives and friends move away or die. She concludes that "old people progressively lose their group support as networks of relatives, friends and neighbors wither away through time, and asks, "What possible substitutes exist for these deteriorating social ties?" Hess posits that elderly people form new friendships with younger people living nearby. However, she also claims that "there is an effective social barrier between older and younger people that proximity does not destroy," and found that in a large apartment building with old and young residents, less than 4% of friendships in the building were between the old and the young.

It may be possible to increase the social contacts of elderly people by making it easier for them to be in touch with others. The present study is aimed, in part, to show that an inexpensive door-to-door bus service may become a means for facilitating old peoples' social contacts with their friends and families and increasing their visits to social and cultural centers. In order

to test such a hypothesis, it would be useful to see whether the social life of the people in this sample shows the effects of the "shrinkage" of old people's social world that Hess describes. The social life of the respondents in this study is examined through their reports of how much they are in touch with friends and family and how often they visit social and religious centers, or go to parks, movies and other places of entertainment. The data which are discussed in this section are from the second wave of the pilot study (interviews conducted in the spring of 1978, N = 140), because data about social life are more extensive in this wave than in the first wave.

The Family

1) Living Arrangements

A high proportion of people in this sample live alone. Out of 131 people who describe their living arrangements, 80% say that they live alone, while 17% live with a spouse, and three percent live with someone other than a spouse. These living arrangment patterns are not peculiar to this sample. Cantor (1973) notes that New York City has proportionately more older people living alone than in the country as a whole (30% in New York, 22% nationally). According to Harris (1978), the small percentage of elderly living with relatives other than a spouse may be seen in the light of the fact that in 1976 multigenerational families represented only 4% of all families and the number of three or four generation families decreased by 10%

during the 1960's. The New York City Office for the Aging also reports on a study in which a small fraction of their respondents, 8 percent, lives in another person's household, usually a child's (Cantor, 1973: 14). Most of the respondents in the pilot study who live alone have, at some time, experienced a change in their marital status. Out of 139, 60% were widowed, 10% were divorced and 3% were separated. Only 9% of the respondents were never married. Riley, Riley and Johnson (1969) found that the loss of a spouse is one of the factors that leads old people to diminish social contacts and to withdraw from many social relations. The length of time an individual has been widowed is an important variable about which, unfortunately, the present study has no adequate information.

Among the 22 respondents who do not live alone, not all can rely on their spouse for help. Ten respondents who are married or who live with someone other than a spouse replied "no" to the question, "Is (your husband, wife, friend) able to go outdoors without help from another person?" Eight respondents said "no" to the question "Is (your husband, wife, friend) able to use public transportation without the help of another person?" Respondents were also asked "Does the health condition of your spouse in any way limit where you can go and the kinds of things you do?" Six respondents said "yes". It therefore seems that many married old people are like other old people who live alone in that they will need help from others who do not live with them.

2) Children

Cantor (1975: 5) found in a study conducted in the inner city of New York that most elderly people's children have not abandoned them. On the contrary, "familial bonds are strong and there is evidence of mutual affection and assistance between generations." Maddox (1975) writes that children view their parents as dependent on them, while Kahana and Felton find that old people see their children and friends as sources of information and advice to whom they turn when the need arises. Kahana and Felton also find that elderly people who choose to be near family or friends do so because they prefer to live with people sympathetic to them. Lowenthal and Haven (1968) say that the availability of a confidant who is not necessarily, or even ordinarily, the spouse is especially important for older people. Neither the living arrangements of elderly people which tend to separate them from the young, nor the tendency of old widowed parents to live alone imply that there is generational separation and emotional detachment. On the contrary, Maddox claims that a decade of research has documented that "parents with living children demonstrably have contact with these children, and substantial transfer of goods and services between generations has been documented". (Maddox 1975) However, Maddox cautions the reader that this closeness is not universal and that it does not mean that older persons never feel isolated or

lonely or that generations within families do not deny responsibility for one another. There is no clear picture of inter-generational relationships, neither the interaction between old parents and their children nor of its consequences.

Analysis here will focus on the quality of the relationship between older parents and their children: more specifically, on the support elderly people expect to receive during times of emergency or when they need help for a more extended period and on the support they say they will provide.

Old People and Their Children

Seventy-three percent of the respondents in the pilot study have living children and 47% say that they have two or more. Half of the 99 people who responded to the question about where their children live said that they live in the same neighborhood, 25% report that children live in other parts of the city, and 23% report that children live out of the city (distance is not reported). The fact that a large percentage of our respondents live near their children suggests that there is some level of interaction between them.

In the pilot study, 44% of the 97 respondents who have children and answered the question about how often they see their children say that they see the child who lives nearest to them at least once a week (some see them daily), 27% at least once a month (though less than once a week), and 29% see their children only once or "a few times" per year. Of 101 respondents

who have children, 33% call their children more than 5 times per month (one respondent claims she calls over ninety), 39% call between 4 to 5 times a month and 28% call between one and three times a month.

Among the 105 respondents who live alone, 30 do not have children. Of the 21 married respondents, 16 have children and 5 do not. Clearly, old people who live alone and do not have children have to rely on outside help when the need arises.

The Elderly People and Their Friends

Hess reports that friendship and neighborly relations tend to be maintained well into later life. However, this claim applies more to people who occupy a high socioeconomic position. Length of residence, which is often a function of age, is directly associated with the likelihood of knowing and visiting neighbors, and of having evolved close relationships with some of the neighbors. Hess found that among people 65 and over, nearly half say that most of their friends live nearby.

The data in this study provide information on how many visits respondents made to friends during the previous year and their satisfaction with the frequency of their visits. 53% of 102 respondents who answered the question how often they visit their friends say that they visited their friends a "few times a year" or "rarely". Forty-seven percent visit their friends once a month or more often. Of the 29 respondents who answered

the question of how they usually go to visit friends, 21 go by foot, while 8 go by a car, bus or subway.

Respondents were also asked how many blocks their friends live from them. 40 people responded to this question and 70% of them answered "six blocks or less", 15% "seven blocks or more" and 15% "out of the borough" (of Manhattan).

The distance elderly people must cover to reach their friends is a hardship for many. In fact, 42% of 130 respondents said "yes" to the question: "Is there a friend or acquaintance living in the city who you would like to visit but have not this past year because it is too hard to get there?"

Respondents were also asked, "Compared to a year ago, do your friends and relatives visit you more often, less often, about the same?" 36% of 126 respondents say that their friends or relatives visit them less, 59% about the same and 5% more.

In response to the question: "Compared to a year ago, do you go out and visit friends and relatives less, the same, or more?" 48% of 131 said that they visit less, 50% about the same and 2% more. Table V-1 shows the relationship between receiving visits and visiting others.

TABLE V.1: Respondents' Report of How Much Their Friends and Relatives Visit Them by How Much They Visit Their Friends and Relatives

Pilot Study, Wave II, N = 140 - 14 = 126

Friends and Relatives Visit Respondent	Visit Friends and Relatives: Less	About the Same	More
Less	66%	8%	*#33%
About same	29	89	#33
More	5	3	#33
TOTAL:	100%	100%	100%
	(61)	(62)	(3)

* The symbol # is used to warn the reader that a percentage is based on a total less than 15.

Decreases in visits to friends are directly related to decreases in visits by friends. Thus, people who made less trips to friends are not compensated by receiving visits from friends. On the contrary, it appears that one deprivation, inability to visit friends, leads to another deprivation, being visited less by them.

Festinger, Schechter and Back (1950) found that the effects of physical or functional distance upon friendship were striking: The closer the neighbor, the more likely he will become a friend. They also found that the more advantageously located the apartment is in terms of the traffic flow within the complex, the more likely are its occupants to have extensive friendship networks. It is reasonable to think that elderly people who say it

is hard to visit friends, who live at a physical and functional distance which is hard for them to cover, will decrease the number of their visits to friends. Table 2 presents the relationship betwen the difficulty of visiting friends and respondents' reports as to their change in the frequency of their visiting.

TABLE V-2: Respondents' Reported Change in the Frequency of Their Visits to Friends by Their Claim That it is Hard for Them to Visit Friends

Pilot Study, Wave II, N = 140

	TOO HARD TO VISIT FRIENDS	
VISIT FRIENDS	Yes	No
Less	56%	39%
About the same	42	59
More	2	2
TOTAL:	100% (57)	100% (64)

People who say that it is difficult to visit their friends tend also to say that they visit them less. It should be noted that many of those who say that they don't visit friends because it is too hard have not changed their visiting frequency over the past year. However, just about as many of those who deny that they have difficulty <u>have</u> reduced their visits to friends. We cannot tell whether this is a general trend. Thus, it can be stated that transportation may increase the number of visits

some respondents can make while for others, factors other than transportation prevent them from making visits. It must also be pointed out that even though many respondents find it difficult to visit their friends it does not mean that they do not want to visit them. In Table V-3, the places to which respondents reported not going but wanting to go is correlated by their view that it is too hard for them to visit their friends.

TABLE V.3: Places Respondent Reported Wanting to Visit But Do Not By Their Claim That It Is "Hard to Visit"

Pilot Study, Wave II, N = 140 - 19 = 121

	HARD TO VISIT	
DO NOT GO	Yes	No
No place	16%	68%
Visiting	54	9
Recreation or cultural centers	18	12
Other	12	11
TOTAL:	100% (56)	100% (65)

A partial reliability check can be done on respondents' statements regarding their visiting friends. Besides the question which was asked them specifically about whether they did not visit friends because it was too hard to get there, they were also asked whether there was any other place they wanted to go but don't. Dispro-

portionately, many respondents who had said that they didn't visit a friend because it was too hard to get there also said that they would like to go visiting (54% as contrasted to 9% in the remainder of the sample). Among those who did not say that they would have liked to visit a friend, and didn't, two-thirds (68%) did not mention one additional place they would like to go. However, these numbers should be regarded with special caution since the two questions appear consecutively in the interview, and responses to the second question may have been heavily influenced by responses to the first. Nonetheless, it may be true, and thus be a matter worth further investigation, that those who are satisfied with the amount of visiting to friends that they do, are relatively satisfied with the total amount of travelling they do.

Visits to Social and Religious Centers and Recreational Facilities

In the year between the first and second pilot interview, respondents in this study seem to have sustained their ties to their social center. Out of 131 respondents, 43% go daily to a social center, 26% go several times a week, 9% go several times a year, and 16% don't go at all or at most "rarely". This high visiting frequency can be explained in part by the fact that the social centers have lunch programs where many get a meal at very low cost and can meet other people there. Besides, the social centers are located in the respondents' neighborhood and

are thus comparatively easy to get to. Respondents' high level of satisfaction with social center activities may also explain why they are so highly frequented. Out of 119 people who visited their centers, 58% are very satisfied with social activities, 29% are somewhat satisfied, and 13% are dissatisfied. Another source of social gratification for elderly people is religious worship. For the widowed especially, the cemetery is also a focus of interest. Reported attendance and visits to church, a synogogue or a cemetery is also high. Altogether, 32% out of 120 who answered the relevant question go daily to once a week or more often to one or more of these places, 37% go several times a month, 4% several times a year and 27% go rarely or never.

Barbara Myerhoff's (1979) study of a community of elderly urban Jews stresses the importance of parks and benches as places where old people socialize with friends and spend most of their time. She found that old people develop a highly stylized "bench behavior" and that benches are segregated by sex and by conversation topic.

> "The men's benches are devoted to abstract, ideological concerns--philosophical debates, politics, religion, and economics. The women's benches are given more to talk about immediate, personal matters--children, food, health, neighbors, love affairs, scandals, and "managing". Men and women talk about Israel and its welfare, about being a Jew, and about Center politics. On the benches, reputations are made and broken, controversies explored, leaders selected, factions formed and dissolved. Here is the outdoor dimension of Center life; like a village plaza, it is a focus of protracted, intense sociability."

Respondents in the pilot study sample also reported going to the park; 10% out of 105 go daily, 48% go several times a week,

and 42% go less frequently. Few respondents go to the movies; 18% out of 98 respondents go once a month or more often, 12% go several times a year, and 69% go rarely or never. 18 respondents reported not going but wanting to go to social centers or to recreational facilities.

An index which measures the amount of respondents' social contact is presented Table V-4 This index is based on how many of four types of social contact the respondent experienced at least once during the past year. The four types of contact are: visits to a social center, visits with children, with family members, and with friends.

TABLE V-4: Distribution of People According to the Number of Social Contacts They Have

Pilot Study, Wave II, N = 140 - 8 = 132

No. of Contacts	Percent of People	
One Contact	20%	
Two Contacts	27	
Three Contacts	33	
Four Contacts	20	
TOTAL:	100%	(132)

Excluding the 8 respondents who did not answer any of the questions of which the index is made, all of the other respondents have one or more social ties. Most respondents go to social centers and have maintained their primary ties. It may be assumed

*The items that are used in the creation of the index are: (1) total personal contacts with children including phone contact and visits; (2) How often respondents usually visit their family; (3)How often they usually visit their friends; and (4) How often they usually go to a social center.

that social ties are important because respondents can rely on others for help in case of emergency or in other times of need. This view is tested in the following two tables.

TABLE V.5: Receiving Emergency Help by Number of Social Ties
Pilot Study, Wave II, N = 140

	HELP		
SOCIAL TIES	No	Yes	Total
1-2	43%	57%	100% (35)
3	32	68	100% (57)
4	11	89	100% (35)

TABLE V.6: Receiving Long-Term Help by
The Number of Social Ties
Pilot Study, Wave II, N = 140

	HELP		
SOCIAL TIES	No	Yes	Total
1-2	62%	38%	100% (34)
3	50	50	100% (58)
4	43	57	100% (35)

Table V.5 shows that the greater number of ties respondents have, the greater is the likelihood of their receiving emergency help. This is also true for respondents receiving long-term help as may be seen in Table V.6. However, the expectation for

long-term help is much lower and the differences between the different levels of social support are much smaller.

Respondents in the pilot study seem to have maintained contact with their family, their children, and their friends, and are able to get to their social centers. Are people with more contacts more satisfied with their social life? A subjective measure of how these old people feel about their social life is related in Table V.7 to the number of social contacts they have. Respondents in this study were asked whether they were satisfied or dissatisfied with social life and the degree of their satisfaction or dissatisfaction. Out of 119 respondents, 21% are very satisfied, 51% somewhat satisfied, and 28% are dissatisfied.

TABLE V.5: Satisfaction With Social Life by Number of Social Contacts

Pilot Study, Wave II, N = 140 - 21 = 119

	NO. OF CONTACTS		
SATISFACTION	1-2	3	4
Very Satisfied	9%	25%	28%
Some Satisfied	47	45	66
Dissatisfied	44	30	6
TOTAL:	100%	100%	100%
	(34)	(53)	(32)

People who have 4 social contacts are more likely to be satisfied and much less likely to be dissatisfied with their social life than are people who have fewer contacts. One possible

way of increasing the social contacts of elderly people, as was hypothesized earlier, is to provide them with an inexpensive door-to-door transportation service.

Obstacles Related to the Number of Social Contacts

Casady (1977) relates adjustment to old age to elderly people's levels of sociability and their proximity to family and friends. Those elderly people who are considered to be least well-adjusted to old age tend to be widowed, in poor health, somewhat economically deprived, and have few interests and social contacts. Results from the second wave of the pilot study show little difference between the sexes in relation to their social contacts. Age, as well, has little, but it does have some, bearing on the number of respondents' social contacts: Respondents who are under 75 are slightly more inclined to have four contacts than are those who are 75 or older, and whites seem to have more social contacts than non-whites. Results from the second wave of the pilot study also suggest that health/disability and a low economic status function as obstacles which can be related to the number of social contacts elderly people have.

People who are in poor health or disabled seem likely to have fewer social contacts. Tables 8 and 9 support this hypothesis.

TABLE V.8: Number of Social Contacts by Self-Reported Health

Pilot Study, Wave II, N = 140

	HEALTH		
SOCIAL CONTACTS	Poor	Fair	Good
1	14%	2%	4%
2	25	27	9
3	45	49	35
4	16	22	52
TOTAL:	100%	100%	100%
	(56)	(59)	(23)

TABLE V.9: Number of Social Contacts by Functional Incapacity for Mobility Index

	FUNCTIONAL INCAPACITY			
SOCIAL CONTACT	0	1	2	3
1	8%	3%	13%	#17%
2	19	23	31	#50
3	41	51	56	#33
4	33	23	0	# 0
TOTAL:	100%	100%	100%	100%
	(79)	(35)	(16)	(6)

percent based on N < 15.

Another barrier to the maintenance of social ties is low economic status. Surely, having the financial means to get to

places or to visit friends and relatives is usually a prerequisite for maintaining social relationships. In the following table, the number of respondents' social contacts is correlated to their answers to the question about their ability to make ends meet.

TABLE V.10: Number of Social Contacts by Ability to Make Ends Meet

	ABILITY TO MAKE ENDS MEET		
SOCIAL CONTACTS	Not enough to make ends meet	Just Enough	Enough And Extra
1	18%	7%	6%
2	41	23	12
3	29	47	49
4	12	25	33
TOTAL:	100%	100%	100%
	(17)	(88)	(33)

Respondents who feel that they have enough and even have extra money are more likely to have four contacts than respondents who cannot make ends meet.

Type of Support Old Persons Expect to Receive From Their Children Or Close Friend

G.L. Groman, G.L. (1978) states that "the inner-city elderly enjoy an ongoing and satisfactory relationship with their children and are able to offer aid (such as baby-sitting) at the same time

as they receive it." Unfortunately in this pilot study, data are unavailable on the different forms of assistance and interaction that take place between parents and children. But three questions were asked that do give an indication of respondents' relations to their children and friends. The questions deal with the receiving and the giving of help. One of these questions is: "If some emergency came up, can you depend on one of your (children) or their (spouses) or (close friends) to come over and help out?" Only half of the 128 respondents say that they will definitely receive help from children or from a friend in case of emergency.

The second question is: "If you needed help for a longer period--say a couple of weeks--can you depend on one of your (children) or their (spouses) or a (close friend) to help you out during that time?" The percent of respondents who say that they will definitely receive long-term help is even smaller: 22%.

The third question respondents were asked is: "If some emergency came up in the lives of your (children) or (close friend), is it likely that you would go and help out?" 37% of 127 respondents said that it was likely that they would provide help for others in case of emergency, 12% said it was somewhat likely, and 41% say it is unlikely.

Who Assists With Specific Needs?

In general, old people refrain from asking for help. They do seem to ask for specific help when the need arises. In this study, respondents were asked about their level of disability in relation to performing certain tasks, whether or not help is available for them and who assists them when they need help. The responses to these questions are presented in Table V.11.

TABLE V.11: The Number Needing Help, and the Type of Help Received for Each Task

Pilot Study, Wave II, N = 140

	TASK					
HELP	Going out doors	Walking up down stairs	Getting about house	Washing & bathing	Putting on shoes & dressing	Cutting toenails
Total # of Respondents	137	100	137	137	119	138
# who say they can do the task only with help	22	20	5	14	11	46
Total # receiving help	25	19	6	14	11	46
Source: Paid	17	12	6	12	10	40
Source: Spouse	1	2	--	1	--	1
Source: Other family, Relatives, Friends or Neighbors	7	5	--	1	1	2

TABLE V.11 continued

	TASK					
	Preparing Meals	Grocery Shopping	House Work	Tele-phone	Get out of bed	Getting to Dr./Clinic
Total # of Respondents	136	137	135	136	137	140
# who say they can do the task only with help	32	58	58	3	7	42
Total # receiving help	37	63	63	5	8	43
Source: Paid	29	40	46	4	6	32
Source: Spouse	3	4	5	1	1	1
Source: Other family, Relatives, Friends or Neighbors	5	19	12	--	1	10

It is interesting that respondents rely more on paid help than on members of their primary groups to accomplish daily tasks. However, nothing in this table implies that these people get sufficient assistance. And even sufficient assistance, if they were to receive it, does not overcome all obstacles. For example, when respondents were asked what kept them in the house last week, eight respondents replied that their physical condition prevented them from going out. Of these eight respondents, three had not been out for more than a month, one had not been out for 3 weeks, and four had been house-bound less than a week. It is to be hoped that these people had gotten necessary help, though that help may not have been for going out.

That some assistance is needed may be inferred when respondents say that they do not get enough to eat. In response to the questions asked in 1978, "Do you sometimes not get enough to eat because of money problems", and "Do you sometimes not get enough to eat because you cannot get to a store?", 18 out of 140 claim not to eat enough because of money problems and 22 because they can not get to a store. In response to the question posed to them in 1977, "Do you feel you are able to eat well-balanced meals these days?", 49 out of 188 respondents said no: 1 cited income as the reason, 22 poor appetite, 10 inability, and 17 other reasons.

One way of getting help with eating is to eat outside the

home, although sociability may be a more common motive for eating out. 42 of the respondents said in 1978 that they go out to eat between one to four times a week and 53 go out more frequently. Since we know that Easyride provides many trips for nutritional lunches, these high frequency figures are not surprising. However, there remains a group of people who never go out to eat, and, as Table V-12 indicates, these people are more numerous among those who use Easyride most often. This fact undoubtedly reflects the concentration of the more severely disabled and poorer sample members among those who use the Easyride service most often. Disability and poverty, both associated with frequent Easyride use, are likely inhibitors to going out to eat.

TABLE V.12: Easyride Use by Eating Out
Pilot Study, Wave II, N = 140

	EATING OUT		
EASYRIDE USE	No	Yes	Total
Never	24%	76%	100% (38)
Occasionally	26	74	100% (43)
Often	36	64	100% (42)

If anything, frequent Easyride users eat out less. This finding might be expected if these respondents are more disabled or poorer, and warrants further analysis.

TABLE V.13: Social Ties by Eating Out

Pilot Study, Wave II, N = 140

	EATING OUT		
SOCIAL CONTACTS	No	Yes	Total
1	60%	40%	100% (10)
2	43	57	100% (30)
3	29	71	100% (62)
4	12	88	100% (34)

The hypothesis of sociability seems to be borne out by this table. People with many contacts are much more likely to go out to eat than are people who have only one contact.

In the attempt to evaluate Easyride's influence on the social life of its passengers, changes in some of the social relationship variables which were asked in both 1977 and 1978 were related to whether or not respondents used Easyride, and if they did use the service, the frequency of their use. Table V.13 presents the "turnover" of the following question:

> "Is there a friend or acquaintance living in the city who you would like to visit but have not this past year because it is too hard to get there?

TABLE V.13: Respondents' Report That It Is Too Hard to Visit Friends in 1977 and 1978

Pilot Study (Raw Figures)

	1978	
1977	No	Yes
Yes	/37/	27
No	22	/38/

/124/

The number of cases in each cell of the table are given to make it clear both how large and how similar the two change cells are. Forty-nine out of 124 respondents (40%) shifted their response. With so much change, one might be able to discern the influence of some mechanism, such as transportation, that might have an effect on the difficulty people had in visiting their friends. On the other hand, since as many respondents reported having more difficulty visiting friends as did others who reported having less, if Easyride use explains respondents having less difficulty, it might be difficult to account for those who had more. Indeed, when Table V.13 is stratified by Easyride use, no differences between Easyride users and non-users are found. For the given sample, the given question, and the one-year time interval, it could not be demonstrated that Easyride use affected ease of social contact.

Table V.14 presented the turnover on the number of places respondents wanted to go but did not.

TABLE V.14: The Number of Places the Respondents Would Like To Go To But Do Not in 1977-78

Pilot Study (Raw Figures)

		1978		
1977	No place	1	2	3
No place	/4/	0	0	1
1	22	/6/	4	2
2	19	11	/7/	5
3	10	19	7	/6/

The table shows a general decline from 1977 to 1978, in the number of places to which respondents wanted to go, but did not. This decline does not seem to vary with the frequency of Easyride use (i.e., never, occasional, once a month, or more) in that between 71 and 74% of the users in each category show a decrease in the number of desired destinations which they could not reach in 1978. Nevertheless, the general downward drift in this statistic may reflect a trend to which Easyride contributes. Thus, among those who indicate a decrease in the number of unfulfilled desires for visiting places, the extent of the decrease (e.g., from 3 destinations to 1) is greatest among those who use the Easyride service most often.

VI. MORALE

a. Morale is a somewhat abstract idea which is often conceptualized in terms of such indicators as life satisfaction and subjective well-being. "Life Satisfaction" captures part of what is commonly meant by morale and is empirically measurable through people's responses to questions about their satisfactions and dissatisfactions with their health, their activity level, their formal and informal group participation, their education, and their income (Edwards and Klemmack,1973). Subjective well-being, on the other hand, seems a more inclusive concept (Larson, 1978) which measures people's affective experiences in terms of a positive-negative continuum. A related concept of morale refers to people's sense of independence, which itself includes at least two quite different ideas: a person's ability to get along without others' help -- "practical independence"--, and the feeling that one can manage, is not a burden to others, and is able to cope with the world. That older people should be supported in ways which maximize their independence is often mentioned as a motive behind public program policy. Part of this policy is oriented towards the minimization of public expense while another part includes as a goal not merely "practical independence" but also helping people to feel a "sense of independence". (HEW. #20, 1970)

Sometimes, summary questions such as the following are used to measure morale: "Taking all things together, how would

you say things are these days -- Would you say you are very happy, pretty happy, or not so happy?" and "As you grow older, do you find things are better, worse, or about the same as you expected Besides these two questions, respondents in the pilot study were also asked questions which make it possible to tap such other dimensions of morale as their sense of independence satisfaction, and optimism, level of activity, worries about safety, sense of limitation of free movement and actions, and feelings of isolation.

Respondents' answers to questions in the pilot study were analyzed to a great extent according to what is known about elderly people's morale so that it could be determined in what ways respondents resembled other populations of elderly people. Much of the literature about elderly people's morale indicates a high correlation between morale and self-assessments of health, various socio-economic factors, and degree of social interaction . Various studies contend that marital status and aspects of elderly people's living arrangements are conclusively related to morale in terms of subjective well-being and satisfaction. It is also suggested in the literature that single elderly people's well-being tends to be roughly equivalent to that of married persons, while widowed, divorced, and separated people tend to report lower levels of well-being (Pihlblad and Adams, 1972). Other studies show that age, sex, race, and employment show no consistent relationship to morale, especially when controls are

introduced for such factors associated with age as decreased health and financial resources, widowhood and loss of friends, and decreased activity (Edwards and Klemmack, 1973; Thompson, 1973; Clemente and Saver, 1974). Thus, poor health, low income, and a low degree or absence of social interaction are, among other factors, related to the expression of low morale. In addition, Reed Larson (1978) states that negative situational factors, particularly low income, appear to be related to a greater vulnerability to the impact of other negative experiences.

As Morris and Sherwood make explicit (1975), most studies of elderly people's morale assume that morale can be conceived of as consisting of a series of interrelated parts, some of which can be measured by self report items. Most studies also concede that one of the most important elements in older peoples' life situations, and the one which most strongly relates to subjective well-being, is how elderly people assess their health. Measurements of health are often based on respondents' self-assessments which have been shown to reflect even more than do medical assessments actual health status (Fillenbaum, 1979), though varying with such factors as social isolation, socioeconomic status (SES). (Maddox and Eisdorfer, 1962), and degree of social activity. It has been found that, relative to medical evaluations of their conditions, many elderly people assess their health quite positively having learned, presumably, to accept certain disabilities and limitation. Various studies also have found that poor health has a greater impact on

the well-being of older persons of lower, rather than higher SES . However, it must be emphasized that persons with poor health are less likely to participate in surveys, leaving only the reports of those whose health is better. For them, lowered well-being is associated with the pain, confinement, and uncertainty which accompany ill health.

Socio-economic status and related variables such as income, occupational success, and education also help to determine elderly people's morale (Larson, 1978). Larson found that older persons of lower SES tend to have lower subjective well-being and appear to be more vulnerable to the negative emotional effects of life situation contingencies. Maddox (1966) found that individuals maintaining a pattern of high activity and high satisfaction, in contrast to those maintaining low activity levels and low satisfaction, are likely to be higher in SES status as well as somewhat younger, in better health, and higher in average intelligence. Larson (1978) also implies that while SES is associated with a person's day to day morale, it is more highly correlated with a long term sense of well-being. He also suggests that there is a level of sufficient income, above which additional income is less consequential in determining elderly people's sense of well-being.

Yet another important predictor of elderly people's morale is their level of activity and social interaction. Those elderly people with low over-all activity levels tend to be comparatively dissatisfied and feel lonely, useless (Maddox, 1963) and no longer

the objects of affection (Kutner, et al, 1956). Yet individuals develop widely different modes of adjustment and styles of life, all of which can lead to feelings of satisfaction (Binstock and Shanas, 1976). One question that must then be addressed, and which Larson (1978) poses, is whether old people who choose to withdraw from social activity are more satisfied than are those whose withdrawal has been forced upon them. Because of the absence of longitudinal studies, the question which must also be posed is whether or not measures of well-being reflect life long personality characteristics on patterns of social activity which cannot be influenced by an increase or decrease in activity.

The need for further research on the relationship between elderly people's morale and their level of activity and social interaction becomes clear if one looks at specific areas of elderly people's social life. Larson (1978) believes that no studies have succeeded in correlating well-being with frequency of activity with family. (Edwards and Klemmack, 1973; Martin, 1973). However, he reports that studies across diverse populations have associated well-being with general measures of activity (Wylie, 1970; Havighurst, Newgarten and Tobin, 1968), though these relationships are not as strong for elderly people with higher SES and good health. Cutler (1973) and Edwards and Klemmack (1973) found that, when health and SES controls were introduced, participation in voluntary associations has a much weaker relation to well-being.

Much of this literature on activity level and social interaction has been criticized by Lowenthal and Haven (1968) for not considering the quality and intimacy of elderly people's activities. In their study, "Interaction and Adaptation: Intimacy as a Critical Variable", they found a significant relationship between morale and respondents' reports as to whether or not they had a confidant. They also found that for people who had a confidant changes in activity had no relation to morale. Other studies found that physical disability and the absence of a confidant tend to be associated with greater vulnerability and that effects of negative life situations are multiplicative.

In a study of life satisfactions, Wolk and Telleen (1976) studied the psychological and social correlates of life satisfaction as a function of residential constraints. They wanted to find out if there are social-psychological variables which consistently relate to satisfaction across the types of settings in which elderly people live. They found that self-assessed health, level of activity, economic sufficiency, and success with developmental tasks were significant predictors of life satisfaction. They also introduced the notion of developmental tasks and defined them as biological, psychological, or social age-related challenges which require a degree of successful resolution if development is to proceed. They discussed developmental tasks of later maturity as "defensive strategies" during which elderly people must work

harder to stay where they are. In this study, they quote from Lawton, Nahemow, and Teaff (1975) who found that elderly people residing in high-rise buildings manifested lower satisfaction and lower mobility, and from Cutler (1972, 75) who demonstrated a significant relationship between well-being and the availability of transportation. Wolk and Telleen also found that the social-psychological constraints placed upon elderly people by their residence influences both their level of satisfaction as well as the nature of the most important correlates of satisfaction. Earlier, Smith and Lipman (1972) investigated environmental constraints and stressed the importance of elderly people's ability to perform various self-care tasks, to move about, and to be gainfully employed, facets of their lives which can be facilitated by accessible, available transportation. Accessible, available transportation, in turn, influences elderly people's perception of their environment and their feelings about the amount of autonomy they have.

Besides concentrating on the predictors of elderly people's morale, many studies also discuss the methods of this kind of research. Morris and Sherwood (1975) cite the need to determine whether different types of people respond similarly to a battery of tests. Reed Larson (1978) states that morale data must be interpreted cautiously because of the almost exclusive reliance on survey self-assessments. He stresses the need for caution

when comparing scores across differing populations and he claims that such measures reveal little about individual informants because responses of single persons are likely to be shrouded by unique shades of meaning and individual response styles. Larson also states that because respondents' answers to survey questions are quick assessments given in a social situation, survey measures should not be interpreted as revealing "deep" psychological factors but, instead, are "statements about affective experience as might be expressed in day-to-day conversation with a friend". What they do provide, he claims, is important information about the social-psychological level of people's daily verbal behavior.

With these qualifications in mind, generalizations from the literature about elderly people's morale can be made.

1) Old people seem to be generally positive (or at least neutral) in their self-assessments, although individuals show considerable variation.
2) Only a small minority of elderly people appear to be either predominantly rejecting (negative) or ambivalent (equally positive and negative) in their self-concepts.
3) Elderly people's self-images are better among those who have higher SES, are living in communities rather than in institutions, and are men rather than women.
4) A lower proportion of old people 65+ than of younger people state that their health in general is good or excellent.

5) Older people have less sense of mastery over the conditions of their lives than do younger people and consider the world potentially less changeable.

6) In periods of worry or unhappiness, there is a decrease with age in seeking help from family and friends and an increase in seeking help through prayer.

7) Contrary to popular assumptions, old people are not exclusively preoccupied with personal concerns. Conditions in the world at large hold notably greater salience for old than young, although older people may be more pessimistic.

8) Older people are less likely to voice feelings of positive gratification.

9) Age is associated with a general diminution of opportunities for satisfaction.

10) Happiness reflects primarily the gratification derived from individuals' central relationships, especially those within their family.

11) Widowed elderly people may, on the average, feel less over-all satisfaction with their lives than do married elderly people and are thus less likely to show high morale.

b. History of Morale Variables

With this information in mind about the morale of elderly people, Easyride research attempted to show the relationship

between mobility and mental health status. To this end, various measurements of mental well-being were considered--the Havighurst Life Scale, The Anomia Scale, The Bradburn Affect Scale, and the Philadelphia Geriatric Center Morale Measure. However, all of these measures were deemed inappropriate, although a few questions from some were incorporated into later studies. These scales were considered inappropriate for Easyride research because the concept of morale they were intended to measure appeared too general to tap aspects of a person's life that might change through the availability of better transportation. In pretests, it also appeared that elderly people had trouble grasping abstract concepts of which these scales assumed an understanding and were disquieted by some of the questions.

In the pilot study, the initial plan was to measure mental well-being by a transportation-specific morale scale which was intended to provide a relatively specific item of information--mobility-related morale. However, it became clear that the measures tapping transportation-related morale were confounding issues that our analysis required to be kept distinct. We wanted to know the relationship between transportation and morale, the possible effects one might have on the other--not how much our respondents' ideas about this relationship changed. The study of the relationship required two separate measures: one of transportation use and another of morale.

In addition, measures of morale, of autonomy, and of competence which were used in the first wave of the pilot study, were revised in both form and content and have been expanded. Revision was undertaken because several questions in the original questionnaire "did not work", (i.e. their marginal distributions were too skewed or showed too little dispersion). Expansion was felt to be justified in part by a view expressed in the literature on evaluation studies (see, e.g., Boruch and Gomez, 1977) which argues that evaluation studies should measure a range of possible effects of a "treatment" and not just those narrowly specified in the objectives. It was also thought to be necessary to add to the pilot study questions which would measure autonomy, competence, and respondents' feelings that they have control over events in their lives. Hypothesizing that transportation would allow old persons not only to make plans but be better able to carry them out, to accomplish more, become better managers of their lives, and to exercise greater choice in what they might do, items were searched for that would tap these potential effects. However, it was soon apparent that these scales would also be inadequate. For example, the Rotter Scale, measuring internal-external control, would, if included, make the interview too long and would insufficiently focus on the variables of greatest interest to us. Moreover, where response categories of scales are dichotomous, we felt that they would be somewhat insensitive to small changes over time.

These difficulties led us to the conclusion that we had to rethink the morale measure and include measures for competence and autonomy. In addition, whatever new measures were selected had to meet the criteria of being easy and relatively quick to administer. Noting that Campbell, Converse and Rodgers had used a type of semantic differential technique in assessing "quality of life" and, after consultation with a social psychologist experienced in the use of morale and I-E measures who recommended using an "adjective approach" and given our own experience with the semantic differential technique, we decided to use such a technique to tap relevant dimensions of morale, autonomy, and competence. Several other virtues of the technique made the decision to move in this direction all the more compelling: the ease and rapidity of administration; the lack of positive or negative bias (both extremes are part of every item); the simplicity of vocabulary it requires; the relatively easy translation into Spanish; the necessity of respondents having to keep only two words in mind; and its potential sensitivity to change over time.

However, in pretesting the questionnaire, we found that we would have to adapt the technique for our old and very old sample population. Pretesting revealed that many old people had difficulty conceptualizing a 5 or 7 point continuum and so had difficulty locating their current feelings and attitudes on a scale. As a result of this pretest finding, we altered the form

of the questions and, in so doing, increased the time it takes to ask them. Now respondents are first given a forced choice, e.g.: These days would you say your life is mostly boring and monotonous or interesting and varied? Once the choice is made, degrees are asked on the assessment, e.g.: Is that a little, somewhat, or very boring (or interesting, as the case may be)? This adjustment appears to work very well.

The need to revise questions in the pilot study as well as the need to add new ones derived also from a reconceptualization of morale, autonomy and competence. Specifically, we sought to identify what dimensions of these constructs might react to improvement in the ability to get around and might therefore reflect the impact of Easyride.

With regard to morale, we focused on the following dimensions: interest in surroundings, interest in activity, feeling safe and free to go about, the absence of anxiety, restlessness, loneliness; positive evaluations of "life these days". In addition, we ask for assessments of satisfaction in several life domains (housing, social life, neighborhood, etc.) and asked a question about "worry" about the future.

In order to analyze these various dimensions of morale in both waves of the pilot study, 33 of the 37 variables by which morale was tested in wave II were subjected to a correlation analysis, in part by means of a factor analysis. From this last

procedure, 4 indices of morale were constructed for wave II variables: Limits which measures the feeling of being limited by factors believed by respondents to be external or at least external to their own volition; Safety--respondents' sense of safety from various dangers; Activity--respondents' interest in activity and their sense of how active they are; Aloneness --respondents' feelings about how isolated they are in the world. In addition, two indices were constructed made up of those morale items in the first wave which also appear in the second wave.

VI. c. Morale & Characteristics of Respondents

It now becomes of interest to ask what social characteristics and experiences of respondents are related to the different dimensions of morale -- Aloneness, Limits, Safety, and Activity -- after which the moral items that are in both wave I and II will be discussed.

As it was to be expected, the number of social contacts respondents reported was positively correlated to all 4 morale indices. This finding accords with the literature which discusses high positive correlations between morale and the degree of elderly people's social interaction -- more specifically, their activity levels and their formal and informal group participation in various activities. The literature also indirectly suggests a proposition which warrants further research, that old people's level of activity is as important as what activities they are

involved in: that going out has positive benefits in itself. (A more complete discussion of an index which measures the number of social contacts may be found in Chapter V, Social Support).

Respondents" self-assessments of their health were found to be another important predictor of morale. Health-self-assessments correlate strongly with three of the four morale indexes: that is, the more positively respondents assessed their health, the more positive their morale was as measured by the three morale indexes -- Limits, Safety, and Activity. Self-assessments of health correlate less strongly with the index Aloneness -- but it does correlate to some extent -- despite the heterogeneous nature of the variables which constitute this index.

Respondents' disability was measured according to three indices, a functional mobility index, a personal care index, and an overall functional index which combines these two. The following discussion of the relationship between disability and morale will focus on mobility and overall functional indices.

Mobility

In general, the 79 (out of 140) respondents who do not require assistance for any of the items included in the Shanas/Wilker Index of Functional Capacity for Mobility consistently show the highest morale as measured by the indices Aloneness (54%), Limits

(43%), Safety (37%), and Activity (43%); as mobility incapacity goes up, respondents tend to report having lower morale.

A clear example of how morale correlates with disability can be seen when the Limits index is related to disability. Only 5% of the respondents who need assistance for 2 to 3 of the mobility items rank in the most positive "Limits" category while 43% of those who require no assistance (as measured by their scoring in the "no item" category) have high morale as measured by this index. A similarly clear relationship is also seen in Table VI-2 between the activity index and incapacity for mobility, although the contrast between low and high disability and ranking in this index is somewhat less dramatic as shown in Table VI-1.

The relationship between Aloneness and disability deserves special note. Respondents who don't require assistance with any of the mobility items are the most likely by far not to feel alone. However, those needing assistance on two to three items are about equally likely to score in any category on the aloneness index. Of course, factors other than functional incapacity make people feel alone.

Also striking in Table VI-1 is the relatively few respondents, among those who need no assistance for the mobility items, who rank high on the Safety Index. These respondents are equally likely to indicate that they feel only moderately "safe" as they are to indicate that they feel safe. The Lower East Side, like many other parts of large cities, frightens old people even if

TABLE VI-1: Morale Indexes by Functional Capacity for Mobility: Pilot Study, Wave 2, n=140-3

	Functional Capacity for Mobility Needing Assistance on:		
	No items (N=79)	1 item (W=36)	2-3 items (N=22)
Aloneness			
-Most Alone	17%	25%	32%
Somewhat Alone	29	42	32
+Least Alone	54	33	36
Limits			
-Most Limited	24%	50%	56%
Somewhat Limited	33	22	41
+Least Limited	43	28	5
Safety			
-Least Safe	28%	47%	50%
Somewhat Safe	35	28	41
+Most Safe	37	25	9
Activity			
-Least Activity	27%	47%	50%
Somewhat Activity	47	36	36
+Most Activity	43	17	14

TABLE VI-2: Morale Indexes by Overall Functional Capacity: Pilot Study, Wave 2, N=140-3

	No Items (N=67)	1 Item (N=37)	2-6 Items (N=37)
Aloneness			
-Most Alone	14%	27%	27%
Somewhat Alone	29	41	32
+Least Alone	57	32	41
Limits			
-Most Limited	24%	38%	54%
Somewhat Limited	33	24	35
+Least Limited	43	38	11
Safety			
-Least Safe	24%	43%	51%
Somewhat Safe	38	24	38
+Most Safe	38	32	11
Activity			
-Least Active	21%	46%	51%
Somewhat Active	29	38	35
+Most Active	51	16	14

they are not disabled.

Morale and Overall Functional Capacity

When items which measure the functional capacity of respondents to do personal care tasks are added to the items tapping capacity for mobility, the relationship between morale and overall functional capacity varies according to the particular dimensions of morale that it is related to.

As with functional capacity for mobility, the relationship between overall functional capacity and the Limits index is fairly clear cut: those who do not need assistance on any of the six items are most likely to rank positively on the Limits index while those needing assistance on two or more items score the lowest on this index. Again the relationship between the Activity Index and the overall functional capacity is most similar to that between the Limits index and overall functional capacity.

Other Respondent Characteristics & Morale

It is of interest to know whether income is in any way related to respondents' morale. Income level is measured by whether or not respondents have Supplementary Security Income, (SSI). But the relatively small economic difference between those who do and those who do not have Supplementary Security Income does not affect their sense of safety. Other social differences -- the neighborhood, the social connectedness with other people -- are more likely to account for differences in the sense of safety. Meanwhile, the fact that this economic

difference does have an effect on the other dimensions of morale should not be ignored.

Living arrangements are uncorrelated with the four morale indexes but respondents who live with a spouse are particularly negative on the Limits and Safety Indices. Men score high on the Limits index, implying that they feel less limited by external constraints. Thus it appears that wives feel such constraints more, for which there might be many reasons, though in this age group a sick or disabled husband might constitute a very serious constraint, and indeed such a husband may also particularly deprive a woman of a sense of safety previously associated with having a man's company. If now,when they themselves feel more vulnerable, they have to do all the shopping and errands in a neighborhood that appears increasingly dangerous, on treacherous pavements that increase the danger of falling, it is not surprising that they score low on the safety index. Correlations were found with all the indexes except the Safety index.

In every case, except the safety index, higher economic level was associated with good morale. The respondents who get Supplemental Security Income were more negative on the Aloneness, Limits and Active indices. Respondents who live with their spouses scored positively on the Activity Index. The support and interaction with another may very well keep people more active; a confidant may also support a greater level of interest in what is going on.

A low correlation exists between the four morale indices and sex. Female respondents were more positive and males more negative on the Aloneness Index, a finding which might suggest that women are possibly more able, or more resigned, to manage on their own: Most of their husbands have died and they expect to have to manage on their own. On the other hand, as mentioned above, men score higher on the Limits Index; they feel less limited. Perhaps they, unlike the women respondents, are not as likely to have to take care of a sick spouse. Sex does not correlate with the Safety Index, possibly because for both men and women such other factors as disability, health and social contacts are the determining factors.

Some interesting findings emerged when the four morale indices were correlated with ethnicity. However, further study is warranted because the literature suggests that any correlations found are attributable to income and social interaction rather than ethnic differences. In the pilot study, Hispanics score more positively and Jews more negatively on the Aloneness and Active Indices, which may be related to the fact that the Hispanics on the lower East Side are more likely to be embedded in a younger community than the Jews. On the other hand, Jews scored more positively and Hispanics more negatively on the Limits and Safety Indexes. It seems reasonable that since Jews travel less, and therefore fear less for their safety, and complain less about limits because -- with increasing age and

level of disability--they have modified their expectations. In addition, it must also be noted that--according to the literature --when controls are introduced for such other factors associated with age as decreased health and financial resources, widowhood, loss of friends, and decreased activity levels, ethnicity shows no consistent relationship to morale. This lack of relationship may also be true for age. Age did not correlate with any of the indices except Activity. On the Activity Index, older respondents scored slightly more negatively.

The four morale indices also were correlated with three travel variables which measure the number of times respondents went out per month (the General Frequency Index), the number of destinations to which respondents went per month, and the distance respondents travelled to their most frequent destination.

The number of times respondents went out per month correlated positively with all four of the morale indices. That is, those taking the most trips consistently score highest on all morale indices, and, with one exception--the Activity Index, those taking the fewest trips are most likely to score negatively on morale. High travel frequency thus suggests high activity levels which may result in respondents feeling a general sense of satisfaction, not feeling lonely, and feeling that the outside world is accessible to them. Respondents who travel frequently are more likely to score high on the Activity Index than they are to score high on any of the other indices. The Activity Index stands out in one other respect: those who take the fewest trips

are equally likely to have negative feelings of how active they are as they are to have positive feelings of how active they are. Perhaps for infrequent travellers, feelings of how active they are depend on the particular destinations to which they travel.

TABLE VI-3: Morale Indices by General Frequency of Trips per Month: Pilot Study, Wave 2, N=140-2

	Number of Trips per Month:		
	0-25 (N=46)	26-45 (N=39)	46 or more trips (N=53)
Aloneness			
-Most Alone	43%	28%	17%
Somewhat Alone	26	46	34
+Least Alone	30	26	49
Limits			
-Most Limited	55%	36%	17%
Somewhat Limited	30	36	30
+Least Limited	17	28	53
Safety			
-Least Safe	43%	36%	28%
Somewhat Safe	39	41	26
+Most Safe	17	23	45
Activity			
-Least Active	33%	15%	6%
Somewhat Active	33	21	13
+Most Active	33	64	81

The number of destinations to which respondents go per month correlates strongly with the Limits and Active Indices and less strongly with the Aloneness and Safety Indices. The farthest distance on the most frequent destination to which respondents travel has a strong relationship to two of the Morale Indices, Limits and Safety.

Respondents who travel frequently a distance of 3-6 blocks score lower on the Safety and Limits Indices than do those travelling shorter or longer distances. One possible explanation for this finding is that respondents who can travel 3-6 blocks may be, in some respects, more transportation handicapped than are those who go 7-20 blocks, assuming that these latter respondents go to the hospital and may be transportation handicapped in the extreme sense that they cannot use transportation at all and make other arrangements to get there: they may not be able to negotiate one block on foot, much less three. Thus, for those who do walk 3-6 blocks, their travelling may be exceedingly difficult for them so that the amount of travelling they do will negatively affect their feelings--as measured on the Limitations and Safety Indices: They may feel limited because of their physical disabilities and fear for their safety. Respondents whose farthest distance on their most frequent destination was 7-20 blocks are most likely to have negative responses on the Activity Index, possibly because they travelled these distances

to get to their hospitals. No relationship was found between this travel variable and the Aloneness Index. Perhaps distance travelled does not relate to feelings of being alone and deprived, whereas other variables are most important predictors.

VI. d. Worry About Being Mugged

A good indicator in the pilot study which can be used to evaluate the impact of a transportation system such as Easyride on elderly people's sense of safety, a specific dimension of morale, is their worry about being mugged, which here will be further discussed. Respondents were asked to express their worry about being mugged in 1977, before Easyride was in full operation in the Lower East Side, and in 1978, when this transportation system had been in full operation for a year. The respondents in 1977 and in 1978 were asked "How worried are you about being mugged if you go out somewhere in the daytime? Would you say you are: very worried, pretty worried, not too worried or not worried?"

Response rates for both years is presented in the following table.

TABLE VIC-1: Reported Worry About Being Mugged in 1977-78

Pilot Study

	1977 (Wave I)	1978 (Wave II)
Very worried	56%	45%
Pretty worried	28	14
Not too worried, and not worried	16	41
TOTAL:	100%	100%
	(134)	(132)

In both years, more people were worried than were not worried about being mugged. However, in 1978 the percent of respon-

dents who are very worried is smaller than it was in 1977. In addition, the percent of respondents who are not too worried or not worried at all is larger in 1978 than in 1977.

To find out whether respondents who worried about being mugged in 1977 do not worry in 1978, their responses in both years are crosstabulated against each other in the following table.

TABLE VIC-2: Reported Worry About Mugging in 1978 by Reported Worry About Mugging 1977

Pilot Study, N = 140 (Raw Figures)

WORRY ABOUT MUGGING 1977	WORRY ABOUT MUGGING 1978		
	Very	Pretty	Not Too/No
Very	/39/	12	20
Pretty	12	/4/	20
Not too/no	6	2	/11/

/126/

Seventy-two out of 126 respondents (57%) shifted their responses: 41% became less worried or not worried in 1978, while only 16% who were either pretty worried or not worried in 1977 became worried in 1978. It can be assumed that a transportation system like Easyride might effect the lesser degree to which respondents worry about being mugged. Thus, perhaps it is likely that respondents who were worried about being mugged would intend to use a door-to-door transportation service like

Easyride. In Table VIC-3, respondents' reported intention to use Easyride is correlated to their reported worry about being mugged.

TABLE VIC-3: The Intention to Use a Free or Inexpensive Door-to-Door Transportation System by Reported Worry About Being Mugged

Pilot Study, Wave I, N = 140

Intention to Use a Free or Inexpensive Door-to-Door Bus Service	Worried About Being Mugged		
	Very	Pretty	Not Too/No
Maybe or Unlikely	29%	46%	45%
Yes	71%	54%	55%
TOTAL:	100%	100%	100%
	(73)	(35)	(20)

Respondents who are very worried about being mugged are more likely to say that they will use Easyride than are those who are less worried. Table VIC-4 correlates Easyride use with respondents' worry about being mugged.

TABLE VIC-4: Reported Use of Easyride by Reported Worry About Being Mugged

Pilot Study, Wave II, N = 140

	EASYRIDE USE			
WORRY ABOUT BEING MUGGED	Never	Occasional	More Often	Total
Very Much	19%	27%	54%	100% (52)
Pretty Much	45	33	22	100% (18)
Not Too Much/No	37	43	20	100% (51)

Respondents who are very worried use Easyride more often than do those who worry less about being mugged.

The results in Tables VIC-3 and VIC-4 suggest that respondents who are very worried about being mugged intend to use Easyride and did use it when it went into full operation. The following table correlates the changes in respondents' reported worry about being mugged from 1977 to 1978 by their use of Easyride.

TABLE VIC-5: Worry About Being Mugged in the Day When Going Out in 1978 by the Same Worry in 1977 And the Use of Easyride

(Raw Figures)

NEVER USED EASYRIDE

	Worry About Being Mugged (1978)		
Worry About Being Mugged (1977)	Very Worried	Pretty Worried	Not Too Worried
Very Worried	/6/	5	7
Pretty Worried	4	/1/	6
Not Too Worried	0	1	/5/

/35/

USED EASYRIDE OCCASIONALLY

	1978		
1977	Very Worried	Pretty Worried	Not Too Worried
Very Worried	/9/	3	7
Pretty Worried	2	/3/	9
Not Too Worried	3	0	/5/

/41/

TABLE VIC-5 (CONTINUED)

USED EASYRIDE OFTEN

Worry About Being Mugged (1977)	Worry About Being Mugged (1978)		
	Very Worried	Pretty Worried	Not Too Worried
Very Worried	/19/	3	6
Pretty Worried	5	/0/	2
Not Too Worried	3	1	/1/

/40/

Since the number of cases in the cells of this table are small, they are presented without percentaging. Only two digit numbers stand out: Among the frequent Easyride users, there is a disproportionate number of people who were very worried in 1977, and in 1978 were still very worried. Unfortunately it does not seem that Easyride has up to the time of the 1978 interviews alleviated the worries of this group. More Easyride users have become more worried, and fewer Easyride users have become less worried than Easyride non-users. While these tables were constructed with the intention of ascribing to Easyride a possible change Easyride had neither the anticipated improvements as its effect, not does it seem likely that it had the adverse effects that appear in these tables. When similar tables are constructed showing separately the change in worrying for respondents who have different numbers of social

ties--a favorite sociological explanation for any morale question--it turns out that indeed those who have fewer social ties tend more than any other group to become more worried. Since we know that Easyride users have fewer social ties than non-users, this seems a probable explanation of both the high level of worry and increasing worry among Easyride users. It may, nonetheless, be that in the longer run Easyride will help to connect these people with others, and through this mechanism, if no other, reduce their worries.

E. Morale and Easyride Use

In order to approach the relationship between Easyride use and a notion of morale more general than the specific worry about being mugged which is described in the previous section, two indexes of morale for which data are available from both 1977 and 1978 are here considered. Index 1 primarily measures isolation and travel deprivation, while index 2 taps worries about going out and deprivations of specific social contacts. (See list of items in the Appendix in this section.)

In Tables 1 and 3 (skipping Table 2 for the moment), we focus first on the row percentages in order to answer in what way morale in 1977 affected involvement with Easyride. The relationships to the two different indexes are remarkably similar: Those respondents in the highest morale category, while not noticeably different in terms of their ever using Easyride from those with lower morale, seem to avoid using Easyride frequently, "once a month or more often." In other words, it appears that morale has no bearing on respondents becoming Easyride users, but does make a difference as to whether respondents become <u>frequent</u> rather than occasional users. In particular, those with lower morale are more likely to become frequent users.

TABLE VI-E1: Index 1, Wave I, by Easyride Use

Pilot Study, Wave 4, N = 140

Raw Percents and Column Percents

	Easyride Use			
Index Score	Never Use	Occasionally	1x/month or more	Total
1. Low Morale	33% 37%	26% 26%	42% 42%	100% (43)
2.	31 31	23 21	46 42	100% (39)
3. High Morale	29 32	55 53	17 16	100% (42)
TOTAL:	100% (38)	100% (43)	100% (43)	

TABLE VI-E2: Index, Wave II, By Easyride Use

Pilot Study, Wave II, N = 140, Column Percents

Index Score	Never Use	Occasionally	1x/month or more
1. Low	26%	14%	23%
2.	16	16	23
3. High	58	70	53
TOTAL:	100% (38)	100% (43)	100% (43)

In considering the morale indexes for the second wave of interviews, we ask whether Easyride use affects morale. Accordingly, we study the column percents in Tables 2 and 4.

TABLE VI-E3: Index 1, Wave I, by Easyride Use

Pilot Study, Wave I, N = 140

	Raw Percents and Column Percents			
Index Score	Never Use	Occasionally	1x/month or more	Total
1. Low	33% 29%	24% 19%	42% 32%	100% (33)
2.	30 34	28 28	42 42	100% (43)
3. High	29 37	48 53	23 26	100% (48)
TOTAL:	100% (38)	100% (43)	100% (43)	

TABLE VI-E4: Index 1, Wave II, by Easyride Use

Pilot Study, Wave II, N = 140, Column Percents

Index Score	Never Use	Occasionally	1x/month or more
1. Low	18%	12%	40%
2.	32%	35%	32%
3. High	50%	53%	28%
TOTAL:	100% (38)	100% (43)	100% (43)

Index 1 (in Table 2) shows that occasional Easyride users have a higher morale than do the frequent "once a month or more" users who are very similar to those who never use Easyride. Index 2 (in Table 4), on the other hand, shows what might have been more expected: that frequent Easyride users have a much

lower level of morale. At this point, because we should compare each index for the two time periods, we include both column percents in Tables 1 and 3 as well as the raw percents we have already discussed, since this makes the comparisons between Tables 1 and 2, and Tables 3 and 4 possible.

It is immediately apparent that an enormous upward shift in morale, between 1977 and 1978, has occured. While we do not know how much the weather, the interviewers, or some unknown events influenced this shift, it is nonetheless worth noting that the shift towards better morale in Index I is vastly greater for the frequent Easyride users than it is for the other two groups. While their morale distribution is not quite as positive as that of the occasional users, it does reach the level of those who never use Easyride. Here, then, it appears that in this morale dimension, Easyride has made a real difference to its more frequent users. Index 2 shows, if anything, a slight decline in morale of the Easyride users while the non-users' morale improves. This draws our attention to the fact, implicit in the construction of indices, that there are different dimensions of morale; it will be interesting to find which dimensions respond to the changes that Easyride may bring about in people's lives. Inasmuch as Index 2 contains the item about worries about being mugged, it is not surprising, in the light of the previous section, if improvements in morale as measured by this index might not be found for Easyride users.

In Section III-a, it is shown that 1977 respondents who said that they would probably use an inexpensive bus service were more likely to become Easyride users than were those who expressed less interest in such a service. In 1978, those who had expressed a firm intention of using this service in 1977 expressed much less satisfaction with transportation than those who had expressed no, or only lukewarm, interest. Since it is not a far-fetched idea that those who had more interest had indeed been more dissatisfied, it is now of interest to ask whether among them, there was any difference in satisfaction with transportation depending on whether and how much they used Easyride. Table 5 shows that the percent dissatisfied is not very different between those who use Easyride once a month or more often and those who use Easyride less; but the percent Very Satisfied is dramatically higher among the frequent Easyride users than among those who use Easyride less.

TABLE VI-E5: Satisfaction With Transportation 1978 by Easyride Use in 1978 Among Those Reporting Their Intention to Frequently Use a Door-to-Door Minibus in 1977. N = 71

	Satisfaction			
Easyride Use	Dissatisfied	Satisfied	Very Satisfied	Total
Never	#25%	#75%	#0%	100% #(12)
Occasionally	28	64	8	100% (25)
Often	21	38	41	100% (34)

#N < 15

This happy note seems an appropriate conclusion to a section on morale.

VI - Appendex

Each of the 4 moral indexes, aloneness, limits, safety, and activity, are constructed by variables from questions in the Wave II interview. These questions are here listed by the index to which they belong.

1. Aloneness — some of the time — most of the time

(check one)

a. Do you feel that most people nowadays:

		some of the time	most of the time
Are friendly	(_____)	4	5
or			
Are unfriendly	(_____)	2	1

b. You feel that others care

		some of the time	most of the time
about you	(_____)	4	5
or			
You feel alone in the world	(_____)	2	1

c. I would like to find out now about various aspects of your life these days. For each one of things I mention, I'd like to know whether you are satisfied or dissatisfied: and if you are satisfied, are you very or somewhat satisfied, and if you are dissatisfied are you somewhat or very dissatisfied.

	vs	ss	mw	sd	vd	na
Your social life	1	2	3	4	5	9

1. Aloneness (Con't)

d. If some emergency came up in the lives of your (children) or (close friend) is it likely that you would go and help out?

1. Very likely.....1
2. Somewhat likely.....2
3. Not likely at all.....3

e. If some emergency came up, can you depend on one of your (children) or their (spouses) or (close friends) to come and help out?

1. Yes, definitely.....1
2. Yes, probably.....2
3. Unlike ly.....3
4. Definitely No.....4

f. If you needed help for a longer period--say a couple of weeks--can you depend on one of your (children) or their (spouses) or a (close friend) to help you out during that time?

1. Yes, definitely.....1
2. Yes, probably.....2
3. Unlikely.....3
4. Definitely No.....4
5. Would send money or other help.....5

g. Compared to a year ago, do you now get out and do things?

1. More often.....1
2. Less often.....2
3. About the same.....3

h. Compared to a year ago, do your friends and relatives visit you?

1. More often.....1
2. Less often.....2
3. About the same.....3
4. Doesn't apply.....4

i. Compared to a year ago, do you go out and visit friends and relatives?

1. More often.....1
2. Less often.....2
3. About the same.....3

2. Limits

All in all these days, do you feel (probe: which do you feel more?)		Just a Little	Somewhat	Very
a. Young	(____)	5	6	7
or				
Old	(____)	3	2	1
b. Trapped in your house	(____)	3	2	1
or				
Free to go out	(____)	5	6	7
c. You have a lot to complain about	(____)	2		1
or				
You have little to complain about	(____)	4		5
d. You are easily upset	(____)	2		1
or				
You take things calmly	(____)	4		5

e. Are there times when you don't go to the doctor or to the clinic because it's hard for you to get there? Would you say this happens:

Often.....1
Sometimes.....2
Never.....3

f. Do you feel you get to enough places to give your life some variety or change?

Yes, definitely.....1
To some extent?.....2
No?.....3

g. Do you feel like you're a prisoner in your house these days? Would you say:

Very much?.....1
A bit?.....2
Not at all?.....3

2. Limits (Con't)

h. Are there times when you stay at home when you want to go somewhere because you feel you'll be imposing on someone to take you?

Often.....1
Sometimes.....2
Never.....3

i. Is there a friend or acquaintance living in the city who you'd like to visit but haven't this past year because it's too hard to get there?

Yes.....1
Yes, but other reasons are involved.....2
No.....3

J. I would like to find out about various aspects of your life these days. For each on the things I mention, I'd like to know whether you are satisfied or dissatisfied. If you are satisfied are you very or somewhat? and if you are dissatisfied are you very or somewhat?

	vs	ss	mw	sd	vd	na
Your housing (the place you live)	1	2	3	4	5	9
The neighborhood in which you live	1	2	3	4	5	9
The health care you receive	1	2	3	4	5	9
Transportation available to you	1	2	3	4	5	9

3. Safety

a. How worried are you about being mugged if you go out somewhere in the daytime? Would you say you're:

Very worried?.....1
Pretty worried?.....2
Not too worried?....3

b. How worried are you about falling down in the street if you go out somewhere? Would you say you're:

Very worried?.....1
Pretty worried?.....2
Not too worried?....3

c. All in all these days, do you feel		Just a Little	Somewhat	Very
Safe?	(_____)	5	6	7
Or		_____	_____	_____
Unsafe?	(_____)	3	2	1

4. Activity

These days do you find that		Is that so Some of the time	Most of the time
a. You would like more to do?	(_____)	4	5
or		_____	_____
You would like less to do?	(_____)	2	1
b. You are energetic?	(_____)	4	5
Or		_____	_____
You have no pep?	(_____)	2	1
c. You are not interested in the news of the day?	(_____)	2	1
or		_____	_____
You are interested in the news of the day?	(_____)	4	5

4. Activity (Con't)

d. Do you feel that you are likely to have some interesting experiences if you go out somewhere? Would you say:

Very likely?.....1
Maybe?.....2
Unlikely.....3

e. As you grow older, do you find things are better, worse, or about the same as you expected?

Better.....1
Worse.....2
About the same...3

f. I would like to find out now about various aspects of your life these days. For each of the things I mention, I'd like to know whether you are satisfied or dissatisfied. If you are satisfied are you very or somewhat and if you are dissatisfied are you very or somewhat

	vs	ss	mw	sd	vd	na
The activities of your senior center or other social activities	1	2	3	4	5	9
Stores you shop in	1	2	3	4	5	9
The food you eat	1	2	3	4	5	9

Index I & II each are composed of 4 variables which were asked in both 1977 & 1978

Index I

1. Do you feel you get to enough places to give your life some variety or change?

   Yes, definitely.....1
   To some extent.....2
   No.....3

2. Do you feel like you're a prisoner in your house these days? Would you say:

   Very much?.....1
   A bit?.....2
   Not at all?.....3

3a. If you go out somewhere by yourself do you feel like you're alone in the world?

   Often?.....1
   Sometimes?.....2
   Never?.....3

3b. These days do you find that	Some of the time	Most of the time
You feel others care about you? (____)	4	5
or		
You feel alone in the world? (____)	2	1

4. Do you feel that you are likely to have some interesting experiences if you go out somewhere? Would you say its:

   Very likely?.....1
   Maybe?.....2
   Unlikely?.....3

Index II

1. How worried are you about falling down in the street if you go out somehwere? Would you say you're:

   Very worried?.....1
   Pretty worried?.....2
   Not too worried?.....3

2. How worried are you about being mugged if you go out somewhere in the daytime? Would you say you're:

   Very worried?.....1
   Pretty worried?.....2
   Not too worried?.....3

3. Are there times when you stay at home when you want to go somewhere because you feel you'll be imposing on someone to take you?

   Often.....1
   Sometimes.....2
   Never.....3

4. Is there a friend or acquaintance living somewhere in the city who you'd like to visit but haven't this past year because it's too hard to get there?

   Yes.....1
   Yes, but other reasons involved.....2
   No.....3

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